HCCA Physician Practice Compliance Conference

601- Audit Plan for Medicare’s Shared Visit Rule
Elin Baklid-Kunz, MBA, CPC, CCS

Handouts Included:

1. Self Audit Checklist – Shared Visits
2. Self Audit Checklist – “Incident-to” Physician Services
4. Standard/Policy for Supervision Requirements and “Incident-to”

Note: Regulations and Medicare’s policies are referenced, but also available in pdf format by request.
## DOCUmentation Task

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Are auxiliary personnel performing physician services qualified non-physician practitioners (NPP)? This includes Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialist.</td>
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<td>Does the physician or group incur an expense and meet the employment requirements for the NPPs?</td>
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<td>Are the NPPs employees, leased employees, or independent contractors of the physician or the entity that employs or contracts with the physician?</td>
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<td>Are collaboration agreements for NPs filed with the state and available?</td>
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<td>Are services performed by NPP within the state’s Scope of Practice?</td>
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<td>Is the NPPs salary excluded from the facility’s cost report? If the NPP performs both facility and professional services, are time sheets kept?</td>
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<td>Did the physician personally perform the initial service and develop the plan of care? NPPs cannot see new patients or established patients with new problems since incident-to regulations apply in this setting.</td>
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<td>Did the physician perform direct supervision? (The physician was present in the office suite during the encounter.)</td>
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<td>Shared visits are only used for the following services?</td>
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<td>- New* (provider based only) or established patients (99201-99215).</td>
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<td>* New patients can only be shared in provider based hospital clinics or outpatient departments, not in the office setting.</td>
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<td>Cannot be shared If the NPP performed consultations (99241-99255), critical care services (99291-99292) or procedures is the service billed under the NPP’s provider number for Medicare?</td>
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<td>Did the physician and NPP from the same group practice both partly perform the service? (The physician has a face-to-face encounter with the patient.)</td>
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<td>Did the physician have a face-to-face encounter with the patient on the same calendar date as the NPP?</td>
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<td>Did the physician document his part of the service, history, exam or medical decision making? (i.e., “I saw and evaluated the patient. Agree with NPP’s note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”)</td>
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<td>Scribing If a scribe was used did they only document what was dictated to them by the physician and the is scribe is identified as such? (Scribes do not act on their own)</td>
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<tr>
<td>Shared Visit Can this service be billed under the physician’s provider number?</td>
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<td>DOCUMENTATION TASK</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Location</td>
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<td>Does the place of service (POS) fall within the definition of an office or a physician directed clinic?</td>
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<td>The service is not performed in the institutional setting (i.e. hospital or skilled nursing facility)? Incident-to services cannot be performed in the emergency room, hospital outpatient department or provider based physician office (POS 22).</td>
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<td>Supervision</td>
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<td>Is there direct supervision by the physician? (Present in the office suite to assist, if necessary. The physician does not need to be physically present in the patient’s treatment room for these services.)</td>
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<td>Is there a documentation link between auxiliary staff and the physician when the incident-to service was performed? (Records of when the supervising physician was in the office suite, i.e. physician schedules, etc or documentation in the medical record by the physician.)</td>
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<td>Services performed</td>
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<td>Auxiliary staff services</td>
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<td>If service is performed by auxiliary staffs, who are not NPPs, is only a level 1 visit (CPT 99211) billed? (NPPs can bill for whatever established patient evaluation and management level that is documented)</td>
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<td>If the review of systems (ROS) and past family and social history (PFSH) were performed by auxiliary is there documentation to support that the physician and/or NPP personally reviewed this documentation by confirming and/or supplementing it in the medical record?</td>
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<td>Incident-to? 100% of feesch.</td>
<td>Yes or No?</td>
<td>If “incident-to” requirements are not met, the services may be billed under the NPP’s own provider number and paid at 85% of the Medicare physician fee schedule.</td>
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</table>
A. Applicability

This standard applies to all institutional affiliates performing and/or billing patient services for which a claim is payable under Part B of the Medicare program including the following departments:

- Business Office
- Health Information Management
- Medical Staff
- Physician Office Staff
- Administration
- Reimbursement
- Compliance
- Quality Management
- Risk Management
- Emergency Department
- Urgent Care Centers
- Clinics

B. Policy

It is the policy of HH to follow the Center for Medicare and Medicaid Services (CMS) guidelines for non-physician practitioners (NPP) services. This policy does not apply to services involving residents and teaching physician participation and documentation.

C. Background/Purpose

The Balanced Budget Act (BBA) eliminated the coverage restrictions for Nurse Practitioners (NPs) and Physician Assistants (PAs), effective for all services furnished on and after January 1, 1998. Therefore, services by the NPPs may be covered in ANY setting regardless of the designation of the area in which the services are furnished. In other words, as long as all applicable criteria are satisfied, Medicare reimbursement can be made for covered services. The criteria include such items as medical necessity and whether or not the treatment is considered “reasonable” by professional standards. Criteria also apply to the beneficiary’s eligibility for the service and provider status of the professional rendering the service.

D. Definitions

Non-Physician Practitioners (NPPs):
Non-physician practitioners (NPPs) are health care professionals permitted by law to provide care and services within the scope of the individual’s licensure and consistent with individually granted privileges by a facility’s Board of Trustees. Examples of NPPs are certified nurse-midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists.
Physician Assistants:
Physician assistants are health care professionals licensed to practice medicine with physician supervision.

