



Payer Reimbursement Policies for PAs

PAs (physician associates/physician assistants) work to ensure the best possible care for patients in every specialty and setting. Their rigorous medical education, versatility, and commitment to patient-centered care help practices function efficiently while providing increased revenues and enhanced continuity of care.¹⁻⁴ Medicare, Medicaid, TRICARE, Workers' Compensation, and nearly all commercial payers cover medical and surgical services delivered by PAs. Due to variation in payer policies pertaining to claims filing, it is important to verify each payer's specific coverage policies for PAs.

MEDICARE

Services provided by PAs are covered by Medicare in all practice settings at 85% of the physician fee. Generally, all services for which Medicare would pay if provided by a physician are covered when performed by a PA, in accordance with state law. Those include services provided in an office or clinic, a hospital department, a skilled nursing facility, an ambulatory surgical center, a patient's home, or via telehealth. Medicare defers to state law on collaboration requirements.†

PA claims are submitted to Medicare at the full physician charge. Use of a PA's National Provider Identifier (NPI) number alerts the Medicare Administrative Contractor (MAC) to pay at 85%.

PAs are authorized to treat new patients and established patients with new, chronic, exacerbated, or stable medical problems when billing Medicare under their name and NPI. Medicare rules do not require the physician to see, treat, or be physically present with the patient when a PA provides a service that is billed to Medicare under the PA's name, except for when PAs first assist at surgery. The Medicare program designates a limited number of services that can be performed only by physicians, such as certifying terminal illness under the hospice Medicare benefit.

Office-based services

Private practices and clinics may bill for services provided by PAs using PA NPI numbers, accepting Medicare reimbursement at 85% of the physician charge. Eligible services include, but are not limited to, all levels of new and established outpatient office services, wellness visit and preventive care, minor surgical procedures, and diagnostic tests.

Practices have the option of billing under Medicare's "incident to" provision, using a collaborating physician's name and NPI number when meeting Medicare's more restrictive payment rules. This results in Medicare reimbursement at 100% of the fee schedule, if the following requirements are met:

1. The service must be performed in a medical office or clinic (Place of Service 11 or 50)
2. The physician must personally furnish a professional service, establish a diagnosis, and initiate treatment
3. The service the PA provides must be care related to the course of treatment initiated by the physician

4. The physician (or another physician within the practice) must be available via two-way audio-visual communication
5. The physician is responsible for the overall care of the patient and must perform services at a frequency that reflects his or her active and ongoing participation in the management of the patient's course of treatment
6. The PA must represent a direct financial expense to the physician billing (W-2, leased employee, or independent contractor) or have the same employer (same tax ID)

If a practice is audited, the auditors will look for verification that the above “incident to” criteria were met if records indicate that claims for services provided by PAs were submitted using the physician's NPI.

Hospital-based services

Services provided by PAs in hospitals (e.g., inpatient, outpatient, and emergency departments or operating rooms) may be billed using a PA's NPI number with reimbursement at 85% of the physician charge, or as split (or shared) visits (reimbursed at 100%) if specific requirements are met. The requirements for a service to be billed as split (or shared) are:

- The PA and physician work for the same group
- The physician and PA provide the service on the same calendar day (not within the same 24-hour period); they do not need to see the patient at the same time
- The physician must perform a “substantive portion” of the service (defined below)
- Either the PA or physician must have a face-to-face encounter with the patient
- The physician must sign and date the medical record

“Substantive Portion” will be defined differently starting in 2024

- Definition of “Substantive Portion” in 2024 and beyond
 - More than half the total time spent on the service (more than half the combined time spent by the PA and physician)

See AAPA's [split \(or shared\) visit brief](#) for information about corresponding documentation and modifier.

Professional services delivered by hospital-employed PAs must be billed to Medicare Part B. Hospitals may not include PA salaries in their Part A cost reports unless the PAs are providing nonclinical, administrative services. The percentage of a PA's time/salary dedicated to administrative responsibilities may be placed in the hospital's cost report.

Medicare restricts coverage for PAs, nurse practitioners (NPs), and physicians who first assist in teaching hospitals with specialty programs related to a surgery in question, with limited exceptions. Qualified residents must be used in these circumstances unless a resident is not available, surgeons have an across-the-board policy of never involving a resident in peri-operative care, or in exceptional medical circumstances (e.g., trauma surgeries). This restriction applies only to first assisting at surgery; the presence of residents does not limit the ability of PAs to deliver and be reimbursed for all other covered services in a teaching hospital.

Physician involvement

Medicare generally follows state law regarding the need for physician involvement/collaboration. Previously, Medicare exclusively used the term “supervision” to describe the relationship between PAs and physicians. Recognizing the increased role of PAs, state laws are moving away from the concept of physician supervision and using other terms, such as collaboration, that provide PAs with a higher degree of practice autonomy or are eliminating the need for a specific relationship between a PA and a physician. Physicians need not be physically present when PAs provide care to a Medicare patient, unless required by state law or facility policy. Having a physician review or co-sign a patient’s chart, or discuss a patient with a PA, does not allow PA-provided service to be billed under a physician’s name.

