American Academy of Physician Associates

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Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Dear Dr. Quinton,

Thank you for taking the time to meet with AAPA to discuss regulatory obstacles that continue to limit timely access to care and constrain the efficient use of the healthcare workforce – particularly in rural areas. We appreciate the opportunity to build on our conversation and to share additional detail following the meeting.

Please find below a list of regulatory and subregulatory provisions that AAPA has identified as unnecessarily restrictive, along with the appropriate context and our recommended modifications.

The list includes topics that were raised during our meeting, such as hospice, skilled nursing facilities, prohibitive NCDs, and provider specialty identification. We have also included additional policies that AAPA believes impede the MAHA agenda by increasing administrative burden, limiting flexibility in care delivery, and constraining the ability of clinicians to practice to the top of their education and training – ultimately affecting access and outcomes for patients.

All the policies included fall within CMS's regulatory or subregulatory authority. Importantly, none of the recommended changes would override state laws and regulations regarding who may provide which services. For ease of review, we have separated our recommendations into site-of-care locations.

Should you or your team have any questions, AAPA would be happy to discuss any of these items further.

Contents

HOSPICE

Ordering Medications

42 CFR § 418.106(b)(1)(iii)

Current Policy: This regulation indicates that PAs must be a patient's attending physician and must not be employed by a hospice to order medications for hospice patients.
Change Request: Rescind §418.106(b)(1)(iii)(A) and (B) and revise the language in §418.106(b)(1)(iii) to remove any notion of qualifiers to authorize PAs employed by the hospice to order medications for hospice patients.
Reason for Change: This restriction prevents PAs from providing needed treatments to hospice patients, which may result in inefficiency. Removing this restriction will improve patient access to medications, increase healthcare efficiency for this population, and reduce administrative burden.

Acting as an Attending Physician if One Not Previously Selected

Section 40.1.3.3, Chapter 9 of the Medicare Benefit Policy Manual

Current Policy: This section of the manual contains a policy whereby if a beneficiary does not have a physician, nurse practitioner (NP), or PA who provided primary care to them before, or at the time of, terminal illness, the beneficiary is given the choice of having either a physician or NP (but not a PA) who works for the hospice as an attending physician.
Change Request: Revise Section 40.1.3.3 of Chapter 9 of the Medicare Benefit Policy Manual to authorize PAs employed by a hospice to serve in the role of a patient's attending physician if an attending physician was not previously selected by the patient.
Reason for Change: In addition to the conflict with Section 1861(s)(2)(k)(i) of the SSA, mentioned previously, this policy also conflicts with the statutory authority of the Section 1861(dd)(3)(B) of the SSA that authorizes PAs to serve as "attending physicians" for hospice. This policy omits PAs who are otherwise authorized to serve in the role of a hospice attending physician when not employed by a hospice.

SKILLED NURSING FACILITIES

Performing the Initial Comprehensive and Required Visits

42 CFR §483.30

Current Policy: This regulation restricts PAs from performing the initial comprehensive visit and alternate required visits for Medicare beneficiaries in Skilled Nursing Facilities (SNFs).
Change Request: Revise to authorize PAs to perform the initial comprehensive visit and all required visits in SNFs. Specifically, §483.30, §483.30(b) and §483.30(b)(1), §483.30(c) and §483.30(c)(1) and (2) should be revised to be inclusive of PAs. §483.30(c)(3) and (4) and §483.30(e)(1), (e)(1)(i), (e)(1)(ii), and(e)(1)(iii) should be rescinded. Additionally, §483.30(e)(2) and §483.30(e)(3) should be revised to be inclusive of PAs and §483.30(e)(4) should be rescinded.
Reason for Change: Such restrictions are not based on medical evidence but on outdated policies that should be modernized to reflect current medical practice and bring greater efficiency to the system. During the COVID-19 public health emergency, CMS authorized the delegation of "physician-only" visits in SNFs to PAs if there was no conflict with state law or facility policy. This authorization allowed additional qualified health professionals to provide care they are competent to provide and was based on the recognition of the years of experience that

demonstrated that PAs offer high-quality care in SNFs. In a recent report by CMS[1] , the agency acknowledged the benefit of this waiver, indicating that it helped address workforce shortages, increased the provision of care, and protected the health and safety of residents by maximizing the use of available personnel. Unnecessary regulatory requirements in SNFs necessitate physician involvement that may not be readily available in rural settings or in a timely fashion in high-demand settings. Allowing PAs to provide these services will ensure flexibility for SNFs to determine which care delivery processes would most efficiently meet current patient needs and ensure that patients will not have to wait to see a physician when a PA is available.