Advanced Registered Nurse Practitioners:
Advanced registered nurse practitioners (ARNP) are licensed in the state to practice professional nursing and certified in advanced or specialized nursing practice. For the purpose of this text, Advanced Registered Nurse Practitioners will be referred to as Nurse Practitioners (NPs).

Collaboration:
Collaboration is a process by which the practitioner has a professional relationship with one or more physician(s) and the physician agrees to provide medical direction and appropriate supervision regarding issues that are outside the practitioner’s scope of practice.

General Supervision:
The procedure is furnished under a physician’s overall direction and control; however, the physician’s presence is not required during the performance of the procedure.

Direct Supervision:
A physician must be present in the suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It is not required that the physician be present in the room where the procedure is performed.

Personal Supervision:
A physician must be in attendance in the room during the performance of the procedure.

“Incident to”
An “incident to” service is a service that was initiated by the physician-patient or non-physician practitioner–patient encounter and is rendered by ancillary personnel in the continuation of diagnosis or treatment prescribed by the practitioner in the initiation visit.
This incident to service must be performed under the direct supervision of a physician in the same group practice.

Evaluation and Management (E/M):
E/M codes describe services provided by physicians to evaluate patients and manage their care. These codes are widely used by physicians in all specialties and describe a very large portion of the medical care provided to the patient of all ages. The various levels of E/M services describe the wide variations in skill, effort, time, responsibility, and medical knowledge required for the prevention or diagnosis and treatment of illness or injury, and the promotion of optimal health.

CMS-1500
The Center for Medicare and Medicaid Services (CMS) Health Insurance Claim Form (CMS-1500) is the basic form prescribed by CMS for the submission of claims from physicians and suppliers for the Medicare program. (Please note that the CMS-1500 paper form is superseded by HIPAA electronic formats.)
E. Standards

1. Eligibility Requirements

   a. Nurse Practitioners (NPs)
   
      Effective for services rendered after January 1, 1998, any individual who is participating under the Medicare program as a nurse practitioner (NP) for the first time ever, may have his or her professional services covered if he or she meets the qualifications listed below, and he or she is legally authorized to furnish NP services in the state where the services are performed.

      In order to furnish covered NP services, an NP must meet the conditions as follows:

      - Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law; and
      - Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or
      - Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

      NPs who qualified for a Medicare Billing number for the first time from January 1, 2001 through December 31, 2002 must meet the requirements as follows:

      - Be a registered professional nurse professional nurse authorized by the state in which the services are furnished to practice as a NP in accordance with state law; and
      - Be certified as a NP by a recognized national certifying body that has established standards for NPs.

      NPs who qualify for Medicare billing number for the first time on or after January 1, 2003 must meet the requirements as follows:

      - Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a NP in accordance with state law; and
      - Be certified as a NP by a recognized national certifying body that has established standards for NPs; and
      - Possess a Master’s degree in nursing.

   The following organizations are recognized national certifying bodies:

   - American Academy of Nurse Practitioners
   - American Nurses Credentialing Center
   - National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
   - Pediatric Nursing Certification Board
b. Physician Assistants (PAs)

Effective for services rendered on or after January 1, 1998, any individual who is participating under the Medicare program as a physician assistant for the first time may have his or her professional services covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish PA services in the state where the services are performed.

To furnish covered PA services, the PA must meet the conditions as follows:

- Must currently be certified by the National Commission on Certification of Physician Assistants (NCCPA) to assist primary care physicians; or
- Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant; and
- Be licensed by the state to practice as a physician assistant.

2. Coverage Requirements

a. General Requirements

In order to be considered for payment by Medicare, a NPP must meet the general requirements listed below.

- The practitioner must be providing services that are within the scope of licensure particular to the provider and the state in which he/she is practicing.
- The services are considered “physician services”.
- The services would not be otherwise excluded from Medicare coverage.
- The service must also meet the general criteria requirements, (e.g., medical necessity, reasonableness and appropriateness of service and patient eligibility.
- NPs must work in collaboration with a physician. The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP. The original of the protocol and the original of the notice should be filed with the state yearly, and a copy of the protocol should be kept at the site of practice of each party of the protocol.
- PAs must work under the general supervision of a physician. On behalf of a PA, the employer must file all claims for services rendered by the PA to Medicare beneficiaries. The PA’s physician supervisor (or a physician designated by the supervising physician or employer as provided under state law) is primarily responsible for the overall direction and management of the PA’s professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary. Florida state law requires the supervising physician to review, sign, and date all documentation by a physician assistant within 30 days.
(within 7 days during the initial six months of supervision). A physician may not supervise more than four currently licensed physicians at any one time.

b. Types of NPP Services That May Be Covered:

State law or regulation governs a NPP’s scope of practice in the state in which the services are performed. Examples of the types of services that NPPs may furnish include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient’s condition.

- **NPs** may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician and authorized under the scope of their state license.

- **PAs** may furnish services billed under all levels of evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician and authorized under the scope of their state license.

c. Services Otherwise Excluded From Coverage:

The NPP services may not be covered if they are otherwise excluded from coverage even though an NPP may be authorized by state law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical checkups, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from Medicare coverage even though they may be within a NP/PA scope of practice under state law.

