



Third-Party Reimbursement for PAs

PAs work to ensure the best possible care for patients in every specialty and setting. Their rigorous medical education, versatility, and commitment to collaborative care help practices function efficiently while providing increased revenues and enhanced continuity of care.¹⁻⁴ Medicare, Medicaid, TRICARE, and nearly all commercial payers cover medical and surgical services delivered by PAs. Because of variation in policies pertaining to claims filing, it is crucial to verify each payer's specific coverage policies for PAs.

MEDICARE

Services provided by PAs are covered by Medicare in all practice settings at 85 percent of the physician fee. Generally, all services for which Medicare would pay if provided by a physician are covered when performed by a PA, in accordance with state law. Those include services provided in an office or clinic, any hospital department—including the emergency department—a skilled nursing facility, ambulatory surgical center, and patient's home. Medicare defers to state law on collaboration requirements.[†]

PA claims are submitted to Medicare at the full physician charge. Use of the PA's National Provider Identifier (NPI) number alerts the Medicare Administrative Contractor (MAC) to pay at 85 percent.

PAs are authorized to treat new and established patients with new, chronic, or worsened medical problems when billing Medicare under their name and NPI. Medicare rules do not require the physician to see, treat, or be physically present with the patient when a PA provides a service that is billed to Medicare under the PA's name. The Medicare program designates a limited number of services that can be performed only by physicians.

Office-based services

High-performing private practices and clinics may bill for services provided by PAs using PA NPI numbers, accepting Medicare reimbursement at 85 percent of the physician charge. Despite the 15 percent differential this approach allows maximum efficiency in scheduling new Medicare patients and those being seen for new conditions.

Practices have the option of billing under Medicare's "incident to" provision, using a collaborating physician's name and NPI number when indicating who provided the service. This results in Medicare reimbursement at 100 percent of the fee schedule, as long as the following requirements are met:

1. The physician personally treats, establishes the diagnosis, and develops the plan of care for a Medicare patient on the first visit in the office for a particular medical problem.
2. The physician personally treats and diagnoses established Medicare patients who present in the office with new medical problems.
3. A PA must be following the plan of care established by the physician.
4. A physician in the group (need not be the same physician who originally treated the patient) is physically on site when the PA provides follow-up care on a future visit.

[†] AAPA policy describes the working relationship between PAs and physicians as collaborative. Medicare uses the term supervision.

5. The physician has an active part in the ongoing care of the patient. Subsequent services by the physician must be of a frequency that reflects his/her continuing active participation in, and management of, the course of the treatment.

If a practice is audited, the auditors will look for verification that the above “incident to” criteria were met, if records indicate that billing was submitted using the physician’s NPI.

Hospital-based services

Services provided by PAs in hospitals (inpatient, outpatient, operating room, or emergency department) may be billed as evaluation and management (E/M) services using PA NPI numbers with reimbursement at 85 percent of the physician charge, or as “shared visits” (reimbursed at 100 percent) if specific requirements are met. According to Medicare policy, hospitals may bill under the physician’s name when a PA and a physician each personally “provide any face-to-face portion of the E/M encounter with the patient” on the same calendar day.⁵ A PA and a physician must perform “a *substantive portion* of an E/M visit” with the same patient on the same calendar day, defining “substantive portion” as all or some portion of the history, exam, or medical decision-making key components of an E/M service. PA and physician must have the same employer. MAC documentation rules on shared visits vary by state; it is critical to know the specific policy of the local MAC.

If a hospital employs a PA, only the hospital is authorized to receive reimbursement for the PA-provided services. A physician who is not employed by the hospital can supervise a hospital-employed PA but may not capture or benefit from the PA’s reimbursement or professional work. There may be lease agreements and other arrangements that would allow a physician not employed by the same entity as the PA to receive remuneration for their work.

Professional services delivered by hospital-employed PAs must be billed to Medicare Part B. Hospitals may not include PA salaries in their Part A cost reports unless the PAs are providing nonclinical, administrative services. The percentage of a PA’s time/salary dedicated to administrative responsibilities may be placed in the hospital’s cost report.

Medicare restricts coverage for PAs, nurse practitioners, and physicians who first assist in teaching hospitals, with limited exceptions. Qualified residents and fellows have priority. This restriction applies only to first assisting at surgery; the presence of residents or fellows does not limit the ability of PAs to deliver and be reimbursed for all other eligible services in the hospital.

Physician involvement

Medicare generally follows state law regarding the need for physician involvement/collaboration. Previously, Medicare used the term “supervision” to describe the relationship between PAs and physicians. Recognizing the increasing value of PA practice, state laws are moving away from the concept of physician supervision and using other terms that provide PAs with a high degree of practice autonomy. Physicians need not be physically present when PAs provide care to a Medicare patient, unless required by state law or facility policy. Having the physician review or co-sign a patient’s chart, or discuss the patient with the PA, does not allow billing the PA-provided service under the physician’s name.

