Policy

**Independent / Directly Contracted**
Community Health Options allows reimbursement for Physician Assistant (PA) professional services based on all the following:

- The service is performed by a person who meets all the PA qualifications;
- The PA is legally authorized to perform the services in the state in which they are performed;
- The service is within the scope of PA provider’s scope of practice; and
- The service is not otherwise precluded from coverage based on Member eligibility, benefits or Community Health Options policies and authorization requirements; and
- Provider is credentialed with Community Health Options and has a signed direct contract.

Contracted PAs should submit claims using the CMS-1500 claim form, or electronic equivalent.

PA applied payment reduction consistent with Center for Medicare & Medicaid Services (CMS) or 85% of Community Health Options Fee Schedule or contract allowable.

*This does not apply to facility-based contracts and requires the PA to be directly contracted.

**Non-contracted PA for Medical Services**
Services are required to be billed on the CMS-1500
Paper Claims: the supervising physician’s National Provider Identifier (NPI) in box 24J and supervising physician’s name in box 31.
Electronic Claims (837p, version 5010): Rendering Provider Loop 2310B; enter the supervising physician’s NPI in segment NM109 with XX qualifier in NM108.

**Assist at Surgery**
Services required to be billed on the CMS-1500:
Paper Claims: PA’s National Provider Identifier (NPI) in box 24J along with modifier AS and *supervising physician’s name in box 31.
Electronic Claims (837p, version 5010): Rendering Provider Loop 2310B; enter the *supervising physician’s NPI in segment NM109 with XX qualifier in NM108 along with AS modifier.

“AS” modifier is required in the first modifier field with the rendering physician NPI; either contracted or non-contracted. Primary surgeon and assistant surgeon CMS-1500 claims are required to be submitted separately for appropriate reimbursement to each provider following the above billing standards.

*Supervising physician needed for non-contracted PAs only.
**Exceptions** would fall under specific provider contract language, state, or federal regulations. This policy does not apply to the state of New Hampshire and Massachusetts.

### CMS-1500 claim form fields

<table>
<thead>
<tr>
<th>Form Locator Number</th>
<th>Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>24J</td>
<td>Rendering Provider ID number</td>
<td>Enter the rendering provider’s NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion. The shaded portion of 24J is not to be reported.</td>
</tr>
</tbody>
</table>
| 31                  | Signature of physician or supplier and date | Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed.  

In the case of a service that is provided incident to the service of a physician or nonphysician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field; however, the claim can be processed if the following is true: if a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer-generated signature.

Table Reference: Medicare Claims Processing Manual, Chapter 26 - Completing and Processing Form CMS-1500 Data Set
Resources/References


Related Policies

Modifier Reference Guide
Outpatient & Professional Services

Document Publication History

8/18/2023  Annual Review: update dates on resources/references
7/29/2022  Update: Added sections for transparency of various billing for contracted, non-contracted, and assist at surgery with claim form billing guidelines. Added CMS-1500 claim form table.
12/28/2021 Annual Review: removed unrelated modifier and added more excluded states
11/9/2020  Initial publication, Effective date 1/1/2021

This policy provides information on Community Health Options’ claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion. Policies are enforced unless underpinning direction stated otherwise.