3. **Employment Relationships**

The employer of the NP and PA may be a physician, hospital, medical group (Professional Association), or nursing facility. The following are considered valid employer/employee relationships:

- The NP/PA is directly employed by a physician, physician group, hospital, or nursing facility (i.e., the employer files IRS Form W-2 and W-4); or

- The NP/PA has a contractual agreement or is a leased employee of the physician, group, hospital, or facility (IRS Form 1099). In these instances, the physician, group, hospital, or facility is considered the employer.

F. **Procedural Guidelines**

1. **Billing Guidelines**

The practitioner’s provider number (PIN/NPI) must be reported in block 33 or 24J on the CMS-1500 (or electronic equivalent). Claims for services rendered by nonphysician practitioners must be
assigned. Services billed by the physician assistant must be paid to his or her employer (“Reassignment of benefits” From 855 required), because direct payment to PAs are not allowed under the Medicare program. Direct billing and payment for NP services may be made to the NP.

<table>
<thead>
<tr>
<th>Billing Options</th>
<th>CMS- 1500 Requirements</th>
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<tbody>
<tr>
<td>Independent Practitioner</td>
<td>NP/PA/CNS PIN in block 33 only</td>
</tr>
<tr>
<td>“Incident to” provision physician billing</td>
<td>Physician’s PIN in block 33 only, unless group number assigned</td>
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2. **Reimbursement**

- Services rendered by non-physician practitioners are reimbursed at 85 percent of the Medicare Physician Fee Schedule (MPFS) amount.
- Services for assistant-at-surgery charges are reimbursed at 85 percent of the allowed MPFS amount for surgery (16 percent of the MPFS amount is allowed for a physician performing as a surgical assistant).

No separate payment will be made to a NPP when a facility or other provider payment or charge is also made for such professional services.

3. **“Incident to” Reimbursement**

Services and supplies furnished as “incident to” a physician’s/NPP’s service may be billed as though the physician/NPP personally performed the service. Services meeting the “incident to” requirements are billed under the physician’s Medicare provider number and paid at 100% of the Medicare physician fee schedule. If “incident to” requirements are not met, the services may be billed under the NPPs own provider number and paid at 85% of the Medicare physician fee schedule.

The “incident to” billing concept only applies to services provided in physician offices and clinics. It should not be used in hospitals or nursing facilities.

To be covered “incident to” the services of the physician/NPP, the services and supplies must meet the following requirements:

- The service must be performed under the direct supervision of the physician (the physician must be physically present in the same office suite and immediately available to render assistance).
- The service must be an integral part of the physician’s personal in-office service.

4. **“Incident to” Requirements**

Services of auxiliary personnel such as nurses, technicians, and therapists may be covered when furnished incident to the professional services of a physician.

In order for the services of a NPP to be covered as “incident to” the services of a physician, the services must meet all the requirements for coverage specified in the Medicare Benefit Policy
Manual Pub. 100-02, Chapter 15 §60.1 - 60.3. The service must be an integral, although incidental part of the physician’s personal professional services, and they must be performed under the physician’s direct supervision.

This does not mean that each occasion of an incidental service performed by an NPP must always be the occasion of a service actually rendered by the physician. It does mean that:

- there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the NPP is an incidental part;
- there must be subsequent services by the physician’s continuing active participation in and management of the course of treatment; and
- the physician must be physically present in the same office suite and immediately available to render assistance if that becomes necessary.

For more information on “incident to” services, please see: GB-440: Professional Services: Supervision Requirements and “Incident-to”.

a. Group Practice Setting:

Services and supplies incident to a physician’s services in a physician directed clinic or group association are basically the same. A physician directed clinic is one where:

- A physician or numbers of physicians are present to perform medical (rather than administrative) services of all times the clinic is open.
- Each patient is under the care of a clinic physician.
- The non-physician services are under medical supervision. This recognizes that the physician establishing the treatment plan (ordering) may be different than the physician providing direct supervision.

b. NPPs Services “Incident to” a Physician:

NPPs must meet all of the requirements specified in the Medicare Benefit Policy Manual in order to bill “incident to” a physician, but unlike other auxiliary staff:

- NPPs may render a much broader range of services under their scope of practice, including minor surgeries and Evaluation and Management (E/M) services.
- NPPs may bill independently for their services when the “incident to” requirements are not met.
- NPPs may have auxiliary staff that provide services “incident to” their services.

c. “Incident to” Basic Requirements:

- The service or supplies are an integral, although incidental, part of the physician’s or practitioner’s professional services.
- The services or supplies are of a type that are commonly furnished in a physician’s/NPPs office or clinic
- The services or supplies are furnished under the physician’s/NPPs direct supervision.
• An individual who qualifies as an employee of the physician/NPP or professional association or group furnishes the services or supplies.

• Must be part of the patient’s normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment.

5. **Shared Visits**

Shared visits between the physician and NPP may be reported as one visit, if each provider sees the patient separately and each documents separately. Each component of the visit must be medically necessary.

a. **Clinic and Physician Office Setting:**

When a non-hospital outpatient clinic/office E/M encounter is shared/split between physician and a NNP, the EM encounter may be billed under the physician’s name and provider number if:

- The patient is an established patient; and
- The “incident to” rules are met. (Note: Medicare has clarified that “incident to” billing is not allowed for new patient visits).

If the patient is an established patient and the “incident to” rules are not met, then the E/M encounter cannot be billed under the physician’s provider number and may be billed only under the NPP’s provider number.