INPATIENT REHABILITATION FACILITIES

"Physician Only" Requirements in IRFs

42 CFR §412.622(a) and §412.29

Current Policy: Regulations §412.622(a)(3)(iv) and §412.29(e) identify the need to conduct face-to-face visits with an Inpatient Rehabilitation Facility (IRF) patient three days a week to assess medical status and functionality and to modify the course of treatment as necessary. However, language contained in these sections of the CFR also requires that for the first week, a physician must do all three visits, and in each subsequent week, a non-physician health professional, such as a PA, may only do one of the three visits per week. §412.29(h) indicates that a physician must establish, review, and revise a plan of treatment in an IRF. §412.622(a)(4)(ii), requires a rehabilitation physician to develop a plan of care for a patient within four days of admission. §412.29(d) requires that a patient's preadmission screening be reviewed and approved by a physician.

Change Request: Revise sections §412.622(a)(3)(iv), §412.29(e), §412.29(h), §412.622(a)(4)(ii), §412.29(d) to include PAs.

Reason for Change: Requiring a physician to perform these duties is inefficient and may impact patient treatment if a patient must wait to see a physician for care that another health professional is qualified to provide. To address concerns of regulatory burdens in IRFs and ensure an adequate healthcare workforce in these settings, CMS had previously expressed interest in amending requirements under §412.622(a)(3)(iv) and §412.622(a)(4)(ii) to permit PAs to fulfill many of the medical responsibilities previously assigned only to rehabilitation physicians. AAPA supported CMS's proposal to expand the role of PAs in IRFs by authorizing PAs to fulfill many of the CMS "physician-only" requirements currently in place. Unfortunately, CMS did not choose to finalize the flexibilities as initially proposed, maintaining much of the physician-centric requirements. AAPA requests that CMS revisit removing these inefficient barriers to care. CMS should authorize PAs to perform medical duties that are currently only allowed to be performed by a rehabilitation physician when those services are within the PA's scope of practice under applicable state law. Granting an expanded authorization in this setting would not impose a requirement on IRFs. Rather, it would give rehabilitation facilities maximum flexibility by allowing them to utilize appropriately qualified PAs in the same manner as rehabilitation physicians to ensure a robust rehabilitation workforce that provides patients with timely access to care. Each IRF would continue to be able to determine which health professionals have the necessary education, training, and experience to meet the care needs of their patients. Decisions regarding which qualified health professional provides care for a patient should be made according to the IRF's patient and staffing needs rather than limited by arbitrary restrictions.

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[1] Centers for Medicare & Medicaid Services. *COVID-19 Public Health Emergency Response and Use of Section 1135 Waivers and Other Flexibilities: Report to Congress, Fiscal Year 2023.* U.S. Department of Health & Human Services; January 2025. 2025. https://www.cms.gov/files/document/covid-19-phe-report-congress.pdf

CRITICAL ACCESS HOSPITALS

Surgery in CAHs

42 CFR §485.639(a)

Current Policy: This regulation uses physician-centric language regarding who may perform surgery for patients in Critical Access Hospitals (CAHs).
Change Request: §485.639(a) should be revised to authorize PAs to perform surgical procedures in CAHs.
Reason for Change: States authorize PA to perform minor surgeries and other medical procedures. Amending these regulations will increase workforce adequacy and improve efficiency.

Physician Requirements in CAHs

42 CFR § 485.631(b)

Current Policy: This regulation requires physician co-signature of medical records for patients not cared for by a physician in Critical Access Hospitals (CAHs) and a periodic physician presence at CAHs.
Change Request: §485.631(b)(1)(iv) and (v) should be rescinded to remove the requirement of physician co-signature for medical records of patients cared for by PAs and other non-physician practitioners in CAHs and §485.631(b)(2) should be revised to remove the requirement that a physician be present at a CAH for "sufficient periods of time."
Reason for Change: At nearly all other sites of service under Medicare, PAs are authorized to provide inpatient care without a physician's presence. Meanwhile, the requirement for physician co-signature of medical records for services PAs are qualified to provide compromises facility efficiency by placing an unnecessary administrative burden on physicians. To meet these requirements, physicians must take time from patient care to perform an administrative requirement that does not improve quality of care.

RURAL EMERGENCY HOSPITALS

Surgery in REHs

42 CFR §485.524(d)(1)

Current Policy: This regulation uses physician-centric language regarding who may perform surgery for patients in Rural Emergency Hospitals (REHs)
Change Request: §485.524(d)(1) should be revised to authorize PAs to perform surgical procedures in REHs.
Reason for Change: States authorize PAs to perform minor surgeries and other medical procedures. Amending these regulations will increase workforce adequacy and improve efficiency.

Physician Requirements in REHs

42 CFR §485.528(c)

Current Policy: This regulation requires physician co-signature of medical records for patients cared for by PAs if required by state law in rural emergency hospitals (REHs) and periodic physician presence at REHs.
Change Request: §485.528(c)(1)(iv) should be rescinded to remove the requirement of a physician co-signature of records in REHs, and §485.528(c)(2) should be revised to remove the requirement that a physician be present at an REH for "sufficient periods of time."
Reason for Change: At nearly all other sites of service under Medicare, PAs are authorized to provide inpatient care without the need for a physician to be present. Meanwhile, a hypothetical requirement for physician co-

signature of medical records that is generally not required by state law is confusing and could create administrative burdens if misinterpreted.

