Medicare-Ohio

Overview

Medicare is a government-administered program providing health insurance to 43 million Americans. The Centers for Medicare and Medicaid Services (CMS) implements laws and establishes policies affecting Medicare and contracts with health care professionals to process Medicare claims.

Medicare rules require that services provided by physician assistants (PAs) be reimbursed at 85 percent of the physician fee schedule unless specific billing exceptions discussed below ("incident to" and "shared visits billing") apply. To receive reimbursement, PAs must bill Medicare at the full physician rate. A PA must enroll in the Medicare program by submitting the 855I form, and use his or her National Provider Identifier (NPI) number to alert the carrier to implement the 15 percent discount.

Enrollment:

NPI numbers can be obtained on-line. After completing the NPI application, you should receive an NPI number within 2 weeks. If after 2 weeks you have not received your number contact the NPI Enumerator at: 1-800-465-3203 or 1-800-692-2326 (TTY).

Once you have obtained your NPI, the Medicare 855I form should be submitted to your local Medicare Administrative Contractor (MAC).

All providers should be verifying their enrollment on the CMS on-line enrollment systems known as Internet-based PECOS. CMS has posted a PECOS Ordering/Referring File where you can easily check to see if you are current. If you are not listed in this file, you will need to update your information in the PECOS system. If you do not know your NPI number, it is easily accessed from the NPI Registry.

Covered Services:

Services provided by PAs are reimbursable by Medicare when provided in offices or clinics, nursing facilities, hospitals, and ambulatory surgical centers. Medicare pays PAs for nearly all types of medical and surgical services as allowed by state law. See the Medicare Benefit Policy Manual, Chapter 15, Section 190. Covered services include, but are not limited to, high-level evaluation and management services, consultations, initial hospital histories and physicals, mental health services, diagnostic tests, telemedicine services, and ordering durable medical equipment.

Medicare Carrier/Contractor:

CMS is reforming its scattered collection of Medicare carriers and fiscal intermediaries into a jurisdictional system of 15 Medicare Administrative Contractors (MACS). **Ohio has been assigned to the J15 MAC, served by Highmark Medicare Services. However, the contract is currently under protest, and there is a stop order in effect. The legacy (current) Part B carrier is Palmetto GBA. Sign up for the Part B list-serve to receive policy notifications. Local policies and coverage determinations can be found at the MAC website.**

"Incident to" Billing in an Office or Clinic Setting

"Incident to" is a Medicare billing provision that allows reimbursement for services delivered by PAs at 100 percent of the physician fee schedule, provided that all "incident to" criteria are met. "Incident to" billing only applies in the office or clinic. It requires that:

1. The physician must have personally treated the patient on his or her initial visit for the particular medical problem and established the diagnosis and treatment plan. The physician must also diagnose and establish a treatment plan for any new medical conditions that may arise.
2. The physician is within the suite of offices when the PA renders the service.
3. The service is within the PA's scope of practice and in accordance with state law.

If all criteria are met, the PA's services are billable under the supervising physician's Medicare number with payment at 100 percent of the fee schedule. If the criteria are not met, the PA can still perform the service; however, the PA's services must be billed to Medicare under the PA's own number for reimbursement at 85 percent of the physician fee schedule.

There must be subsequent services performed by the physician of a frequency that reflects his or her continuing and active participation in patient management and course of treatment.

Medicare references regarding "incident-to" can be found in the Medicare Benefit Policy Manual, Chapter 15, Section 60.1 and in Transmittal 1764 .

FAQ: "Incident-To"

- **Will a PA Service Be Reimbursed When He or She Sees a New Medicare Patient?**
  Yes, as long as visits with new patients are allowed by state law, a PA may see a new Medicare patient. This visit should be billed using the PA's Medicare number for reimbursement at 85 percent of the physician fee schedule.

- **May I Bill "Incident to" for a Visit if My Supervising Physician Is Next Door at the Hospital?**
  No. In order to qualify for "incident to" billing, the supervising physician must be within the suite of offices.

- **May I Bill "Incident to" in a Hospital or a Nursing Facility?**
  No. "Incident to" exists only in a physician's office or clinic.

Of note, Highmark has posted policy regarding "incident-to" documentation requirements.
"While it is not required for the supervising physician to cosign the medical record, there must be evidence that the direct supervision requirements for incident-to services were met. Some examples of direct supervision could be: cosigning the record with a date and time, a specific reference to the supervising physician in the performing provider's documentation, or clinic records that show that the supervising physician was present in the office suite when the incident-to services were performed."

Shared Visits and Billing in a Hospital Setting

Medicare regulations defer to state law with regard to physician supervision requirements in the hospital and reimburse for services provided by PAs under Medicare Part B.

If a service is within a PA's scope of practice as defined by state law and is allowable by the hospital bylaws, a PA may perform and be covered by Medicare for that service. To obtain reimbursement for his or her services, the PA should bill Medicare using his or her own NPI number. Billing Medicare in this manner will result in the PA being reimbursed at 85 percent of the physician fee schedule rate.

However, it is possible for services provided by a PA to be reimbursed at 100 percent of the physician fee schedule for services rendered in a hospital by billing under the physician's name and provider number under the shared bulling guidelines. Shared visit billing can be used for initial and subsequent hospital visits and for visits in the Emergency Department when the following criteria are met:

1) Both the PA and the physician work for the same entity (i.e., same practice, same hospital, etc.).
2) The service performed was an evaluation and management (E/M) service and neither a procedure nor a critical care service.
3) The physician provided some face-to-face portion of the E/M service with the patient. (He or she did not simply review and agree with the PA's description on the patient's chart.)
4) Both the PA and the physician see the patient on the same calendar day.

