

National Coverage Provision

Subject Name: Physician Assistants

Policy Number: PHYS-026

- A. *As of **January 1, 1987 through December 31, 1997**, the services of a Physician Assistant were payable by the Medicare program using the following:*
1. *They are performed by a person who meets the definition of a PA;*
 2. *They are services which are considered physician's services if performed by a doctor of medicine or osteopathy;*
 3. *They are performed under the supervision of a physician (MD or DO) for patients who are in a hospital, skilled nursing facility, intermediate care facility, or are the services of an assistant-at-surgery;*
 4. *They are not otherwise precluded from coverage because of Medicare policies and regulations, even though they may be within the scope of practice of the PA.*
- B. *As of **January 1, 1989**, the PA may perform the services in a designated rural Health Professional Shortage Area, (HPSA) regardless of the site of services.*
- C. *Effective for services rendered **on or after January 1, 1998**, any individual who is participating under the Medicare program as a physician assistant for the first time ever, may have his or her professional services covered, if he or she meets the qualifications listed below; and he or she is legally authorized to furnish PA services in the State where the services are performed. PAs who were issued billing provider numbers prior to January 1, 1998, may continue to furnish services under the PA benefit.*
- D. **Qualifications for Pas**
- In order to furnish covered PA services, the PA must meet the conditions as follows:*
1. *Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA); or*
 2. *Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and*
 3. *Be licensed by the State to practice as a physician assistant.(To be licensed in the State of Wisconsin, they must have the PA Certified (PA-C)status.*
- E. **Covered Services**
- Coverage is limited to the services a PA is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law).*
1. **General.**--*The services of a PA may be covered under Part B, if all of the following requirements are met:*
 - a. *They are the types of services that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);*
 - b. *The services are performed by a person who meets all of the PA qualifications; and*
 - c. *The PA is legally authorized to perform the services in the State in which they*

are performed;

- d. The services are performed under the general supervision of a MD/DO; and
- e. The services are not otherwise precluded from coverage because of one of the statutory exclusions.

2 **Types of PA Services That May Be Covered**

State law or regulations governing a PA's scope of practice in the State where the services are performed applies. Consider developing lists of covered services based on State scope of practice.

Examples of the types of services that PAs may furnish include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of their State license, PAs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician.

F. **Incident To A Physicians Service.**

If covered PA services are furnished, services and supplies furnished incident to the PA's services may also be covered if they would have been covered when furnished incident to the services of an MD/DO, as described in MCM §2050 and in PHYS004.

G. **Services Otherwise Excluded From Coverage.**

PA services may not be covered if they are otherwise excluded from coverage even though a PA may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care and, routine physical checkups, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within a PA's scope of practice under State law.

H. **Physician Supervision**

The PA's physician supervisor (or a physician designated by the supervising physician or employer as provided under State law or regulations) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone if necessary, unless State law or regulations require otherwise.

I. **Employment Relationship**

Payment for services of a PA may be made only to the actual qualified employer of the PA that is eligible to enroll in the Medicare program under existing Medicare provider/supplier categories. If the employer of the PA is a professional corporation or other duly qualified legal entity, (such as a limited liability company or a limited liability partnership), properly formed, authorized, and licensed under State laws and regulations, that permits PA ownership in such corporation or entity as a stockholder or member, that corporation or entity as the employer may bill for PA services even if a PA is a stockholder or officer of the entity, as long as the entity is entitled to enroll as a "provider of services" or a supplier of services in the Medicare program. PAs may not otherwise organize or incorporate and bill for their services directly to the Medicare program, including as, but not limited to as sole proprietorships or general partnerships. Accordingly, a qualified employer is not a group of PAs that incorporate to bill for their services. Leasing agencies and staffing companies do not qualify under the Medicare program as "providers of services" or suppliers of services.

J. **Payment for PA services:**

On or after January 1, 1998, payment is made on an assignment-related basis only. Payment for PA services is made only to the PA's employer, regardless of whether the PA is employed as a W-2 employee or whether the PA is a 1099 employee, who is acting as an independent contractor. Accordingly, while a PA has an option in terms of selecting employment arrangements, only the "employer" (W-2 or 1099 as the case may be) can bill a carrier or intermediary for the PA's services.

1. *The Balanced Budget Act (BBA) of 1997 increases the payment to 80% of either the actual charge or 85% of the physician fee schedule amount. For assistant -at-surgery services, payments equal 80% of the lesser of either the actual charge or 85% of the physician fee schedule amount paid to a physician serving as an assistant-at-surgery. The limitation **does not** apply to:*
 - Mammography screening (CPT 76092); including all components (26, TC, or total).
 - Influenza (CPT 90724), pneumococcal (CPT 90732), and hepatitis B (CPT 90744-90747) vaccinations and their administration (HCPCS G0008-G0010).
 - The technical component (TC) of radiology services (CPT 70000-79999).
 - The technical component (TC) of pathology services (CPT 88304-88399).
 - The technical component (TC) of electrocardiographic services (CPT 93005, 93012, 93017, 93041, 93202, 93208, 93221, 93225, 93226, 93231, 93232, 93236, 93270, 93271, G0005, G0006, G0015).