INPATIENT HOSPITALS

Inpatient Admission Orders

Hospital Inpatient Admission Order and Certification Statement – Jan 30, 2014[2]

Current Policy: CMS stated in a 2014 document that a PA may write an inpatient admission order if the physician responsible for the patient's care "accepts responsibility for the admission decision by counter-signing the order prior to discharge."

Change Request: CMS should remove all outdated guidance documents suggesting a physician must co-sign an admission order issued by a PA and clearly state that a physician co-signature is not needed when a PA issues an inpatient order.

Reason for Change: The status of this requirement, due to conflicting guidance documents, has resulted in a lack of clarity. CMS relaxed[3] the time frame for critical access hospitals, requiring that co-signature be obtained one day prior to the submission of the claim as opposed to prior to the patient discharge. A 2017 transmittal[4] indicated that an order for admission could be furnished by a physician or other qualified practitioner if that practitioner is: (a) licensed by the state to admit inpatients to hospitals, (b) granted privileges by the hospital to admit inpatients to that specific facility, and (c) knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission. As of January 1, 2019, CMS no longer requires a written inpatient admission order from a physician as a specific condition of Medicare Part A payment. However, CMS never clarified if an admission order from a PA or other non-physician practitioner that a physician did not co-sign would be afforded the same waiver of not being required as a condition of payment. Clarifying that a physician co-signature for hospital admissions is no longer necessary would decrease the physician documentation burden of co-signing an order after a determination of inpatient medical care has already been made.

Extended Hospital Stay

42 CFR §424.13

Current Policy: This regulation contains policies that require physician certification/recertification of need for acute care hospital services that are 20 inpatient days or more, and continued hospitalization if a SNF bed is not available.

Change Request: Revise sections §424.13(a), §424.13(c)(1) and (2), and §424.13(d)(1) to include PAs.

Reason for Change: These restrictions present a significant barrier to the coordination of care and ensuring that patients receive a duration of care sufficient to meet health objectives. Such certifications should be performed by the health professional most familiar with the needs of the patient to confirm the appropriateness of extended care scenarios.

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[2] Centers for Medicare & Medicaid Services. *Hospital Inpatient Admission Order and Certification.* U.S. Department of Health & Human Services; January 30, 2014. Accessed June 26, 2025. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf

[3] Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; and Other Revisions. *Fed Regist.* 2014;79(163):49853-50536. Published August 22, 2014. Accessed June 26, 2025. https://www.govinfo.gov/content/pkg/FR-2014-08-22/pdf/2014-18545.pdf

[4] Centers for Medicare & Medicaid Services. Clarification of Admission Order and Medical Review Requirements. *Transmittal 234, Medicare Benefit Policy Manual (Pub. 100-02).* Issued March 10, 2017. Accessed June 26, 2025. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R234BP.pdf

Certification for Inpatient Psychiatric Services

42 CFR §424.14

Current Policy: This regulation contains policies that require physician certification/recertification of need for inpatient psychiatric services

Change Request: Revise section §424.14(a) and (b) to include PAs.

Reason for Change: These restrictions present a significant barrier to timely access and coordination of care, especially in rural and underserved areas where psychiatrists are in short supply. PAs are trained and authorized to diagnose and manage behavioral and mental health conditions, including determining medical necessity for psychiatric hospitalization. They perform psychiatric evaluations, manage medications, and develop treatment plans in collaboration with psychiatrists and other clinicians. The inability to certify care they are already delivering undermines both patient access and the efficiency of psychiatric facilities.

OUTPATIENT HOSPITALS

Outpatient Psychiatry and Psychology

Local Coverage Determination (LCD) L34353 re: Outpatient Psychiatry and Psychology Services

Current Policy: This LCD indicates that only physicians may prescribe and establish an individualized treatment plan for outpatient psychiatry and psychology services and bill for electroconvulsive therapy.

Change Request: The LCD should be revised to authorize PAs to prescribe and establish individualized treatment plans for outpatient psychiatry and psychology services and bill for electroconvulsive therapy.

Reason for Change: Removing these limitations would improve access to behavioral and mental health services and could improve program integrity by reducing waste if patients do not have to have an encounter with a physician to obtain services and treatment plans that their PA could otherwise provide.

Ambulatory Surgical Centers

42 CFR §416.42, §416.48, §416.52

Current Policy: These regulations contain physician-centric language regarding the provision of services in Ambulatory Surgical Centers (ASCs).

Change Request: §416.42 should be revised to authorize PAs to perform surgical procedures in ASCs, §416.42(a)(1)(i) and (ii) should be revised to authorize PAs to evaluate the risk of the procedure to be performed and the risk of anesthesia in ASCs, §416.48(a)(1) should be revised to authorize PAs to receive reporting of adverse reactions, §416.48(a)(2) should be revised to authorize PAs to administer blood and blood products, §416.48(a)(3) should be revised to authorize PAs to order drugs and biologicals in ASCs, §416.52(c)(1) should be revised to authorize PAs to provide follow up appointments, §416.52(c)(2) should be revised to authorize PAs to discharge patients (and issue and sign discharge orders), and §416.52(c)(3) should be revised to authorize PAs to determine if patients are exempted from being discharged in the presence of a responsible adult.