If all criteria are met, the PA's services are billable under the supervising physician's Medicare number with payment at 100 percent of the fee schedule. If the criteria are not met, the PA can still perform the service; however, the PA's services must be billed to Medicare under the PA's own number for reimbursement at 85 percent of the physician fee schedule.

Shared Visits in the Office

In the office/clinic, a shared visit only applies to an established patient.
"When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed "incident to" if the requirements for "incident to" are met ***and the patient is an established patient****."*
(See Transmittal 1776.)

Shared Visit in the Nursing Facility

Shared Visit billing is not allowed in Nursing Facilities or Skilled Nursing Facilities.

First Assisting at Surgery

PAs first assisting at surgery are reimbursed at 85 percent of the first-assisting fee paid to a physician (16 percent), or 13.6 percent. PAs cannot act as primary surgeons, but they are eligible for reimbursement for first assisting in any procedure where a physician would receive such a reimbursement. PAs are also covered when performing minor surgical procedures.

PAs should bill for their services at the full physician fee schedule. The use of the PA's NPI number and the "AS" surgical assistant billing modifier will indicate to the Medicare carrier to implement the appropriate discount. For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 110.3.

Medicare maintains a list of approximately 1,900 Current Procedure Terminology (CPT) codes for which a first assistant at surgery will not be reimbursed. For these codes, Medicare determined that a first assistant is not needed and will not pay for the services of any medical professional acting as a first assistant. If a physician deems that a first assistant is medically needed, and Medicare agrees, Medicare may grant an exception and reimburse for that service.

In teaching hospitals, Medicare restricts coverage of physicians, PAs, NPs, and Clinical Nurse Specialists for first assisting at surgery only. There are no restrictions for other services PAs provide in teaching hospitals. If a teaching hospital has an approved, accredited surgical training program related to the surgery being performed and has a qualified resident available to perform the service, no reimbursement is made for a licensed health care professional first assisting. If, however, a primary surgeon has an across-the-board policy of never allowing residents to act as first assistants, or in trauma cases, or if the surgeon believes that the resident is not the best individual to perform the service, Medicare will reimburse for a first assist provided by a PA. In these cases, claims should be accompanied by an explanation that the first assist was medically necessary and that no qualified resident was available to first assist at that time. For more information, including the "explanation statement" required by Medicare for "no qualified resident available", see the Medicare Claims Processing Manual Chapter 12, Section 100.1.7.

Billing Medicare in a Nursing/Skilled Nursing Facility

The key to accurate interpretation of payment policy in the nursing home setting is identifying in which setting, skilled nursing facility (SNF) or nursing facility (NF), the physician services are being provided. Inaccurate interpretation of these regulations may affect compliance, and may also affect payment to providers.

Physicians managing patient care in nursing facilities and skilled nursing facilities may delegate visits to PAs. In skilled nursing facilities, services assigned to a physician (such as the initial comprehensive visit) must be performed by a physician and not delegated to a PA. If allowed by state law, Medicare allows PAs practicing in nursing facilities to provide services that are designated as physician services, as long as they are not employed by the facility. Additionally, Medicare regulations dictate that nursing home patients be seen at least once every 30 days for the first 90 days of care and every 60 days thereafter. Of these visits, a physician and a PA may alternate visits and a PA may perform any necessary unscheduled visits without disrupting the established alternating visit pattern. [42 CFR, § 483.40]

The CMS Survey & Certification letter (S&C-04-08), which includes the table below, addresses the differences in requirements concerning the delegation of physician tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs).

Table 1: Authority for Non-physician Practitioners to Perform Visits, Sign Orders and Sign Certifications/Re-certifications When Permitted by the State*

	Initial Comprehensive Visit / Orders	Other Required Visits^	Other Medically Necessary Visits & Orders+	Certification/Recertification
SNFs				
NP & CNS employed by the facility	May not perform/May not sign	May perform	May perform and sign	May not sign
NP & CNS not a facility employee	May not perform/May not sign	May perform	May perform and sign	May sign subject to State Requirements
PA regardless of employer	May not perform/ May not sign	May perform	May perform and sign	May not sign
NFs				
NP, CNS & PA employed by the facility	May not perform/May not sign	May not perform	May perform and sign	May sign subject to State Requirements
NP, CNS & PA not a facility employee	May perform/ May sign	May perform	May perform and sign	May sign subject to State Requirements

*This reflects clinical practice guidelines

^Other required visits are the required monthly visits that may be alternated between physician and non-physician practitioner after the initial comprehensive visit is completed

+Medically necessary visits may be performed prior to the initial comprehensive visit

For more information on non-physician practitioners providing services in skilled nursing facilities and nursing facilities, see the Medicare Learning Network publication, ***Medlearn Matters SE0418*****.**

FAQ

May I Bill Medicare for an Unscheduled Nursing Home Visit if I Performed the Most Recent Scheduled Visit?

Yes. Medicare will cover additional medically necessary visits (beyond the required visits). These visits can be performed exclusively by a PA and do not affect the established alternating physician-PA visit schedule.

For More Information

To learn more about Medicare reimbursement policy, visit AAPA's Web site. If you still have questions, please contact AAPA's reimbursement staff:

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