This means that a physician cannot combine the E/M services for a NPP and a physician for a **new** patient on a **first** visit E/M encounter and bill under the physician’s name and provider number.

b. **Hospital Inpatient, Outpatient and Emergency Department Setting:**

When a hospital inpatient/hospital outpatient/emergency department E/M encounter is shared/split between a physician and an NPP from the same group practice, the E/M encounter may be billed under the physician’s name and provider number if:

- The physician provides any **face-to-face** portion of the E/M encounter (even if late in the same day as the NPP’s portion); and

- The physician **personally documents** in the patient’s record the physician’s face-to-face portion of the E/M encounter with the patient. Co-signatures are **not** sufficient.

If the physician does not personally perform and **personally document a face-to-face** portion of the E/M encounter with the patient, then the E/M encounter cannot be billed under the physician’s name and provider number and may be billed only under the NPP’s name and provider number. If the physician participated in the service by only reviewing the patient medical record, the service may only be billed under the NPPs. Payment will be
made at the appropriate physician fee schedule based on the provider number entered on
the claim.

c. **E/M Codes That May be Reported as Shared Visits**

Shared visits in the hospital apply to:
- Hospital admissions (99221-99223)
- Subsequent hospital visits (99231-99233)
- Discharge management (99238-99239)
- Observation care (99217-99220, 99234-99236)
- Emergency department visits (99281-99285)
- Prolonged care (99354-99357)
- New and established patients in outpatient hospital department (99201-99215)

**Consultations and Critical Care may not be billed as a split/shared visit.**

Shared visits for physician office or clinic settings apply to established patients (99211-
99215) with an established plan of treatment. **New patients (99201 -99205) cannot be
shared in this setting.**

d. **Examples of Split/Shared Visit**

- Hospital rounds at different times of the day (must be same date of service).
- Office visit where NPP performs history and physical exam and physician performs
  medical decision making and the “incident to” requirements are met.

c. **Documentation of Split/Shared Visit**

- Follow the Documentation Guidelines as for any E/M Service.
- Each physician/NPP should personally document in the medical record his/her
  portion of the E/M split/shared visit.
- Documentation must support the combined service level reported on the claim.
- Ancillary staff may document the review of systems and past family and social
  history. The physician and NPP must personally review this documentation and
  confirm and/or supplement in the medical record.

6. **Scribing and NPPs**

The use of NPPs as scribes is not recommended since only the physician’s work will support the
physician’s bill. If “scribes” are used, some of the work performed by the “scribe”, and not the
physician, could inadvertently be documented by the “scribe” and erroneously used to support the
physician’s bill.

Medicare pays for medically necessary and reasonable services, and expects the person receiving
payment to be the one delivering the services and creating the record. There is no carrier Part B
“incident-to” billing in the hospital setting (inpatient or outpatient). Thus, the scribe should be
merely that, a person who writes what the physician dictates and does. This individual should not act independently, and there is no payment for this activity.

- If a nurse or NPP acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note “written by X, acting as scribe for Dr. Y.” Then, Dr. Y should co-sign, indicating that the note accurately reflects work and decisions made by him/her.
- It is inappropriate for an employee of the physician to make rounds at one time and make entries in the record, and then for the physician to make rounds several hours later and note “agree with above,” unless the employee is a licensed, certified provider (PA, NP) billing Medicare for services under his/her own name and number.
- Record entries made by a “scribe” should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement.

7. Commercial Payers

It is important to make a distinction between Medicare regulations and the policies for private payers. Medicare rules do not necessarily impact private payers. Most private payers do not issue numbers to NPPs and request that billing occur under the supervising physician. For example, some payers might only ask that state law is followed when PAs deliver care. Therefore it might be appropriate for the PA to provide care without a physician face-to-face encounter in a hospital setting and bill under the physician’s number.

It is important to follow the requirements set out by private payers, and the billing department should ask each payer the following questions in order to establish a written billing protocol for NPPs:

1. Do you cover medical services that NPPs perform under the supervision of a physician?
2. Are NPPs credentialed or enrolled? Some payers will enroll NPPs and give them billing numbers, so they have the capability of billing for services directly and not just under the physician.
3. Can the NPP see the patient during the initial office visit? If not, then the physician must fulfill this obligation.
4. What are your specific supervision requirements?
5. Do you issue provider numbers to NPPs? For example Medicare gives provider numbers for NPPs, while TRICARE and some Blue Cross Shields carriers do not. This gives the NPP the ability to bill for services directly to the payer and often when this is done; the supervision requirements are not as stringent.

An alternative to querying the private payers is to send the private plans a certified letter advising the plan of the hospital’s procedures for billing NPP service, unless the plan advises the hospital otherwise in writing.

8. Florida Medicaid

Services provided by NPP under the direct supervision of a physician may be billed using the physician’s provider number instead of the NPPs provider number. Direct supervision means the physician:
• Is on the premises when the services are rendered, and
• Reviews, signs and dates the medical record.

Exceptions are deliveries, psychiatric services and Child Health Check-Up screenings. The NPP must directly render these services and bill using his or her Medicaid ID number. Medicaid will not reimburse the physician and the ARNP for the same service to the same recipient on the same day.

Medicaid reimburses NPP using a separate fee schedule (reimbursed at 80% of physician fee).