Certain optional billing provisions, such as “incident to” in the office or clinic and shared visit billing in the hospital setting require a higher level of physician involvement. Medicare does not require that either of these billing mechanisms be utilized. PAs can treat Medicare patients with a high degree of

autonomy and without direct physician involvement if the service is billed under the name and NPI of the PA.

PA employment status

PAs may be W-2 employees, “leased employees,” or independent contractors. In every case, the PA’s employer bills Medicare and receives reimbursement for services provided by the PA.

NPI numbers

All healthcare professionals who transmit or receive healthcare information electronically, including insurance billing, must have an NPI number. An NPI number can be [obtained from CMS](#).

Medicare enrollment

After obtaining their NPI, PAs who treat Medicare patients should enroll in the Medicare program using the Provider Enrollment, Chain, and Ownership System (PECOS) [online enrollment system](#).

PA ownership

If a state-approved corporate entity (e.g., professional medical corporation) qualifies as a provider of Medicare services, then CMS will allow PAs to own up to 99 percent of the corporation. Anyone who is not a PA may own the rest, as allowed by state law.

MACRA/QPP

Signed into law in 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) repealed the sustainable growth rate formula and combined various Medicare quality and value programs into the Quality Payment Program (QPP). PAs qualify as eligible clinicians and in most instances are required to participate in one of two reporting and reimbursement tracks: the Merit-Based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models (Advanced APMs).

MEDICAID

All 50 states and the District of Columbia cover medical services provided by PAs under Medicaid fee-for-service or Medicaid managed care programs. The reimbursement rate is either the same as or lower than that paid to physicians. Medicaid programs in forty-four states and DC specifically enroll PAs in their programs. Whether enrolled or not, most services PAs deliver to Medicaid beneficiaries are covered.

TRICARE

TRICARE, the health benefit program for all seven uniformed services of the U.S. military, covers all medically necessary services provided by a PA. The physician with whom the PA works must be an authorized TRICARE provider. The employer bills, indicating the PA as the provider of care, and is reimbursed for services provided by the PA. Coverage under TRICARE for PAs is at 85 percent of the physician fee schedule, including for assisting at surgery. The program does not permit “incident to” billing for medical services provided by PAs. However, there are instances in home, office, or hospital care when a PA and physician can perform components of a procedure, other than assistant-at-surgery, and bill the combined service using the physician’s NPI number. In these cases, the allowable charge “may not exceed the allowable charge for the procedure rendered by a physician.”⁶

COMMERCIAL INSURANCE COMPANIES

Nearly all commercial payers reimburse for services provided by PAs; however, billing terms vary. Take four big insurers for example—Aetna, Anthem, Cigna, and United Health Group (UHG).

- Aetna, Anthem, and Cigna determine who is a primary care provider (PCP) by following state law. UHG policy says if the supervising physician is a PCP, the PA can be a PCP.
- Aetna, Cigna, and UHG allow claims for services provided by PAs to be submitted identifying the PA as having rendered the services. Anthem identifies PAs on claims as having rendered services in ten states but requires attribution of the services to a physician in four others.
- Aetna and UHG list PAs in provider directories. Cigna lists credentialed PAs. Anthem policy says state law determines whether PAs are included in provider directories.

Given these and other variations, checking with individual payers about how they want PA-provided services billed is essential.

LACK OF TRANSPARENCY AFFECTS PAs

Billing for medical services provided by a PA under the name of the physician (for example, under “incident to” or shared visit provisions) creates a lack of transparency in the billing process that could have negative consequences for PAs in programs such as MIPS. The result is PA care and productivity that is “hidden” or not reported within the Medicare claim systems and databases. A PA cannot be evaluated on care quality metrics when the care he or she delivers is attributed to another professional. Similar transparency concerns exist under Medicaid and commercial payers due to lack of enrollment.

AAPA advocates for increased transparency that would permit services performed by PAs to be correctly attributed to them. Transparency of PA-provided services is particularly important as quality reporting programs and publicly facing comparative websites, such as Physician Compare, rely on the accuracy of such data to assess PA capability and reimbursement.

Enrolling PAs and billing services under their names to identify them as distinctly recognizable professionals on claims creates clarity and accountability for PA-provided patient care services.

THIRD-PARTY PAYMENT RESOURCES ONLINE

The single most comprehensive resource on billing for PA services is “[The Essential Guide to PA Reimbursement](#),” available through the [AAPA Store](#). AAPA members pay \$25. Nonmembers pay \$125.

[AAPA’s Reimbursement webpage](#) is the access point to a wide range of topics related to payment for services provided by PAs.

Disclaimer

Every reasonable effort is made to ensure the accuracy of this information. The final responsibility for the correct submission of claims and the understanding of payer regulations and requirements remains with the provider of the service and with those who submit claims. Medicare, Medicaid and commercial payer policies change frequently. The information presented is not meant to be construed as legal, medical or payment advice.

References

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- ⁶ TRICARE Policy Manual Sections 6010.58-M. <http://manuals.tricare.osd.mil/> Accessed April 13, 2018.

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