

Physician Assistant Payment Policy

Policy

The Plan contracts with physician assistants as primary care providers (PCPs) when contracting criteria are met. Physician assistants may elect to be listed in the Plan Provider Directory as a PCP for the areas which the Plan recognizes PCPs (pediatrics, geriatrics, internal medicine, and family practice). Physician assistants may also elect to participate as physician extenders and they will not appear in the Provider Directory.

The Plan will reimburse for covered services provided by a physician assistant (PA) who is participating through a contracted entity, and that are within the legal scope of practice. The services must also be rendered in collaboration with or under the supervision of a physician.

Services must be within the legal scope of practice. Each state is responsible for mandating and enforcing specific requirements for licensure and for defining the legal scope of practice.

Definitions

A physician assistant (or PA) is a nationally certified and state-licensed medical professional. PAs practice medicine on healthcare teams with physicians and other providers.

A primary care provider (PCP) has the primary responsibility for managing and monitoring overall care and for providing the continuity of care for each member in his/her panel. In Massachusetts, NPs who are PCPs with the Plan must have a signed collaborative agreement with a Plan-participating PCP.

A collaborating physician is the physician with whom a PA has an agreement specifying the scope of services which will be provided by the PA.

Incident-to services are defined as services that are a part of a patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment.

Direct supervision is when the physician is present in the office suite (immediate patient care area) and available to provide assistance and direction throughout the time the PA is providing care; telephone or beeper access does not constitute direct supervision.

Actively involved means that the physician is sufficiently aware of the patient's current condition to endorse or intervene in the patient's care in a timely manner.

Independently provided refers to services where there is no initial physician involvement and which are not incident-to a physician-specified plan of care.

Reimbursement

Reimbursement is limited to those services that a PA is legally authorized to perform in accordance with state law.

Incident-to services:

Covered services provided by a participating PA may be billed as incident-to under the supervising physician's provider number. Services will be reimbursed at 100% of the physician fee schedule only if all of the following are met:

- PA is considered an expense to the physician such as an employee, leased or contracted with the supervising physician and/or group (an entity that employs the physician).
- PA can evaluate only established problems; they cannot render care to a new patient to address a new problem.
- The Plan-participating physician must provide direct supervision. The physician must be present in the office suite (immediate patient care area) and available to provide

assistance and direction throughout the time the PA is providing care; telephone or beeper access does not constitute direct supervision.

- The physician is actively involved in the decision-making process for the care of the patient. The PA must document in the patient's medical record the active involvement of the physician in the decision-making process.
- The physician provides documentation/attestation of the collaboration in the patient's medical record by co-signing and dating the patient's medical record on the date the service is rendered.

Independently provided professional services:

- When a PA is rendering independently provided services as a physician extender, the PA must bill under his/her NPI number for covered services.
- In this case, the physician does not need to be on-site when the care is rendered. The physician also does not need to supervise or document findings, nor co-sign the patient's medical record.
- Plan payment for covered professional services independently rendered by a PA is 85% of the applicable physician fee schedule amount. Ancillary services, such as laboratory and radiology, are paid at 100% of the applicable physician fee schedule amount.

If a supervising provider is billing on behalf of the PA, the SA modifier must be appended to the claim submission.

Federally Qualified Health Centers (FQHC) \ Community Health Centers (CHC):

In accordance with 101 CMR 304.00 issued by the Executive Office of Health and Human Services (EOHHS), covered medical services furnished by a licensed midlevel provider (i.e. nurse practitioner, physician assistant or advanced practice registered nurse) will be reimbursed at 100% of the applicable physician fee schedule for Masshealth member's, regardless if the services are billed incident-to or independently by the contracted FQHC\CHC.

Referral/notification/prior authorization requirements

A PA must abide by the same prior authorization requirements as Plan-contracted physicians.

PCP referrals are required for all specialty visits. For a description of services requiring a PCP referral, please refer to the PCP referral and prior authorization grid located in the Managing Patient Care section of the Provider Manual under PCP Referral and Plan Preauthorization Process.

The ordering physician is required to obtain preauthorization for:

- Unlisted CPT codes
- The applicable codes found on the List of Procedures Requiring Prior Authorization located in the Managing Patient Care section of the Provider Manual under PCP Referral and Prior Authorization Process.

Fallon Health Weinberg, and Navicare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or any other additional appointments or services that may not routinely be authorized or require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

Direct payment may be made to the PA or to the employer or contractor of the provider.

When independently-provided professional services are rendered, PAs are required to submit claims with their own NPI number.

Incident-to services are billed under the supervising physician's NPI number.

PA assistant at surgery claims will be paid to their employing physician or group. Add modifier - AS to the surgery procedure code and indicate the PA's NPI number on the industry standard claim form. See Assistant Surgeon Payment Policy for payment guidelines for assistant surgery claims. Ordering and referral services are included in the payment for services performed. No separate payment is made for ordering or referring services.

Add modifier SA when a supervising provider is billing on behalf of the PA.

Place of service

Incident-to services:

This policy applies to incident-to services which are rendered in the office or clinic setting.

Independently provided services:

This policy applies to independently-provided services rendered in all settings.

Policy history

Origination date:	09/01/09
Previous revision date(s):	03/01/2012 - Updated to clarify that payment for covered professional services independently-provided by a PA is 85% of the applicable physician fee schedule amount but ancillary services are paid at 100% of the applicable physician-fee schedule amount. 11/01/2013 – Added discussion about PAs acting as PCPs. 09/01/2015 - Moved to new Plan template and updated definitions section.
Connection date & details:	September 2016 – Annual review. November 2017 – Annual Review, no updates. October 2018 – Removed language surrounding credentialing. Added language regarding FQHC/CHC October 2019 – Annual review, no updates. January 2020 - Updated reimbursement and Billing/Coding sections.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.