Certain optional billing provisions, such as “incident to” in the office or clinic and split (or shared) visit billing in a hospital setting, require a higher level of physician involvement. Medicare does not require that either of these billing mechanisms be used. PAs can treat Medicare patients without direct physician involvement if the service is billed under the name and NPI of the PA.

PA employment status

PAs may be W-2 employees, “leased employees,” or independent contractors. Recent changes to Medicare policy authorize PAs to receive direct payment for services provided as of January 1, 2022. Most PAs, like most physicians and NPs, will likely continue to reassign benefits to their employer if they are in traditional W-2 employment relationships. However, independent contractors, those who wish to work without a formal employment relationship, or those who own a medical practice or professional corporation (see below) will now be able to be reimbursed directly from Medicare if not prohibited by state law.

NPI numbers

All healthcare professionals who transmit or receive healthcare information electronically, including insurance billing, must have an NPI number. An NPI number can be [obtained from CMS](#).

Medicare enrollment

After obtaining an NPI, PAs who treat Medicare patients are required to enroll in the Medicare program using the Provider Enrollment, Chain, and Ownership System ([PECOS online enrollment system](#)).

PA ownership

If a state-approved corporate entity (e.g., professional medical corporation) qualifies as a provider of Medicare services, CMS allows PAs to own 100% of a corporation, effective January 1, 2022. Previously, PAs were limited to owning 99% of the corporation to ensure they were not receiving direct payment. Medicare policy changes starting in January 2022 authorized direct payment for PAs and allowed PAs to own the entire corporation.

MACRA/QPP

Signed into law in 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) repealed the sustainable growth rate formula and combined various Medicare quality and value programs into the

Quality Payment Program (QPP). PAs qualify as eligible clinicians and in most instances are required to participate in one of two reporting and reimbursement tracks: the Merit-Based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models (Advanced APMs).

MEDICAID

All 50 states and the District of Columbia cover medical services provided by PAs under Medicaid fee-for-service or Medicaid managed care programs. The reimbursement rate is either the same as or lower than that paid to physicians. Medicaid programs in forty-eight states and DC specifically enroll PAs as rendering providers in their programs. Whether enrolled or not, most services PAs deliver to Medicaid beneficiaries are covered.

TRICARE

TRICARE, the health benefit program for all seven uniformed services of the U.S. military, covers all medically necessary services provided by a PA. The physician with whom the PA works must be an authorized TRICARE provider. The employer bills, indicating the PA as the rendering provider, and is reimbursed for services provided by the PA. Coverage under TRICARE for PAs is at 85 percent of the physician fee schedule, including for assisting at surgery. The program does not permit “incident to” billing for medical services provided by PAs. However, there are instances in home, office, or hospital care when a PA and physician can perform components of a procedure, other than assistant-at-surgery, and bill the combined service using the physician’s NPI number. In these cases, the allowable charge “may not exceed the allowable charge for the procedure rendered by a physician.”⁶

PRIVATE INSURANCE COMPANIES

Nearly all private payers reimburse for services provided by PAs; however, billing procedures vary. Private payers are able to set their own coverage and reimbursement policies and such policies may even vary from plan to plan and line of business (commercial, Medicaid managed care, Medicare Advantage, behavioral health). Given these and other variations, checking with individual payers about how they want PA-provided services billed is essential.

LACK OF TRANSPARENCY AFFECTS PAs

Billing for medical services provided by a PA under the name of the physician (for example, under “incident to” or split (or shared) visit provisions) creates a lack of transparency in the billing process that could have negative consequences for PAs in programs such as MIPS. The result is PA care and productivity that is “hidden” or not reported within the Medicare claim systems and databases. A PA cannot be evaluated on care quality metrics when the care he or she delivers is attributed to another professional. Similar transparency concerns exist under state Medicaid programs and commercial payers that do not identify PAs on claims as having provided services.

AAPA advocates for increased [transparency](#) that would permit services performed by PAs to be correctly attributed to them. Transparency of PA-provided services is particularly important as quality reporting programs

and publicly facing comparative websites, such as Medicare Care Compare, rely on the accuracy of such data to assess PA care quality and impact on care delivery. Enrolling PAs and billing services under their names to identify them as distinctly recognizable professionals on claims creates clarity and accountability for PA-provided patient care services.

ONLINE REIMBURSEMENT RESOURCES

The single most comprehensive resource on billing for PA services is “The Essential Guide to PA Reimbursement,” available through the AAPA Store. AAPA’s [Reimbursement webpage](#) is the access point to a wide range of topics related to payment for services provided by PAs.

Disclaimer

Every reasonable effort is made to ensure the accuracy of this information. The final responsibility for the correct submission of claims and the understanding of payer regulations and requirements remains with the provider of the service and with those who submit claims. Medicare, Medicaid and commercial payer policies change frequently. The information presented is not meant to be construed as legal, medical or payment advice.

References

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- 5 U.S. Department of Health and Human Services. CMS Manual, Pub. 100-04. Transmittal 178. 2004. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf>
- 6 TRICARE Policy Manual Sections 6010.58-M. <http://manuals.tricare.osd.mil/> Accessed April 13, 2018.

†AAPA policy describes the working relationship between PAs and physicians as collaborative. Medicare and some states use the term supervision.

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