Third Party Payer Policy for PAs

Enrollment/Credentialing

Almost all private insurance companies cover medical and surgical services provided by PAs. However, with scores of different payers and plans, including preferred provider organizations (PPOs) and health maintenance organizations (HMOs) providing coverage in the United States, there may be differences both in how services delivered by PAs are covered and how claim forms should be filled out. Even within the same insurance company, PA coverage policies can change based on the particular plan type or the specific type of service being provided.

- **Although many private payers do not separately credential PAs or issue provider numbers, PAs are generally covered for most services they provide.**
- **Each practice must ascertain payment policy and claims submission instruction *from each payer with whom they contract***.

When plans do not credential or issue provider numbers to PAs, they typically instruct the practice to bill the service under the name of the supervising physician, occasionally with a modifier code attached. It is critically important that one not assume a policy for billing for PAs. Obtain specific information from a reliable source within the insurer, preferably in writing. Consider starting with your payer's provider representative.

How to Handle Claim Denials from Private Insurance Companies

Before challenging a claim, examine the reason for your denial. The reason for the payer's denial can be found on the Explanation of Benefits or EOB. In some cases, the denial may have been caused by a clerical error such as an incorrect CPT code, a missing signature, or another simple oversight.

A denial of coverage because a PA performed the service is usually phrased as "service only covered when provided by an M.D. or D.O." or "physician assistants not considered authorized providers under the plan." In some cases, first assisting at surgery claims are denied for incorrect use of modifier codes (Do not assume that all companies use the same code; some use -AS, some use -80, -81, or -82.) and in other cases, those claims are denied because of the use of a restricted code or for performing a surgery not necessarily requiring a first assistant. You may need to contact the insurance company to find out what modifier should have been used and, in some cases you may need documentation that a first assistant was medically necessary for the surgery.

Insurance companies strive to (1) retain their subscribers, (2) maintain or increase their market share, and (3) keep a positive corporate image. If the insurance company made the coverage decision and you believe that the coverage decision was unfair, enlist the help of the patient and, if applicable, the business that pays the insurance plan's premium. Their dissatisfaction is

Of greater concern to the insurer with regard to the above-mentioned three areas than you not getting paid. AAPA maintains sample letters contesting claim denials and will also send letters to insurers to substantiate your appeals.

What Should I Do if My Claim Gets Denied by a Private Payer?

If your claims get denied by a private payer, follow these four steps:

- Find out why the claim was denied and attempt to remedy the problem if it was caused by an administrative problem.
- If the claim was not denied for administrative reasons, assemble facts to support your decision to perform that service (e.g., relevant state law, delegation agreement, etc.).
- Prepare your strategy involving the patient, the business purchasing the coverage, and the AAPA reimbursement staff, as needed.
- Write a letter to the insurance carrier explaining the problem and demonstrating why paying for the service is fair and in the best interest of their company.

Third Party Payer Payment Policy Tips

- **Each practice must ascertain payment policy and claims submission instruction from each payer with whom they contract**. When the practice is negotiating contracts with payers, it is an ideal opportunity to ask detailed questions about billing methodology and to obtain claims submission guidance for services provided by PAs.
- Do not assume a payer "follows Medicare."
- Be specific. Walk through the 1500 form box by box.

Resource:

AAPA has compiled a list of questions, and various ways to ask them, in the questionnaire that follows. Some practices have emailed their provider reps using these questions, receiving answers and instructions in writing electronically for their files. Others have chosen to use the questionnaire as a "script" when speaking directly with the payer representatives. Either way, it is a good idea to keep good notes, and record the name of the representative, date and time to tuck away in the payer's file with the contract. As payer policy or instructions change, or when the contract is up for renewal, review the information to ensure that it is current.

Third Party Payer Questionnaire

_____ _____

(Payer Name) (Date obtained)

1. Coverage/Recognition

When the PA in our practice sees patients, how should the claim be submitted?

Are PAs (physician assistants) covered providers according to your plan?

If the payer answer is “No”, be sure to ask if it is appropriate to bill for PA services under the physician’s number/group tax ID.

2. Credentialing/Enrollment

Are PAs credentialed by your plan? Are PAs enrolled in your plan?