2. *Effective January 1, 1998, payments are allowed for services furnished by these non-physician practitioners in all areas and settings permitted under applicable state licensure laws, but only if no facility or other provider charges is paid or any amounts are paid with respect to the furnishing of such professional services.*
 - a. *A facility or other provider includes a hospital, SNF, NF, comprehensive outpatient rehabilitation facility (CORF), ASC, community mental health center (CMHC), rural health center (RHC), or federally qualified health center (FQHC).*
 - *In most cases, separate payment is allowed for services provided in a facility setting. For example: Professional services furnished to patients in a partial hospitalization program provided by a CMHC or a hospital outpatient department, are covered and paid. These professional services are unbundled from the partial hospitalization benefit and billed to the carrier by the employer of the PA.*

 - b. *Ordering and referring services are included in the payment for services performed. No separate payment is made for ordering or referring services.*

K. *Visits by Non-Physician Practitioners To Residents Of Skilled Nursing Facilities and Nursing Facilities.*

Visits to comply with Federal Regulations (see 15509.1B) in SNFs after the initial visit by the physician may, at the option of the physician, be provided by a non-physician practitioner, i.e., physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS). (Refer to [42 CFR 483.40(4)] 42 CFR 483.40(4) and (e).)

Any medically necessary physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied, when performed by an NP,

PA or CNS (at the option of the State) who is not an employee of the facility in which they practice. (Refer to [42 CFR 483.40(f)] 42 CFR 483.40 (f).)

Where a physician establishes an office in a SNF/NF, the "incident to" services and requirements are confined to this discrete part of the facility designated as his/her office. "Incident to" services may not be billed in an hospital setting. Thus, services performed outside the "office" area would be subject to the coverage rules applicable to services provided outside the office setting, i.e., nursing home. (Refer to CIM 45-15.)

Services provided by physician-employed or independent non-physician practitioners must meet Medicare requirements and fall within the scope of services that practitioners are licensed to perform. A physician assistant must be under the general supervision of the physician. These visits and all other medically necessary visits for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are covered under Medicare Part B.

L. Assistant at Surgery Services:

1. *The procedure itself must be one for which an assistant at surgery is covered according to the Medicare Fee Schedule Database.*
2. *The assistant-at-surgery services are covered regardless of the setting if the medical need and reasonableness is met.*
3. *The PA may be covered for assistant at surgery in an ASC*

M. Services Provided in a Rural Health Clinic (RHC) or Federally Qualified Health Clinic (FQHC):

Reimbursement for these services is included in payment to the facility and can include:

1. *Services that would be covered if performed by a MD/DO when they are within the PA's scope of practice, such as: visit codes, surgeries, interpretation of diagnostic tests.*
2. *Visiting nurse services to homebound patients.*
3. *Services or supplies incident to the PA service if ordinarily furnished incident to a physician's service, such as injection of drugs.*

***N. Claims Submission:**

1. *Effective January 1, 1999, HCFA has discontinued the use of the surrogate UPIN "NPP000." Non-physician practitioners should begin using their permanent UPINs immediately. A permanent UPIN will be issued to any new NP/CNS who applies to become a Medicare provider. Claims containing the surrogate UPIN "NPP000" will be returned as "unprocessable."*
2. *Effective for services 01/01/98 the following applies:*
 - a. *When PAs are rendering service(s), Form HCFA-1500 must contain the Provider Identification Number (PIN) of the PA after "PIN#" in item 33. Item 33 must also contain the employer's name, address, etc. where payment is to be directed.*
 - b. *If the employer is a group practice, they must include their group PIN number in item 33 after "GRP PIN#," including the name, address, etc. where payment is to be directed, and list the individual PA's PIN number in item 24k.*

- c. *For NSF claims, providers must submit the individual PA's PIN in field NSF FAO 23.0 of the electronic claim record. Providers submitting ANSI claims must submit the individual PA's PIN in X12N 837 (2-500. B-NM109 (mp,zz). The group PIN will be reported in NSF BA0-09 and ANSI X2N 837 in 2-003-PRV03.*
- d. Services incident to a physician - See Policy PHYS-004.
- e. Modifiers: Effective 01/01/98, payment will be based on PINs and not modifiers except for assistant at surgery claims in which case a modifier is necessary. Use the modifier listed below on claims for PA services other than incident to claims.

AS - PA services as an assistant-at-surgery, non-team member;

Sources of Information:

MCM *2154, 2260, 4105.6, 4112, 4500, 5259 Cross Reference: PHYS-026, PHYS-004; 15509.1; CRIL 46-87; *IL C17B16000/NONPHY, 05/01/96; *BBA, 1997; * Program Memorandum AB-98-15, 04/01/98.

Comments:

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Dates

Wisconsin

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Illinois

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Michigan

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