9. Reassignment of Benefits
Medicare makes payments to the actual individual or entity that furnishes a service or item. However, payment may be made to another entity or organization (such as a medical group or professional association) on behalf of the individual or entity that actually furnishes the service or item. This is known as “reassignment of benefits” and requires certain applications and forms be completed and submitted by Medicare. The reassignment of benefits allows an entity to bill for and receive payment on behalf of the individual who furnishes the service or item.

Physicians and NPPs who do reassign their benefits to a group or entity should consider using the following safeguards to ensure the integrity of the claims filed on their behalf:

• One of the terms of employment or contracting with a group or entity should allow the physician or NPP access to all medical records and any financial records pertaining to the services and items they furnish.
• The physician or NPP should be allowed to periodically review claims and statements from Medicare for services that are submitted on their behalf.
• The physician and NPP should ensure procedure codes, diagnostic codes or other information furnished by the physician or practitioner used for filing claims are not changed or altered without their knowledge and consent.
• The physician or NPP should be kept informed of all correspondence or communication pertaining to claims submitted on their behalf.
• As physicians or NPPs leave or terminate employment with a particular group or entity, they should ensure the Medicare contractor is notified in writing of their termination of employment. If this is not done, the group or entity could continue using their Medicare provider number to file false claims.

G. Implementation
• Effective October 25, 2002, CMS issued new rules giving PA and NP and physicians increased latitude in hospital and office billing for E/M services. The new requirement (Transmittal 1776) allowed NPPs and physicians who work for the same employer/entity to share visits made to patients the same day with the combined work of both billed under the physician at 100% of the fee schedule. This new rule did not extend to procedures.

• Effective April 26, 2007 (the effective date of Change Request 5221), NPs are authorized to bill Medicare carriers directly for their professional services when furnished to hospital patients, both inpatients and outpatients. The employer of a PA rather than the hospital must bill the
carrier for their professional services when furnished to hospital patients. Hospitals should not bill for the professional services of a PA, unless the PA is employed by the hospital.

- Effective November 19, 2007 (the effective date of Change Request 5639), CMS is adding the National Board on Certification of Hospice Palliative Nurses (NBCHPN) to the list of recognized national certifying bodies for NPs at the advanced practice level. CMS is removing the Critical Care Certification Corporation and replacing it with its correct name, “AACN Certification Corporation” and replacing the National Certification Board of Pediatric Nurses with its current name, “Pediatric Nursing Certification Board”.

H. Exhibits

1. Billing Medicare for NPP Services
2. “Incident to” Example
3. Shared Visit Example
4. Shared Visit Documentation Examples

I. Related Policies

GB-440 Professional Services: Supervision Requirements and “Incident-to”

J. Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision/Review</th>
<th>By</th>
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<tbody>
<tr>
<td>11/02/06</td>
<td>Initial adoption</td>
<td>E. Baklid-Kunz</td>
</tr>
<tr>
<td>07/23/07</td>
<td>Final (added commercial payer section)</td>
<td>E. Baklid-Kunz</td>
</tr>
<tr>
<td>09/20/07</td>
<td>Revised section on recognized national certifying bodies for NP. Transmittal 75, CR 5639, 8/17/07</td>
<td>E. Baklid-Kunz</td>
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<tr>
<td>01/22/08</td>
<td>Added source for Exhibit 4</td>
<td>E. Baklid-Kunz</td>
</tr>
<tr>
<td>04/02/08</td>
<td>Revised Exhibit 1: Billing Medicare for NPP Services.</td>
<td>E. Baklid-Kunz</td>
</tr>
<tr>
<td>8/17/08</td>
<td>Revised Exhibit 2: “Incident-to” example, added section on Scribing to Procedural Guidelines.</td>
<td>E. Baklid-Kunz</td>
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</tbody>
</table>
K. References:

1. Medicare Claims Processing Manual, CMS Pub.100-04, Chapter 12, § 30.6.1, § 30.6.4-5 & § 30.6.13


4. CMS Medlearn Matter MM5221, released 1/26/07, effective 4/26/07: Direct billing and payment for non-physician-practitioners (NPPs) furnished to hospital inpatient and outpatient.

5. CMS Medlearn Matter MM4246, released 01/06/06, effective 01/01/06: Provides the same information as CMS Pub 100.4,30.6.13H

6. CMS Transmittal 788m CR 4215, December 20, 2005 (New Consultation Guidelines for 2006, clarifies that NPPs can perform consultations when requirements are met.)

7. CMS Medlearn Matter Number SE0441, November 1, 2004 (“Incident to” clarification)

8. CMS Transmittal 1776, CR 2321, October 25,2002 (addressing payment for E/M services provided by physicians and non physician practitioners (NPP) and also shared E/M services between a physician and NPP in the same group practice).http://www.cms.hhs.gov/transmittals/downloads/R1776B3.pdf

9. Florida Administrative Code, Chapter 64B8-30.012 (PA) & 64B8-35.001 (NP)


11. PA Scope of Practice from American Academy of Physician Assistants


   http://www.floridamedicare.com/Part_B/Medicare_B_Update/Archive/106399.pdf
Exhibit 1: Billing Medicare for NPPs Services

<table>
<thead>
<tr>
<th>Billing Medicare for Non-Physician Practitioners (NPPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Services performed by NPP must be within their state’s scope of practice.</td>
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<tr>
<td>- NPP performs and documents services and signs own notes.</td>
</tr>
<tr>
<td>- Florida Administrative Code (FAC) requires the PA’s supervising physician review, co-sign and record/note within 30 days.</td>
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</table>