Reason for Change: States authorize PAs to perform minor surgeries, risk assessments, and other medical services. Amending these regulations will increase workforce adequacy, improve efficiency, and decrease administrative burden.

COMMUNITY MENTAL HEALTH CENTERS

Mental Health Services

42 CFR §485.914(e)(3)(iii) and §485.916(a)(3)

Current Policy: These regulations use physician-centric language regarding Community Mental Health Centers, including a requirement for the inclusion of only physician orders on a discharge summary and the lack of explicit inclusion of PAs on the interdisciplinary treatment team.

Change Request: §485.914(e)(3)(iii) and §485.916(a)(3) should be revised to be inclusive of PAs.

Reason for Change: Physician-centric language regarding "physician orders" on a discharge summary may be strictly interpreted in a manner that would result in only a subset of orders related to a patient's care (i.e., those issued by a physician) being included in the summary, and omit orders made by non-physician health professionals. This may then provide patients with incomplete information regarding the care received. Meanwhile, the omission of PAs by name in the list of those who may participate in an interdisciplinary team starkly conflicts with §485.916(a)(1), which authorizes PAs to lead such teams.

OTHER/NON-SPECIFIC SITES OF CARE

Ambulance Transfers

42 CFR §410.40(e)(2)(i)

Current Policy: This regulation requires a "physician certification statement" as a condition of payment for nonemergency, scheduled, repetitive ambulance services.

Change Request: Revise to remove the physician-centric language regarding the certification statement.

Reason for Change: Revising the regulation will increase efficiency by authorizing PAs caring for patients to provide certification and could decrease costs if patients have to have an encounter with a physician that would otherwise not be needed to obtain an order that their treating PA could provide. This restriction is arbitrary, as CMS previously extended the ability of PAs to sign a certification statement for other types of ambulance transfers (e.g., for unscheduled or scheduled but not repetitive).

Home Blood Glucose Monitors

National Coverage Determination (NCD) 40.2 re: Home Blood Glucose Monitors

Current Policy: This NCD indicates that coverage of home blood glucose monitors is limited to patients who have either a) been determined by a physician to be capable of or b) can be monitored by a person determined capable of being trained to use the equipment. Further, special glucose monitors are covered only when a physician certifies that a patient has a severe visual impairment that requires this monitoring system.

Change Request: The NCD should be revised to authorize PAs to certify the need for coverage of this durable medical equipment (DME).
Reason for Change: In addition to the conflict with Section 1861(s)(2)(k)(i) of the SSA, mentioned previously, this NCD also conflicts with the regulatory authority of 42 CFR § 410.38(C)(2) for PAs to order/prescribe/certify DME. Revising the NCD will improve chronic disease management, reduce administrative burden of requiring an otherwise unnecessary physician order for patients cared for by PAs, and could improve program integrity by reducing waste if patients do not have to have an encounter with a physician to obtain an order/certification that their treating PA could otherwise provide.

Colorectal Cancer Screening Tests

National Coverage Determination (NCD) 210.3 re: Colorectal Cancer Screening Tests

Current Policy: This NCD indicates that Fecal Occult Blood Tests (FOBT) and Blood-based Biomarker Tests (BBT) for colorectal cancer screening are only covered when ordered by a physician.
Change Request: The NCD should be revised to authorize payment for FOBT and BBT for colorectal cancer screening ordered by PAs.
Reason for Change: In addition to the conflict with Section 1861(s)(2)(k)(i) of the SSA, mentioned previously, this NCD also conflicts with the regulatory authority of 42 CFR §410.37(b) authorizing payment of FOBT ordered by PAs and 42 CFR §410.32 authorizing payment for diagnostic laboratory tests ordered by PAs. Revising the NCD will improve screening and detection of colorectal cancer, promote disease prevention, reduce the administrative burden of requiring an otherwise unnecessary physician order for patients cared for by PAs, and could improve program integrity by reducing waste if patients do not have to have an encounter with a physician to obtain an order that their treating PA could otherwise provide.

Colonoscopies

42 CFR § 410.37(f)

Current Policy: This regulation authorizes coverage of screening colonoscopies only when performed by a physician.
Change Request: §410.37(f) should be rescinded to authorize coverage of screening colonoscopies performed by PAs.
Reason for Change: A study[5] indicated no significant differences in cecal intubation time or success, adenoma detection rate, or adverse reactions reported related to the endoscopic procedure up to 30 days post-colonoscopy for PAs compared to gastroenterologists. The researchers, who included five allopathic physicians, concluded that the findings support the use of trained PAs to perform average-risk screening colonoscopies and that "this approach may be particularly relevant to underserved populations and resource-poor areas where access to and cost of colonoscopy limits the optimization of colorectal cancer screening strategies."

