Payment Policy: Physician Extenders

Reference Number: QCP.PP.032
Last Review Date: 12/1/2025

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy/Criteria

I. Medical services rendered by Physician Extenders (licensed Advanced Practice Nurses (APN) and Physician Assistants (PA)) will be covered within their legal scope of practice, based on specific contract terms. While APNs can practice independently with a collaborating physician agreement, some APNs, instead of practicing independently, choose to practice as Physician Extenders with a supervising physician, PAs cannot practice independently and can only practice with a supervising physician.

A. Covered medical services provided by APNs or PAs must be concordant with the specialty of the collaborative/supervising physician.

B. The physician is present in the immediate patient care area and available to provide immediate assistance and direction throughout the time the Physician Extender is providing care. This does not imply that the physician must be in the same room, but does mean the physician must be within the office suite and not engaged in activities that would prevent the physician from immediately going to the patient's room.

C. Only services rendered in a private physician office or clinic are eligible to be considered as "incident to" services – services provided in a hospital ER, hospital clinic, home, or to a patient who is a resident in a hospital, convalescent hospital, nursing home, rehabilitation facility, or other residential facility may not be billed as "incident to" services. The only exception would be a home visit at which both the physician and the physician extender are in attendance on the patient at the same time.

D. The physician is actively involved in the decision-making process for care of the patient. The Physician Extender must document in the patient's medical record the active involvement of the physician in the decision-making process. Actively involved means that the physician is sufficiently aware of the patient's current condition to endorse or intervene in the patient's care in a timely manner, and that the physician must have initiated the care for the particular injury or illness for which the patient is being treated. Thus, a Physician Extender may bill "incident to" for a follow up visit for a particular condition, but not for an initial visit for that condition. Additionally, there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment.

E. The physician provides documentation/attestation of the collaboration/supervision in the patient's medical record by co-signing and dating the patient's medical record on the date the service is rendered.

F. The supervising/collaborating physician is credentialed by QualChoice or another entity to which QualChoice delegates credentialing.

II. Medical Statement

A. QualChoice reimburses services provided by Physician Extenders based on CMS standard methodologies, AR state law, QualChoice contract terms, and the appropriate QualChoice fee schedule.

B. Direct Billing: An APN eligible to bill QualChoice directly will be reimbursed for Covered Medical Services at the contracted rate. A group employing a PA eligible to bill QualChoice directly will be reimbursed for Covered Medical Services at contracted rates.
C. Incident-to services: Physician Extenders may under certain circumstances bill for their services as "incident-to" physician services, under the NPI of the supervising/collaborating physician. These services will be reimbursed at the physician fee schedule only if ALL the following are met:
    1. Physician Extender is an employee of the supervising/collaborating physician or the entity that employs the physician.
    2. The physician is present in the immediate patient care area and available to provide immediate assistance and direction throughout the time the Physician Extender is providing care. This does not imply that the physician must be in the same room, but does mean the physician must be within the office suite and not engaged in activities that would prevent the physician from immediately going to the patient's room.
    3. Only services rendered in a private physician office or clinic are eligible to be considered as "incident to" services – services provided in a hospital ER, hospital clinic, home, or to a patient who is a resident in a hospital, convalescent hospital, nursing home, rehabilitation facility, or other residential facility may not be billed as "incident to" services. The only exception would be a home visit at which both the physician and the physician extender are in attendance on the patient at the same time.
    4. The physician is actively involved in the decision-making process for care of the patient. The Physician Extender must document in the patient's medical record the active involvement of the physician in the decision-making process. Actively involved means that the physician is sufficiently aware of the patient's current condition to endorse or intervene in the patient's care in a timely manner, and that the physician must have initiated the care for the particular injury or illness for which the patient is being treated. Thus, a Physician Extender may bill "incident to" for a follow up visit for a particular condition, but not for an initial visit for that condition. Additionally, there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment.
    5. The physician provides documentation/attestation of the collaboration/supervision in the patient's medical record by co-signing and dating the patient's medical record on the date the service is rendered.
    6. The supervising/collaborating physician is credentialed by QualChoice or another entity to which QualChoice delegates credentialing.
D. Assistant Surgeon Services: QualChoice will reimburse for assistant at surgery services when:
    1. The procedure is one of the procedure codes approved by QualChoice to be payable to an assistant surgeon; AND
    2. The Physician Extender is employed by a physician or physician group and not by the hospital; AND