<table>
<thead>
<tr>
<th>Billing “Incident to” the Physician: Reimbursed at 100% of the MPFS.</th>
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<tr>
<td>- Billed under supervising physician’s provider number, the physician or group must incur and expense and meet the employment requirements.</td>
</tr>
<tr>
<td>- NPP cannot see and evaluate “New” patients.</td>
</tr>
<tr>
<td>- Services performed by the NPP must be an integral, although incidental, part of the physician’s personal professional services.</td>
</tr>
<tr>
<td>- Services performed by the NPP must be performed under the physicians direct personal supervision (supervising physician must be present in the office suite.)</td>
</tr>
<tr>
<td>- Services performed in the hospital setting cannot be billed ‘incident to”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Billing Directly Under the NPPs Number: Reimbursed at 85% of the MPFS.</th>
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<tbody>
<tr>
<td>- NPP can see and evaluate “New” patients.</td>
</tr>
<tr>
<td>- Supervising physician need not be physically present when NPP treats patient.</td>
</tr>
<tr>
<td>- NPP salaried by facility reimbursed by Medicare via cost report may not bill fee for services if their salary is included in the cost report.</td>
</tr>
<tr>
<td>- Location of service not an issue.</td>
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</table>

<table>
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<tr>
<th>Billing for Split/Shared Visit in the Hospital Setting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared visits between the physician and NPP may be reported as one visit, if each provider sees the patient separately and each documents separately. Each component of the visit must be medically necessary.</td>
</tr>
<tr>
<td>- Shared visits in the hospital setting apply to hospital admissions (99221-99223), follow up visits (99231-99233), discharge management (99238-99239), observation care (99217-99220, 99234-99236), emergency department visits (99281-99285), prolonged care and new and established patients in the hospital outpatient department (99201-99215).</td>
</tr>
<tr>
<td>- Shared visits for physician office or clinic settings apply to established patients (99211-99215) with an established plan of treatment. (New patients cannot be shared in this setting).</td>
</tr>
<tr>
<td>- Consultations and Critical Care cannot be billed as a split/shared visit.</td>
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</table>

Follow the Documentation Guidelines as for any E/M Service:

- Each physician/NPP should personally document in the medical record his/her portion of the E/M split/shared visit. Example: “I saw and evaluated the patient. Agree with NPP's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”
- If the physician participated in the service by only reviewing the patient medical record, the service may only be billed under the NPPs provider number.
- Ancillary staff may document the review of systems and past family and social history. The physician or NPP must personally review this documentation and confirm and/or supplement in the medical record.

It is important to make a distinction between Medicare regulations and the policies for private payers. Medicare rules do not necessarily impact private payers. Most private payers do not issue numbers to NPPs and request that billing occur under the supervising physician. For example, some payers might only ask that state law is followed when PAs deliver care. Therefore it might be appropriate for the PA to provide care without a physician face-to-face encounter in a hospital setting and bill under the physician’s number.
**Exhibit 2: “Incident to” Example**

Example of “Incident to” service (physician office) that can be reimbursed at 100% of the Medicare Physicians Fee Schedule:

A NPP treats an established patient for chronic pain. The patient had a face-to-face encounter with the physician in the past month for this pain. The physician is seeing another patient in the office suite at the same time as the patient’s encounter.

**Exhibit 3: Shared Visit Example**

Example of Shared Visit in Hospital Setting:
Patient is admitted to the hospital by their regular physician for exacerbation of COPD (chronic obstructive pulmonary disease). The patient has been followed in the practice by both the physician and NPP for a long period of time. The NPP performs hospital rounds subsequent to the history and physical performed by the physician, while the physician is in the office.
Exhibit 4: Shared Visit Documentation Examples

A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. The physician may bill the service when he or she performs a substantive portion of the service in a face-to-face encounter. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service.

It appears that the situation of teaching physician services that involve residents is somewhat analogous to split/shared visits. Therefore these examples from the CMS material on teaching physician services, such as CMS Pub.100-4, Chapter 12, Section 100.1.1.A General Documentation Instruction and Common Scenarios, are helpful when establishing documentation examples for split/shared visits.

1. Examples of recommended accepted documentation by the physician include:

   - “I performed a history and physical examination of the patient and discussed his management with the NPP. I reviewed the NPP note and agree with the documented findings and plan of care.”

   - I was present with the NPP during the history and exam. I discussed the case with the NPP and agree with the findings and plan as documented in the NPP’s note.”

   - “I saw and evaluated the patient. I reviewed the NPP’s note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs.”

   - “I saw and evaluated the patient. Discussed with NPP and agree with NPP’s findings and plan as documented in the NPP’s note.”

   - “See NPP’s note for details. I saw and evaluated the patient and agree with the NPP’s finding and plans as written.”

   - “I saw and evaluated the patient. Agree with NPP’s note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

Split/Shared visits do not apply to consultation and critical care services.
Exhibit 4: Shared Visit Documentation Examples (continued)

2. Examples of unacceptable documentation by the physician include:

- “Agree with above.”, followed by legible countersignature or identity;

- “Rounded, Reviewed, Agree.”, followed by legible countersignature or identity;

- “Discussed with NPP. Agree.”, followed by legible countersignature or identity;

- “Seen and agree.”, followed by legible countersignature or identity;

- “Patient seen and evaluated.”, followed by legible countersignature or identity; and

- A legible countersignature or identity alone.

