Private Payer Reimbursement Policy-Ohio

Private Payer Reimbursement Overview

Nearly all private payers reimburse for services provided by PAs; however, insurers may have different policies regarding how PAs are credentialed, what services PAs may provide, and how services provided by PAs should be billed. In general, when state laws are followed, insurance plans cover PAs providing medically necessary services that are within the scope of PA practice.

Many payers request that PAs submit claims for medical services under the physician's name and provider number and reimburse for the PA's services at the same rate a physician would receive. Some payers, however, individually credential PAs and ask that claims be submitted with the PA's name and number.

Tips for Discussing PA Reimbursement with Payers

When contacting insurance companies to determine their coverage policies for medical services provided by PAs, be sure to phrase your questions with terminology that the company understands. Semantic differences matter. If you ask someone in an insurance company's provider relations or claims department if PAs are reimbursed for services provided under the company's health plan, you may be told that PAs are not reimbursed because most insurance companies do not reimburse PAs directly. Instead, if you ask "Are physician services performed by a PA covered when billed under the physician's name," the answer will usually be positive. Below is a list of questions you can ask when requesting that an insurance company clarify its policies.

- Are PAs credentialed or enrolled by [insurance company name]?
- Do you cover surgical first assisting services provided by PAs working with the supervision of a physician? Do you require the use of a modifier on the bill for first assist services performed by a PA?
- Are PAs issued provider numbers? If not, is it appropriate for PAs to submit bills under their supervising physician's provider number?
- Can a PA see a patient on an initial office visit?
- Do you defer to state law regarding supervision?
- Does [insurance company name] defer to state law regarding a PA's scope of practice?
- Are PAs reimbursed for services they provide in a hospital setting?

When contacting a payer, always protect the confidentiality of your practice.

How to Handle Claim Denials from Private Insurance Companies

Before challenging a claim, examine the reason for your denial. The reason for the payer's denial can be found on the EOB or Explanation of Benefits. In some cases, the denial may have been caused by a clerical error such as an incorrect CPT code, a missing signature, or another simple oversight.

A denial of coverage because a PA performed the service is usually phrased as "service only covered when provided by an M.D. or D.O." or "physician assistants not considered authorized providers under the plan." In some cases, first assisting at surgery claims are denied for incorrect use of modifier codes (Do not assume that all companies use the same code; some use AS, some 80, 81, or 82.) and in other cases, those claims are denied because of the use of a restricted code or for performing a surgery not necessarily requiring a first assistant. You may need to contact the insurance company to find out what modifier should have been used and, in some cases, you may need documentation that a first assistant was medically necessary for the surgery.

Insurance companies strive to (1) retain their subscribers, (2) maintain or increase their market share, and (3) keep a positive corporate image. If the insurance company made the coverage decision and you believe that the coverage decision was unfair, enlist the help of the patient and, if applicable, the business that pays the insurance plan's premium. Their dissatisfaction is of greater concern to the insurer with regard to the above-mentioned three areas than you not getting paid. AAPA maintains sample letters contesting claim denials and will also send letters to insurers to substantiate your appeals. For sample letters, contact AAPA's reimbursement staff at 703/836-2272, ext. 3218 or 3219.

What Should I Do if My Claim Gets Denied by a Private Payer?

If your claims get denied by a private payer, follow these four steps.

1. Find out why the claim was denied and attempt to remedy the problem if it was caused by an administrative problem.
2. If the claim was not denied for administrative reasons, assemble facts to support your decision to perform that service (e.g., relevant state law, delegation agreement, etc.).
3. Prepare your strategy involving the patient, the business purchasing the coverage, and the AAPA reimbursement staff, as needed.
4. Write a letter to the insurance carrier explaining the problem and demonstrating why paying for the service is fair and in the best interest of their company.

Of course, remember to follow up with AAPA and keep its reimbursement team informed.

How Can I Obtain Information About Private Payer Reimbursement for Services Provided By PAs?

AAPA has compiled profiles of local payers in Ohio which can be accessed at the following link: http://www.aapa.org/images/stories/state_surveyspayer_profiles/ohio-pp.pdf.

You may ask also AAPA's reimbursement staff for assistance; they can be reached at 703/836-2272, Andrew Iwanik, aiwanik@aapa.org, ext. 3218 or Tricia Marriott, tmarriott@aapa.org, ext.3219.

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