Podiatric Services

Section 290, Chapter 15 of the Medicare Benefit Policy Manual

Current Policy: This section contains exceptions to the routine foot care exclusion (see Section 290 C), systemic conditions that might justify coverage (see Section 290 D), and presumption of coverage (see Section 290 F) that require patients to have been evaluated and treated by a physician.
Change Request: These policies should be revised to authorize coverage of podiatry services for beneficiaries with certain conditions when under the care of a PA.

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[5] Kern LM, Zhou Y, Rajendran N, et al. Quality metrics of screening colonoscopies. *JAAPA.* 2020;33(4):35–41. https://journals.lww.com/jaapa/Fulltext/2020/04000/Quality_metrics_of_screening_colonoscopies.8.aspx

Reason for Change: These requirements may result in patients receiving care from a PA needing to schedule a separate visit with a physician to document a need for podiatric care that PAs are qualified to determine, potentially increasing costs and burdens to patients. Revising the policy will improve chronic disease management, reduce administrative burden, and could improve program integrity by reducing waste if patients do not have to have otherwise unnecessary physician care when already being evaluated and treated by PAs.

Diagnostic Mammography

National Coverage Determination – Mammograms

Current Policy: The NCD indicates that diagnostic mammograms are only covered when ordered by a physician.
Change Request: The NCD should be revised to authorize PAs to order diagnostic mammograms.
Reason for Change: In addition to the conflict with Section 1861(s)(2)(k)(i) of the SSA as previously mentioned, the NCD conflicts with the regulatory authority of § 410.32 for PAs to order diagnostic tests.

Infusion of Drugs and Biologicals

Section 50, Chapter 15 of the Medicare Benefit Policy Manual

Current Policy: The policy indicates that the infusion of drugs and biologicals (including whole blood), when they cannot be self-administered, are covered only "incident to" a physician.
Change Request: The policy should be revised to authorize the coverage of the infusion of drugs and biologicals "incident to" a PA.
Reason for Change: This policy conflicts with Section 1861(s)(2)(k)(i) of the SSA.

Interpretation of Electrocardiograms

National Coverage Determination - Electrocardiographic Services

Current Policy: CMS's policy regarding interpretation of electrocardiograms (EKGs) indicates, "Coverage includes the review and interpretation of EKGs only by a physician."
Change Request: AAPA recommends that CMS revise its policy to authorize PAs to provide professional interpretation of EKGs.
Reason for Change: The interpretation of EKGs is consistent with PA education, training, and scope of practice. [6,7] This policy conflicts with Section 1861(s)(2)(k)(i) of the SSA.

MODERNIZING THE PA TITLE IN REGULATIONS

AAPA requests that all references to PAs in regulations and policies be listed as "physician assistants/physician associates," as recognized in 20 CFR § 220.46 (a)(9).[8] This accurately reflects PAs who currently graduate with degrees as either "physician assistant" or "physician associate" and are state-licensed as a "physician assistant" or

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[6] Accreditation Review Commission on Education for the PA. *Accreditation Standards for PA Education.* Sixth Edition. Updated September 1, 2025. https://www.arc-pa.org/wp-content/uploads/2025/10/Standards-6e-10-03-25-Pub-10-09-25.pdf
[7] National Commission for the Certification of PAs. *Content Blueprint for the Physician Assistant National Certifying Examination (PANCE).* Updated January 2025. https://www.nccpa.net/wp-content/uploads/PANCE-Blueprint.pdf
[8] Code of Federal Regulations: Medical evidence. 20 CFR § 220.46. 2025. https://www.ecfr.gov/current/title-20/chapter-II/subchapter-B/part-220/subpart-F/section-220.46

"physician associate," but who all graduate from programs accredited by the same accrediting organization (Accreditation Review Commission on Education for the Physician Assistant), are certified by the same certifying organization (National Commission on Certification of Physician Assistants), and have the same scopes of practice. Although the profession has been known as "physician assistant," the official title of the profession is now recognized as "physician associate" to more accurately reflect the breadth of education, training, experience, and services of PAs. This is reflected in the title of the AAPA, other professional organizations,[9] professional training programs,[10] and state and territory laws and licensure.[11] Despite the recognized title of "physician associate," it is anticipated to take some time for the title change from "physician assistant" to occur in all states and jurisdictions in which PAs practice. Therefore, a dual reference to "physician assistant" and "physician associate" is recommended to avoid confusion. AAPA urges CMS to reference the profession by the dual title "physician assistant/physician associate."