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.
A. Applicability

This standard applies to all institutional affiliates performing and/or billing patient services for which a claim is payable under Part B of the Medicare program including the following departments:

- Business Office
- Health Information Management
- Medical Staff
- Physician Office Staff
- Administration
- Compliance
- Quality Management
- Risk Management
- Emergency Department
- Clinic

B. Policy

It is the policy of HH to bill "incident-to" services and supplies when services are provided and documented consistent with and as required by the Center for Medicare and Medicaid Services, third party Payers, and/or licensing/accrediting agencies.

C. Background/Purpose

"Incident-to" billing allows physicians to bill for services and supplies, commonly furnished in the physician office setting, which are provided by auxiliary staff or Non-Physician Practitioners (NPPs) and that are an integral, although incidental, to their professional services. "Incident-to" services are paid for by Medicare under the physician fee schedule as though the physician personally performed the services. The purpose of this policy is to ensure that Medicare is billed for such services in accordance with regulatory requirements.

D. Definitions

Non Physician Practitioners:
Non-physician practitioners (NPPs) are health care professionals permitted by law to provide care and services within the scope of the individual's licensure and consistent with individually granted privileges by a facility's Board of Trustees. Examples of NPPs are certified nurse-midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists.

Auxiliary Personnel:
Auxiliary personnel are health care professionals such as nurses, technicians, and therapists.
**Direct Supervision Requirements:**
Direct supervision requires that the physician be present in the office suite and immediately available to assist and provide direction throughout the time the service is being provided.

**Supervising Physician:**
Supervising physician (or other practitioner) is defined as a physician who is authorized to receive payment for services “incident to” his or her own services.

**Physician Office Setting:**
Includes all settings other than a hospital or skilled nursing facility.

**E. Standards**

1. **To be Covered as ”Incident-to”, Services and Supplies Must be:**
   a. An integral, although incidental, part of the physician’s professional services in the course of diagnosis, or treatment of an injury or illness.
      - The physician must personally perform an initial service for each new condition, make an initial diagnosis and set up a treatment plan.
      - The physician must personally perform subsequent services (i.e., face-to-face service with the patient) at a frequency that reflects his/her active participation in and management of the course of the treatment for each medical condition. Excludes self-administered drugs.
   b. Commonly rendered without charge or included in the physician’s bill.
      To be covered, supplies, including drugs and biologicals, must represent an expense to the physician, or entity that employs the physician.
   c. Of a type that are commonly furnished in physician’s offices or clinics.
      If supplies are clearly of a type a physician is not expected to have on hand in the office, or where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the “incident-to” provision.
   d. Furnished under a physician’s **direct personal supervision**.
      - A physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the auxiliary staff or NPP is performing the “incident-to” services.
      - If auxiliary staff provide services outside the physician office setting (i.e., a patient’s home or in an institution), their services are billable as “incident-to” only if there is direct supervision by the physician (i.e., the physician is present and immediately available).
      NOTE: You cannot bill “incident-to” for services provided to patients seen in a hospital. Such services are covered under the hospital outpatient/inpatient benefit.
e. Furnished by an individual who is a part-time, full-time or leased employee of the physician, or employed by the entity that employs the physician.
   - The non-physician personnel providing "incident-to" services must be employed by the physician in order to bill the services to Medicare as "incident-to" the physician's services. Services performed by non-physician personnel not employed or leased by the physician are not billable as “incident-to” a physician's service.

f. Examples of “incident-to” services performed by auxiliary personnel:
   - Anti-coagulation therapy
   - Diabetic education and oversight of blood sugars and insulin levels
   - Care related to diabetes
   - Patient infusion therapy, and some types of cancer chemotherapy treatments
   - Psychological services
   - Some nursing home services
   - Some home care based medical services

   In any of these scenarios, a physician sees a patient in the office prior to the “incident to” service that a clinical assistant performs. A patient might also present for a subsequent visit in which he or she does not see the physician directly.

2. NPPs Services “Incident-to” a Physician

   a. NPPs must meet all of the requirements specified in the Medicare Benefit Policy Manual in order to bill “incident-to” a physician, but unlike other auxiliary staff:
      NPPs may render a much broader range of services under their scope of practice, including minor surgeries and Evaluation and Management (E/M) services. The non-physician practitioner can provide any service on an incident to basis that he or she is otherwise authorized to perform under state scope of practice laws.

   b. If an evaluation and management service is provided on an incident to basis by a non-physician practitioner, the physician can bill for whatever established patient evaluation and management (E/M) level that is documented and medically necessary

   c. NPPs may bill independently for their services when the “incident-to” requirements are not met.

   d. NPPs may have auxiliary staff that provide services “incident-to” their services.

For more information on NPP services “incident-to” a physician service, see: GB-420: Professional Services: Non Physician Practitioners.

3. Services Outside the Office Setting

   If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than a hospital or SNF), their services are covered incident to a physician's service
only if there is direct personal supervision by the physician. For example, if a nurse accompanied the physician on house calls and administered an injection, the nurse's services are covered. If the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician) since the physician is not providing direct personal supervision.

Services provided by auxiliary personnel in an institution (e.g., skilled nursing facility, nursing or convalescent home) present a special problem in determining whether direct physician supervision exists. The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct personal supervision.