What is the process for credentialing and/or enrollment?

Is it the same process/form as physicians?

Do you use CAQH?

3. Provider Numbers (Note: All PAs should have NPI numbers.)

Is the PA’s NPI number utilized?

Are PAs issued provider (PIN) numbers by your plan?

4. Billing/ Claims Submission Instructions

How should PA services be billed?

Examples:

- under the PA’s name/NPI/plan provider #;
- under the physician’s name/NPI/plan provider #;
- under PA’s name, group tax ID #?

Ask for specific instructions for completing claims on the 1500 form for services provided by PAs.

Examples:

- What information, if any, goes into Box 24 J?
- Box 33?
- Whose signature, if any, is required?

5. Reimbursement Rate

What is the reimbursement rate for services provided by PAs? (Rate is usually expressed as a percentage of the contracted physician rate/fee schedule.)

Disclaimer: This summary is provided for informational purposes only and does not constitute legal or payment advice. The ultimate responsibility for statutory and regulatory compliance, as well as the proper submission of claims, rests entirely upon the provider of services.

Do you defer to state law to define physician supervision of PAs?

7. Scope of Practice/Covered Services

Does your plan defer to state law to define PA scope of practice?

Are there any limitations to covered services provided by PAs? (Some plans do not allow coverage for consultations, critical care services, behavioral health services, assisting at surgery...)

8. Assist at Surgery

Are PAs covered for first assisting at surgery by your plan?

Does your plan have a list? (approved procedures or exclusion list)

What modifier should be used for PAs assisting at surgery?

What is the reimbursement rate for PAs first assisting at surgery, as a percentage of the primary surgeon's fee?

Does your plan require prior authorization for PA first assistant at surgery?

May claims for assist at surgery (performed by the PA) be submitted on the same claim as the surgeon's claim for the surgery, or must they be separate?

9. Provider Directories

Are PAs listed by name in any provider directories made available to patients?

May they be listed as PCPs?

10. Hospital Setting

Are PAs covered when providing services in the hospital setting?

Is state law used to guide the services PAs deliver?

If a PA is hospital-employed, but the supervising physician is not, how are the PAs professional services covered by your plan? (Example: PA's NPI in Box 24J, hospital tax ID in Box 33).

11. Plan Types

Does your plan have both fee-for-service plans and managed care plans? Medicare Advantage Plan?

Are the policies for each plan the same in regards to PA services?

Does the managed care plan have a patient panel size for a physician practice?

If yes, what is the panel size?

If a PA joins the practice, does the panel size for the practice increase? If yes, by how many?

12. Special Policy Considerations-"Incident-to"

Note: "Incident-to" billing is a MEDICARE provision with specific rules and conditions that, when all elements are met, allows for a service provided by a PA to be billed under the physician's NPI with reimbursement at the full physician rate. Plans that enroll PAs may also recognize "incident-to" billing.

This is NOT the same as plans who choose not to enroll PAs and claims are submitted under the physician's NPI. Unless specifically stated, do not assume that "Incident-to" rules apply in order to submit claims for PAs. In most cases, no on-site physician is required, nor is the physician required to see the patient on the initial visit, unless specifically stated in policy.

Q: Does this plan recognize/allow for "Incident-to" billing? What are the conditions that apply? (Does this plan recognize "incident-to" consistent with Medicare policy?)

13. Miscellaneous

Do you require physician co-signature on medical records prepared by PAs? (Note: Most plans defer to any state law requirements for chart review and/or co-signature.)

For practices also utilizing Nurse Practitioners/APRNs:

-Are the policies of your plan pertaining to nurse practitioners (NPs) different from those pertaining to PAs?
-If yes, how specifically?
-Are NPs listed as providers?
-Do they bill under their own provider numbers?
-What is their reimbursement rate?

NOTES:

- ✓ Be sure to document the name and contact information of the plan representative providing the information.

- ✓ Ask for references and/or copies of pertinent policy manual citations.

Last Updated: March, 2016

Disclaimer: This summary is provided for informational purposes only and does not constitute legal or payment advice. The ultimate responsibility for statutory and regulatory compliance, as well as the proper submission of claims, rests entirely upon the provider of services.