3. Assistant surgeon services are billed under the Physician Extender's provider identification/NPI number with the appropriate modifier.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
99201	(code deleted eff 01-01-2021)
99202	Ofc or other outpt vst for the eval/mgt of a new pt, which requires a medically appropriate history and/or exam and straightforward mdm. When using time for code selection, 15-29 min of total time is spent on the date of the encounter. (code revised eff 01-01-2021)
99203	Ofc or other outpt vst for the eval/mgt of a new pt, which requires a medically appropriate history and/or exam and low level of mdm. When using time for code selection, 30-44 min of total time is spent on the date of the encounter. (code revised eff 01-01-2021)
99204	Ofc or other outpt vst for the eval/mgt of a new pt, which requires a medically appropriate history and/or exam and moderate level of mdm. When using time for code selection, 4559 min of total time is spent on the date of the encounter.(code revised eff 01-01-2021)
99205	Ofc or other outpt vst for the eval/mgt of a new pt, which requires a medically appropriate history and/or exam and high level of mdm. When using time for code selection, 60-74 min of total time is spent on the date of the encounter. (code revised eff 01-01-2021)
99211	Ofc or other outpt vst for the eval/mgt of an est pt, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. (code revised eff 01-01-2021)
99212	Ofc or other outpt vst for the eval/mgt of an est pt, which requires a medically appropriate history and/or exam and straightforward mdm. When using time for code selection, 10-19 min of total time is spent on the date of the encounter. (code revised eff 01-01-2021)
99213	Ofc or other outpt vst for the eval/mgt of an est pt, which requires a medically appropriate history and/or exam and low level of mdm. When using time for code selection, 20-29 min of total time is spent on the date of the encounter. (code revised eff 01-01-2021)
99214	Ofc or other outpt vst for the eval/mgt of an est pt, which requires a medically appropriate history and/or exam and moderate level of mdm. When using time

CPT® Codes	Description
	for code selection, 30 - 39 min of total time is spent on the date of the encounter. (code revised eff 01-01-2021)
99215	Ofc or other outpt vst for the eval/mgt of an est pt, which requires a medically appropriate history and/or exam and high level of mdm. When using time for code selection, 40-54 min of total time is spent on the date of the encounter (code revised eff 01-01-2021)
99217	Observation care discharge
99218	Initial observation care
99224	Subsequent observation care
99231	Subsequent hospital care
99238	Hospital discharge day
99239	Hospital discharge day
99281	ER visit
99282	ER visit
99283	ER visit
99284	ER visit
99285	ER dept vst for the eval/mgt of a pt, which requires these 3 key components within the constraints imposed by the urgency of the patient`s clinical condition and/or mental status: A comprehensive history; A comprehensive exam; and Mdm of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the pt`s and/or family`s needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99334	Domicil/r-home visit est pat
99335	Domicil/r-home visit est pat
99336	Domicil/r-home visit est pat
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	4/1/2012	4/1/2012

Limits

1. Physician Extenders are not eligible for reimbursement of higher level (level 5) EM codes (99205, 99215, 99285). For this level of complexity, direct physician involvement is expected.
2. Physician Extenders are not eligible for reimbursement of inpatient admissions or for higher level inpatient care.

References

3. Effective 04/01/2020: Language added to more clearly distinguish between practice settings for APNs and PAs.
4. Effective 01-01-2021: Updated deleted code 99201 replaced by 99202. Updated revised codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215. Added codes 99205, 99215 & 99285 to the search box as well as their descriptions to the codes used in this BI since they were listed in the claims statement.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.