AAPA also requests revisions to 42 CFR § 410.74(C), both because of the transition of the profession's title and because there is a reference to an outdated certifying body. As such, we recommend and request the following (with new language in capital letters):

> § 410.74 Physician assistants' services.
> ***
> (C) ***Qualifications.*** For Medicare Part B coverage of his or her services, a physician assistant must meet all of the following conditions:
> > (1) Have graduated from a physician assistant educational program that is accredited by the ~~Commission on Accreditation of Allied Health Education Programs~~ ACCREDITATION REVIEW COMMISSION ON EDUCATION FOR THE PA; or
> > (2) Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants; and
> > (3) Be licensed by the State to practice as a physician assistant OR PHYSICIAN ASSOCIATE.

SAME SPECIALTY DESIGNATION AND MEDICARE BILLING POLICY ISSUES

Overview of the Issue

As Medicare policy has not kept pace with the evolution of team-based, multi-specialty care, certain billing and specialty-designation rules are creating unintended barriers to appropriate reimbursement, efficient care delivery,

[9] Several Constituent Organizations, which are independent organizations affiliated with AAPA, have reflected the title Physician Associate in their professional organization's legal name. Examples: Connecticut Academy of Physician Associates https://connapa.org/aboutconnapa, Kansas Academy of Physician Associates https://kansaspa.mypanetwork.com, Academy of Physician Associates in Cardiology https://www.cardiologypa.org, and Association of Physician Associates in Obstetrics and Gynecology https://apaog.wildapricot.org.

[10] Several universities, which are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARCPA), have Physician Associate Programs and graduate students in Physician Associate Studies. Examples: Yale School of Medicine, Physician Associate Program, https://medicine.yale.edu/pa, Wichita State University, Physician Associate Program https://www.wichita.edu/academics/health_professions/pa/, Alvernia University, Physician Associate Program https://www.alvernia.edu/academics/ug/bio-pa.

[11] Oregon Governor Tina Kotek Signs Law Changing PA Title (April 5, 2024) https://www.aapa.org/newscentral/2024/04/oregongovernor-tina-kotek-signs-law-changing-pa-title/. See also, Or. Rev. Stat. § 677. See also, Wis. Stat. § 448.974(1)(a)(2)-(6). See also, 185 N. MAR. I. ADMIN. CODE § 185-10-4101(p)

and patient access. In particular, Medicare's use of a single specialty code for all PAs and NPs is increasingly misaligned with how these clinicians practice across diverse specialties and care settings.
This issue is the most acute in two key circumstances:

- **For new patient encounters for PAs practicing in a multi-specialty group**: Medicare defines a new patient as a person who has not received any professional services from a clinician or another provider within a group practice within the same specialty in the previous three years. Because PAs all have the same specialty code (97), this has led to denials of claims when more than one PA, but in different specialties within a multi-specialty practice, sees a patient for an initial encounter within three years.
- **For patients who see more than one PA on the same day:** There is a similar problem when a Medicare beneficiary sees more than one PA on the same calendar day, because CMS only permits (page 41) one evaluation and management (E/M) service per beneficiary per date of service for each provider specialty, unless the services are for unrelated problems. NPs, who all have the same specialty code (50), encounter the same problems with reimbursement.

The single specialty code for PAs and NPs has become more of a problem as many practices are consolidating into larger, multi-specialty practices. It has been reported to AAPA that practices have to appeal denials caused by the same specialty identification problem, accept lower (established patient) payment for encounters that would otherwise be considered a new patient if not because of the single-specialty codes for all PAs, or accept denials of claims for same day services performed by more than one PA in the same group practice. This has led to lost payment that would otherwise be appropriate, along with added administrative burden for practitioners and Medicare Administrative Contractors (MACs). More commonly, practices report creating workflows that prohibit PAs and NPs from seeing new patients or more than one PA or NP from seeing a patient per day to avoid claims denials or lower payment. This leads to delays in care, system inefficiencies and added costs, and adversely affects patient access.

MAC Workarounds and Proposed Solution

Three MACS -- NGS, Noridian, WPS – have issued corrective action for the problem related to same-day services provided by more than one PA. They advise providers in their jurisdictions to continue to indicate the provider as either Specialty 97 or Specialty 50, but recommend including the specialty of the collaborating physician or group under which the PA (or NP) has provided the service in the 2300 or 2400 Loop NTE Segment (or Box 19 on paper) for all claims. If the secondary specialty and the primary ICD-10 codes differ, the claims will not be automatically rejected.

NGS had indicated that this policy was initially implemented because they identified a large number of claims that were overturned on appeal due to this. NGS asked practices to use the secondary specialty code to reduce administrative burden for both NGS and the practitioners.

AAPA recommends CMS take one of two actions:

1) **Issue guidance to all MACs to use this billing process for multiple same-day services, as well as for new versus established patients, or**
2) **Identify an alternative solution that does not result in inappropriate claims denials due to PAs' and NPs' single specialty code.**

Illustrative Examples of the Issue

While the below illustrative examples were shared with AAPA by health systems, it is important to note that this problem occurs daily because PAs (and NPs) work in all medical and surgical specialties, providing medically necessary services to patients. One health system noted that if each of the below scenarios involved care provided by *physicians* practicing in different specialties rather than *PAs (or NPs)* in different specialties, the claims would be processed without delay, denial or the need for appeal. Another health system quantified that these billing policies lead to denials that are subsequently appealed and overturned for ~15% of all evaluation and management (E/M) claims they submit annually. The health systems also noted, as explained in several of the examples below, how these policies have resulted in adverse effects to patients, the health systems, and the Medicare program.

