



American Academy of
PHYSICIAN ASSISTANTS

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Medicare-Missouri

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. It is also required for Medicare providers to enroll via the [PECOS system](#).

NPI numbers can be obtained on-line at <https://nppes.cms.hhs.gov>. 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).

The Medicare 855I form can be found at <http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf>. This form should be submitted to your local Medicare Administrative Contractor (MAC). You can also submit enrollment requests on-line at (recommended).

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. [Medicare Benefit Policy Manual, Chapter 15, Section 190](#).

Covered services include, but are not limited to, high-level evaluation and management services, initial hospital histories and physicals, mental health services, diagnostic tests, telemedicine services, and ordering durable medical equipment.

Missouri is assigned to Jurisdiction 5, served by [Wisconsin Physician Services](#) as its Medicare Administrative Contractor. For a list of helpful Missouri WPS telephone contact numbers, [click here](#). To receive Medicare policy updates, sign up for the [Part B list-serve](#) on the WPS 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.

A Medicare reference 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 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.

Shared Visits

A Shared Visit applies to E/M services in which both the physician and the PA participate, allowing the combined service to be billed under the physician's NPI, with reimbursement at 100% of the Physician Fee Schedule.¹ The shared visit concept does not apply to procedures or critical care services or nursing home visits. The PA and physician must be employed by the same entity. Shared visits can be applied to initial and subsequent hospital visits, as well as visits in the Emergency Dept. 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.**”^{1,2}*

The physician must provide some face-to-face time with the patient and must **document** those E/M services and findings in the chart. Simply co-signing the PA's note is not sufficient. The physician's documentation must clearly indicate what portion of the E/M services were provided by the physician.

The patient must be seen by the PA and the physician on the same calendar day. However, this does not mean at the same time. A shared visit example from the Medicare manual states:

“If the NPP (non-physician practitioner) sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.”³

Documentation Requirements: Your local Medicare Administrative Contractor may have some guidance on the share visit documentation requirements. For an example of what is required, as well as what is considered unacceptable, refer to the following article posted by WPS Medicare: [Inpatient Split/Shared Evaluation and Management \(E/M\) Services.](#)

¹ Medicare Claims Processing Manual, Chapter 12, Section 30.6.1 (B)
<http://www.cms.hhs.gov/manuals/Downloads/clm104c12.pdf>

² Medicare Transmittal 1776 <http://www.cms.gov/transmittals/downloads/R1776B3.pdf>

³ Medicare Claims Processing Manual, Chapter 12, Section 30.6.1 (B)

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 [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 sign, effective January 1, 2011. See below **
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

****PAs May Perform SNF Certification and Re-Certification**

The Affordable Care Act included a provision to allow PAs to perform the initial certification and periodic re-certification required for the skilled nursing facility (SNF) level of care. Previously, the list of practitioners allowed to "certify" SNF care included only physicians, nurse practitioners and clinical nurse specialists. The provision was [published in the Federal Register November 29, 2010](#), and became effective January 1, 2011. (See H. Section 3108, page 219 of the pdf).

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](#).

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.

Home Health Certification and Face-to-Face Encounter

As a condition for payment for home health services, the Affordable Care Act mandates that, prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed non-physician practitioner (NPP), has had a face-to-face encounter with the patient. An allowed NPP is defined as a PA, NP, CNM, or CNS.

Key elements of the new rule include:

- Documentation of the face-to-face encounters must be present on certifications for patients with starts of care on and after January 1, 2011.
- As part of the certification form itself, or as an addendum to it, the physician must document:
 1. when the physician or allowed NPP saw the patient, and
 2. how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.
- The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care.

In many cases, home health agencies will not initiate home care services without the certification form documenting the above requirements and **signed by a physician**.

While the PA may complete the face-to-face encounter, the physician must "certify" that the visit occurred by signing the completed form. For complete information regarding this new rule, refer to the [MLN Matters Article SE1038](#) published by CMS, or review the CMS rule itself found in [Transmittal 139](#). (click on hyperlinks)

For More Information:

Go to the AAPA website, www.aapa.org or straight to the [Reimbursement Advocacy Section](#). If you need further assistance, contact Tricia Marriott, AAPA Director of Reimbursement Advocacy, tmarriott@aapa.org.