 JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	JOHNS HOPKINS HEALTHCARE	Policy Number: RPC.011 Effective Date: 6/1/2019 Revision Date: 6/01/2022
	Subject: Physician Assistant Reimbursement Department: Provider Relations Lines of Business: EHP, USFHP, PPMCO, and AdvantageMD	Page 1 of 5

ACTION

- New Policy
- Repealed Policy Date: _____
- Superseded Policy Number: _____

The most current version of the reimbursement policies can be found on www.jhhc.com.


These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Johns Hopkins HealthCare (JHHC) benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services must be billed with ICD-10 codes, CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Johns Hopkins HealthCare (JHHC) may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHC reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHC strives to minimize these variations.

JHHC reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on www.jhhc.com.

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POLICY:

It is the policy of Johns Hopkins HealthCare (JHHC) to reimburse Physician Assistants (PAs) for covered services they are legally authorized to perform within their scope of practice in accordance with, and as defined by State law and CMS guidelines.

SCOPE:

This policy applies to all CPT and HCPCS codes reported on CMS-1500 or UB-04 claim forms or their electronic equivalent, to a JHHC product, from network and non-network physicians, providers, and suppliers.

DEFINITIONS:

Accredited Practitioner/Physician - for the purpose of this policy, refers to providers who are not an excluded, nor opt-out physician or practitioner, and who meet the criteria for participation outlined in the credentialing policy (see References; PCR.002)

Covered Services – may include, though are not limited to; physical exams, diagnosing and treating illnesses, ordering and interpreting tests, counseling on preventive health care, assist in surgery, and prescribing medications. These may be shared or split with, or performed incident to an accredited supervising physician.


Physician Assistant (PA) – a medical professional who is licensed and clinically prepared to provide healthcare services either in collaboration with or under the supervision of a Doctor of Medicine (MD) or Doctor of Osteopathy (DO), and have satisfied all credentialing requirements.

Scope of Practice (for PAs) – According to the Maryland Department of Health, Board of Physicians, a Physician Assistant’s scope of practice is limited to medical acts that are:

- Delegated by the supervising physician;
- Appropriate to the Physician Assistant’s education, training, and experience;
- Customary to the practice of the supervising physician;

BILLING GUIDELINES & PAYMENT METHODOLOGY

Physician Assistants should document their individual NPI in the Rendering Provider section of the claim (*example, box 24J on CMS1500 form*). The supervising physician will also need to be documented on the claim. To do so, per CMS billing guidelines, you must enter the supervising

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physician's name in the appropriate claim field (*example, box 17 on CMS1500 form*). Include the qualifier **DQ** to indicate the provider is a supervising physician. See the below example, from the National Uniform Claim Committee (NUCC) (see References for link).

Enter the applicable qualifier to identify which provider is being reported.

DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

Enter the qualifier to the left of the vertical, dotted line.

DESCRIPTION: The name entered is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service(s) or supply(ies) on the claim. The qualifier indicates the role of the provider being reported.

FIELD SPECIFICATION: This field allows for the entry of 2 characters to the left of the vertical, dotted line and 24 characters to the right of the dotted line.

EXAMPLE:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Jane A Smith MD
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1. Services rendered Incident to or Shared/Split with supervising physician will be paid:

EHP and USFHP: at the lesser of the actual charge or an amount equal to 85% of the physician fee schedule.


PPMCO: in accordance with State guidelines, the lesser of the provider's customary charge (unless the service is free to individuals not covered by Medicaid); or an amount equal to 100% of the then current Maryland Medicaid Professional Services Fee Schedule.

AdvantageMD: Physician assistant services are paid at 80% of the lesser of the actual charge or 85% of what a physician is paid under the Medicare Physician Fee Schedule.

2. Services rendered by the Physician Assistant assisting in surgery must be billed with the appropriate modifier (AS, 80, or 82) and will be paid at the lesser of the actual charge or:

EHP and USFHP: an amount equal to 16% of the Physician Assistants allowable fee, with the Physician Assistants allowable fee defined as 85% of the Physician Fee Schedule.

PPMCO: in accordance with State guidelines for Assistant at Surgery procedures, an amount equal to 20% of the fee for the surgical procedure.

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AdvantageMD: PA assistant-at-surgery services shall pay at 80% of the lesser of the actual charge or 85% of what a physician is paid under the Medicare Physician Fee Schedule.

EXCLUSIONS

N/A

EXEMPTIONS

N/A

REFERENCES: This policy has been developed through consideration of the following:

JHHC [Credentialing Policy PCR.002](#) - *Criteria for Practitioner Participation*

JHHC [Reimbursement Policy RPC.009](#) - *Scope of Practice*

TRICARE [Policy Manual 6010.60-M, April 1, 2015, Chapt.11, Sect. 3.13](#) – *Certified Physician Assistant*

TRICARE [Reimbursement Manual 6010.61-M, April 1, 2015, Chapt.1, Sect.6](#) - *Reimbursement of Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Psychiatric Nurse Specialists (CPNSs)*

COMAR [10.09.55.06](#), *Physician Assistants Authority – Payment Procedures*,

COMAR [10.09.02.07E](#), *Physicians' Services Authority – Payment Procedures*,


COMAR 10.32.03.01-18, *Delegation of Duties by Licensed Physicians – Physician Assistant*;

Maryland Department of Health, [Professional Services Provider Manual and Fee Schedule](#)

Pub.100-02, [Medicare Benefit Policy Manual, Chapt.15, Sect.190](#), *Physician Assistant (PA) Services*

Pub. 100-04, [Medicare Claims Processing Manual, Chapt.12, Sect.110](#), *Physician Assistant (PA) Services Payment Methodology*

National Uniform Claim Committee, [1500 Health Insurance Claim Form Reference Instruction Manual](#) for Form Version 02/12, July 2018

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APPROVALS

Reimbursement Policy Committee Date: 5/24/2022

Review/Revision Dates: 11/1/2017, 4/24/19, 8/5/19, 9/2/2020, 6/10/21, 5/24/22