

Claims Processing  
Medicare Benefit Policy Manual  
Part 100-4 Chapter 12

An attending physician's services to beneficiaries in a teaching setting are covered under the supplementary medical insurance program. Many physicians rendering such services are on the faculty of a medical school or have arrangements with providers to supervise and teach interns and residents. Payment may be made for professional services to a beneficiary by an "attending" physician where the attending physician provides personal identifiable direction to interns or residents who are participating in the care of this patient.

See the Medicare Benefit Policy Manual, Chapter 15, for services furnished by interns and residents within and outside the scope of an approved training program.

### **110 - Physician Assistant (PA) Services Payment Methodology**

(Rev. 1, 10-01-03)

**B3-16001, B3-2156, B3-15004, B3-4112, B3-15024**

See the Medicare Benefit Policy Manual, Chapter 15, for coverage policy for physician's assistant (PA) services.

Physician Assistant services are paid at the lesser of the actual charge or 85 percent of the physician fee schedule, except covered PA assistant at surgery services (described below) and services performed in a hospital.

For services performed in a hospital, carriers limit the payment to 75 percent of the fee schedule amount or the lesser of the actual charge for the service. This payment limit applies to a PA in a hospital or in a rural HPSA.

The AS modifier must be on claim for assistant at surgery claims.

#### **110.1 - Limitations for Assistant-at-Surgery Services**

(Rev. 1, 10-01-03)

**B3-16001**

The carrier shall pay covered PA assistant at surgery services at 85 percent of the 16 percent of the physician fee schedule amount (i.e., 10.4 percent).

Carriers must assure that there is no duplication of payment for surgical services. When surgery is paid on a global charge basis, including a specified number of days of postoperative care, any postoperative services billed for the PA during this period of time are paid only when the physician's global fee for surgery has been reduced to reflect that the services covered under the procedure code have been reduced or eliminated.

## **110.2 - Outpatient Mental Health Limitation**

(Rev. 1, 10-01-03)

**B3-4112, B3-2472.4**

The carrier must apply the outpatient mental health limitation to all covered mental health therapeutic services furnished by PAs. The reduction is 62.5 percent applied after the 85 percent.

Refer to §210 below for a complete discussion of the outpatient mental health limitation.

## **110.3 - PA Billing to Carrier**

(Rev. 1, 10-01-03)

**B3-16001, B3-15044, B3-2156, PM-B-99-16**

### **A - Modifiers**

Physician Assistant as assistant at surgery should be identified with a modifier AS. Billers must identify PA assistant-at-surgery services with the following modifiers as applicable:

Assistant surgeon services billed with modifier “-80”;

Minimum assistant surgeon services with modifier “-81”;

Assistant surgeon services (when assistant resident surgeon not available) with modifier 82.

**NOTE:** 80, 81, and 82 are paid at 65 percent of 16 percent. No other reductions for minimum services take place.

HPSA modifiers shall be used on PA claims for HPSA areas (modifiers QB and QU).

### **B - PA Identification**

PAs must have their own “practitioners” provider identification number (PIN). Specialty code 97 applies.

### **C - Assignment Requirement**

(Rev. 1, 10-01-03)

**B3-17000, B3-3040.4**

A PA like a NP may bill using their own provider number. All claims for PA services must be made on an assignment basis. If any person or entity (employer or PA)

knowingly and willfully bills the beneficiary an amount in excess of the appropriate coinsurance and deductible, the responsible party is subject to a civil monetary penalty not to exceed \$2,000 for each such bill or request for payment.

## **120 - Nurse Practitioner (NP) And Clinical Nurse Specialist (CNS) Services**

**(Rev. 1, 10-01-03)**

**B3-16002, B3-2158-2160**

See the Medicare Benefit Policy Manual Chapter 15, for coverage policy.

### **A - General Payment**

In general, NPs and CNSs are paid for covered services at 85 percent of the Medicare Physician Fee Schedule.

### **B - Mental Health Limitation**

**(Rev. 1, 10-01-03)**

**B3-4112, B3-2472-2472.4**

The carrier must apply the outpatient mental health limitation to all covered mental health therapeutic services furnished by NPs and CNSs. The reduction is 62.5 percent applied after the 85 percent.

Refer to §210, below, for a discussion of the outpatient mental health limitation.

## **120.1 - Direct Billing and Payment**

**(Rev. 1, 10-01-03)**

**B3-2158.E, B3-2160.E, 3040.4**

Prior to January 1, 1998, direct billing and payment for NP services was available only in limited circumstances, as follows:

- Payment for services furnished in SNFs or NFs in urban areas was made to the NP's employer; and
- Payment for services furnished in all settings in rural areas was made to the NP or to his/her employer or contractor.

Effective January 1, 1998, restrictions were removed on the type of areas and settings in which the professional services of NPs and CNSs are paid for by Medicare.

- Payments are allowed for services furnished by them in all areas and settings permitted under applicable state licensure laws.
- Payment may be made to the NP or CNS or to the employer or contractor.

NPs services are paid only on an assignment basis.

However, even though an independent NP or CNS would otherwise bill directly for such services, NP or CNS services provided in a hospital setting must be billed by the facility. This is because the law authorizing coverage of such services did not also authorize their unbundling from the rest of the hospital bill. Therefore, only the hospital, and not the practitioner, may bill.

NPs are identified on the provider file with specialty code 50 and provider type 38. CNSs are identified on the provider file by specialty 89 and provider type 38.

### **130 - Nurse-Midwife Services**

(Rev. 1, 10-01-03)

B3-16004, 5257

See the Medicare Benefit Policy Manual, Chapter 15, for coverage policy for nurse-midwife services.

#### **130.1 - Payment for Services**

(Rev. 1, 10-01-03)

**B3-16004.A, B3-16004.B, B3-5257.B, B3-3040.4, B3-17001.1**

Billing does not have to flow through a physician or facility.

Payment for most nurse-midwife services is based on equal to 65 percent of the physician fee schedule. However, covered drugs furnished by nurse midwives are paid according to the drug payment methodology. Covered clinical diagnostic lab services are paid according to the clinical diagnostic lab fee schedule. Note that clinical lab is not subject to deductible and coinsurance

The NMW limitation is applied to the Medicare allowed amount after application of the outpatient mental health limit. As of January 1, 1998, however, restrictions were lifted requiring payments be made to employers and contractors for services provided in SFS or NFS in urban areas and in all settings in rural areas. Payments can now be directly made for outpatient mental health services in all areas and settings as permitted under applicable state licensure laws. Refer to §210 below for a discussion of the outpatient mental health limitation.

Payment is made only on an assigned basis.