Clinical examples of billing issues with PAs in a multi-specialty group practice billing for services on the same calendar day (in which the PAs are working in different specialties providing care for different medical problems) due to the following Medicare billing policy[12]:

> *If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems.*
>
> *Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group.*

This policy has been applied to non-physician practitioners. When the claims for services submitted by more than one PA (or more than one NP), identified by CMS Specialty Code "97" (or "50") but working in different specialties, are submitted on the same calendar day, claims subsequent to the first claim paid for a PA's service are automatically denied because the claims process assumes the PAs are in the same "specialty".

Examples of the Problem

1. Example 1
    a. **Setting**: A nonprofit healthcare system in Northern Virginia employing practitioners, including PAs, as part of a multi-specialty group practice (under the same tax ID number).
    b. **Clinical Scenario**: A patient was admitted to the hospital with complaints of worsening lower back pain and dyspnea and with a history of prostate cancer, coronary artery disease, aortic aneurysm status-post repair, atrial fibrillation on anticoagulation, heart block status post pacemaker, ischemic cardiomyopathy, stage 4 chronic kidney disease, chronic anemia, and spinal stenosis. The patient was seen daily by a Hospitalist PA (specialty #1 but identified as CMS Specialty Code "97") for the management of the pain (ICD-10 M54.16) and chronic kidney disease (ICD-10 N18.4) and by a Cardiology PA (specialty #2 but identified as CMS Specialty Code "97") for heart failure (ICD-10 I50.23) and atrial fibrillation with a rapid ventricular response (ICD-10 I48.91).
    c. **Issue**: Medicare denied the Cardiology PA claim with remark code "B14-B14-DENIED, 1 VISIT PER PHYS PER DAY" because reimbursement was first issued to the Hospitalist PA. The

[12] Centers for Medicare & Medicaid Services. *Medicare claims processing manual: Chapter 12 – Physicians/Nonphysician practitioners*. Updated July 24, 2025. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

healthcare system appealed with supporting records (indicating the PAs were practicing in two different specialties and were treating different medical conditions), and Medicare issued reimbursement. This created an avoidable administrative burden for the health system and the Medicare Administrative Contractor.

2. Example 2
    a. **Setting**: A nonprofit healthcare system in Northern Virginia employing practitioners, including PAs, as part of a multi-specialty group practice (under the same tax ID number).
    b. **Clinical Scenario**: A patient was admitted to the hospital by an internal medicine physician (specialty #1) with stroke-like symptoms after placement of a ventriculoperitoneal (VP) shunt. The patient was transferred to the Intensive Care Unit (ICU) after becoming unresponsive (ICD-10 R46.4) and was seen by a Critical Care PA (specialty #2 but identified as CMS Specialty Code "97"). The patient was seen on the same day by a Neurosurgery PA (Specialty #3 but identified as CMS Specialty Code "97") to evaluate the VP shunt (ICD-10 T85.698A).
    c. **Issue**: Medicare denied the Neurosurgery PA claim with the remark code "B14-B14-DENIED, 1 VISIT PER PHYS PER DAY" because reimbursement was already issued to the Critical Care PA for the same day. The healthcare system appealed the denial with supporting records (indicating the PAs were practicing in two different specialties and were treating different medical conditions), and Medicare issued reimbursement. This created an avoidable administrative burden for the health system and the Medicare Administrative Contractor.
3. Example 3
    a. **Setting**: A multi-specialty provider organization in Illinois that provides services in Skilled Nursing Facilities (SNF).
    b. **Clinical Scenario**: A patient in a SNF had an exacerbation of chronic obstructive pulmonary disease (COPD) that worsened their general weakness and debility. A Pulmonary PA (specialty #1 but identified as CMS Specialty Code "97") saw the patient for COPD (ICD-10 J44. 1) and a Physical Medicine and Rehabilitation (PM&R) PA (specialty #2 but identified as CMS Specialty Code "97") saw the patient on the same day to evaluate and manage the physical deconditioning (ICD-10 R53.81).
    c. **Issue**: Medicare denied the PM&R PA claim because reimbursement was issued first to the Pulmonary PA. The organization appealed the denial and was reimbursed for both services. This created an avoidable administrative burden for the organization and the Medicare Administrative Contractor.
4. Example 4
    a. **Setting**: A nonprofit healthcare system in Southern California employing practitioners, including PAs, as part of a multi-specialty group practice (under the same tax ID number).
    b. **Clinical Scenario**: A patient was referred to a tertiary care facility for a joint infection. Because the patient had to travel over 60 minutes to the facility, the patient was scheduled to see an Orthopaedic PA (specialty #1 but identified as CMS Specialty Code "97") and an Infectious Disease PA (specialty #2 but identified as CMS Specialty Code "97") on the same day, with one visit to manage the infection and antibiotic regimen (ICD-10 A40.8) and the other visit to manage septic arthritis (ICD-10 M00.861).
    c. **Issue**: Medicare denied the orthopaedic PA claim because reimbursement was issued first to the Infectious Disease PA. The organization did not appeal the claim and lost payment for the second evaluation and management service. The health system changed its scheduling policy for other future patients and made them schedule appointments with PAs on different days

regardless of how far they had to travel. This created a patient access problem and resulted in decreased patient satisfaction.

Clinical examples of billing issues with PAs in a multi-specialty group practice billing for new versus established patients (in which the PAs are working in different specialties providing care for different medical problems) due to the Medicare billing policy[13]:

> *A new patient is one who has not received any professional services from the same physician or another physician of the same specialty and same group practice within the past three years.*

This policy has been applied to non-physician practitioners. In a multi-specialty group practice in which a patient has seen any PA (or any NP), identified by CMS Specialty Code "97" (or "50"), a claim submitted by another PA (or NP) for a new patient encounter (e.g., a patient who has not been seen by that specialty in that practice in the past three years) will be automatically denied because the claims process assumes the PAs are in the same "specialty".

Examples of the Problem

1. Example #1
    a. **Setting**: A nonprofit healthcare system in Southern California employing practitioners, including PAs, as part of a multi-specialty group practice (under the same tax ID number).
    b. **Clinical Scenario**: One practitioner, a Family Medicine PA, has seen a patient for the past two years for primary care management of hypertension (ICD-10 I10) and diabetes (ICD-10 E11.9). The patient developed atrial fibrillation (ICD-10 I48.91), and the Family Medicine PA (specialty #1 but identified as CMS Specialty Code "97") referred the patient to the cardiology department of the multi-specialty practice. The first available cardiology appointment was with a Cardiology PA (specialty #2 but identified as CMS Specialty Code "97") who saw the patient as a "new patient" to cardiology (because the patient had not seen a cardiology practitioner in the past three years).
    d. **Issue**: Although the patient was never seen by a cardiology practitioner in the multi-specialty group practice, the new patient claim was denied because the patient was seen by a PA in the group practice within the past three years. The organization appealed the denial with supporting documentation, and was reimbursed for the "new patient" visit. This created an avoidable administrative burden for the health system and the Medicare Administrative Contractor.
2. Example #2
    a. **Setting**: A nonprofit healthcare system in Southern California employing practitioners, including PAs, as part of a multi-specialty group practice (under the same tax ID number).
    b. **Clinical Scenario**: One practitioner, a Family Medicine PA, has seen a patient for the past year for primary care management with a history of migraine (ICD-10 G43.E09). The patient was diagnosed with rheumatoid arthritis (ICD-10 M06.09), and the Family Medicine PA (specialty #1 but identified as CMS Specialty Code "97") referred the patient to the rheumatology department of the multi-specialty practice.

[13] Centers for Medicare & Medicaid Services. *Official CMS Medicare transmittal: R1231OTN*. May 3, 2013. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1231OTN.pdf

c. **Issue**: A Rheumatology PA (specialty #2 but identified as CMS Specialty Code "97") was available to see the patient in one week but because the practice had "new patient" claims denied under similar circumstances, the patient was made to wait three months to see the physician Rheumatologist so the health system did not experience a denied claim for what was a new patient to rheumatology. This created a patient access problem and resulted in decreased patient satisfaction. It also increased costs to Medicare because the new patient claim was paid to a physician at 100% rather than to a PA at 85%.

3. Example #3
   a. **Setting**: A nonprofit healthcare system in Northern Virginia employing practitioners, including PAs, as part of a multi-specialty group practice (under the same tax ID number).
   b. **Clinical Scenario**: One practitioner, an Endocrinology PA (specialty #1 but identified as CMS Specialty Code "97"), saw a patient for hyperthyroidism (ICD-10 E05.9) two years ago. The patient was later diagnosed with spinal stenosis (ICD-10 M48.06) and their primary care provider referred them to orthopaedics at the multi-specialty group practice.
   c. **Issue**: An Orthopaedic PA (specialty #2 but identified as CMS Specialty Code "97") was available to see the patient i but because the practice had "new patient" claims denied under similar circumstances, the patient was made to wait to see the physician. This was an inefficient use of the physician's time because the patient could have been managed with non-surgical treatment by the PA while the physician could have otherwise performed a medically necessary surgery for another patient. This adversely affected patient access and patient satisfaction. It also increased costs to Medicare because the new patient claim was paid to a physician at 100% rather than to a PA at 85%.

AAPA appreciates your consideration of the suggested changes to improve efficiency and healthcare delivery in the United States. We believe the above suggestions are within the purview of CMS and, as noted during our call, would not override state laws and facility policies, but would provide flexibility and efficiency to those states that would like to benefit from them.

Sincerely,

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