For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare coverage of the services of physician-employed auxiliary personnel as services incident to physicians’ services. Such services are covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a Medicare intermediary.

4. Documentation of Physician’s Involvement

a. Documentation should clearly state that the physician was available at the time the “incident-to” service took place.

b. The physician must perform an initial service and must actively participate in and manage the course of treatment.
   - The physician does not need to see the patient on every visit, as long as the physician has prescribed the plan of care and is actively managing the plan of care.

c. When the NPP provides the “incident-to” service, the documentation should include a link between the NPP and the physician to show that the physician was actively involved in and delegated the service to the NPP
   - It is important that someone is keeping track of physician involvement and that you can prove physician involvement on an “active” level.

d. For each subsequent visit with the non-physician clinician, the physician should review the clinical assistant’s documentation and denote the following:
   - Any input that the physician gave (i.e. agreeing that the current regimen is appropriate)
   - Notation and review of lab values.
   - Review of any adverse reactions.

e. Documentation can take place after the patient has left and the physician is able to meet with staff to complete documentation requirements for direct supervision.
5. Supervision
   
   a. There are three different types of supervision:
      
      - **Direct supervision** means that a physician must be immediately available to provide assistance and direction while an NPP or auxiliary staff is rendering the services. The supervising physician does not need to be the physician who performed the initial patient visit. Any physician in the group who is in the clinic or office seeing other patients qualifies to provide requisite supervision, even if he/she is not the patient’s primary physician or not even of the same specialty as the primary physician. Independently contracting physicians who reassign their right to payment to the group practice can also supervise non-physician services as the on-premises supervisor.
      
      - **Personal supervision** means the physician must be physically in the same room when providing services outside the office setting.
      
      - **General or indirect supervision** means the physician is not on the premises, but available at all times by telephone.

   b. In Florida, “incident-to” services must be furnished under a physician's direct supervision. Once the initial physician relationship has been established, “incident-to” services can be billed even when there is not a physician in the room. However, the physician must be on the premises and immediately available. If the physician is part of a group practice, any physician member of the practice can supervise the “incident-to”.

6. Supervision of Diagnostic Tests:
   Supervision requirements for diagnostic tests are different than for office visits. The Centers of Medicare Medicaid Services (CMS) developed three levels of supervision requirements: general, direct and personal. The CPT code determines which level of supervision is required.
   
   a. **General Supervision**: Services are under the general quality control of physicians, a physician does not need to be in the office, e.g., electrocardiogram (CPT 93000).
   
   b. **Direct Supervision**: Services require that the physician is on the premises in the “office suite”, e.g., “incident-to” services.
   
   c. **Personal Supervision**: The physician must be in the room while the non-physician provider/technician is performing the service, e.g., transesophageal echocardiogram (CPT 93312).

7. Services / Supplies Not Covered Under Incident To Regulations
   
   a. When billing “incident to”, non-physician practitioners cannot be reimbursed for consultations or time-based E/M services. (i.e. more than 50% of the service is counseling or coordination of care. According to the Carrier’s Manual, the only time that counts is face-to-face time between the physician and the patient in the office. Billing for E/M services using time as the dominating factor (more than 50% of the service is counseling or coordination of care) may not be billed “incident to.”
   
   b. “Incident to” can never be applied to a patient's first visit.
   
   c. NPP services provided in a hospital setting cannot be billed “incident-to”.

d. Services of a certified diabetic educator providing nutrition counseling cannot be billed "incident-to."

8. **Scribing**
   
a. The use of NPPs as scribes is not recommended since only the physician’s work will support the physician’s bill. If “scribes” are used, some of the work performed by the “scribe”, and not the physician, could inadvertently be documented by the “scribe” and erroneously used to support the physician’s bill.

b. Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to be the one delivering the services and creating the record. There is no carrier Part B “incident-to” billing in the hospital setting (inpatient or outpatient). Thus, the scribe should be merely that, a person who writes what the physician dictates and does. **This individual should not act independently, and there is no payment for this activity.**
   
   - If a nurse or NPP acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note “written by X, acting as scribe for Dr. Y.” Then, Dr. Y should co-sign, indicating that the note accurately reflects work and decisions made by him/her.
   
   - It is inappropriate for an employee of the physician to make rounds at one time and make entries in the record, and then for the physician to make rounds several hours later and note “agree with above,” unless the employee is a licensed, certified provider (PA, NP) billing Medicare for services under his/her own name and number.
   
   - Record entries made by a “scribe” should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement.
   
   - Nurses gathering information from the chart and writing in the progress notes do not qualify for scribing. The note written by the nurses cannot be taken into account when assigning the CPT code for the physicians' evaluation & management service.

9. **Limitations of Auxiliary Staff**
   
   If an E/M service is provided on an incident to basis by auxiliary personnel who are not non-physician practitioners, only a level 1 office visit (CPT code 99211) can be billed regardless of extent of documentation or length of visit.

   There is no carrier Part B “incident-to” billing in the hospital setting (inpatient or outpatient). Thus it is inappropriate for a nurse to perform the non-billable subsequent hospital visit after surgery.
10. **Billing and Coding Requirements**

   a. In selecting the level of service to bill “incident-to” a physician’s service, the service must be:
      - Provided within the non-physician practitioner's scope of licensure;
      - Documented by the auxiliary staff or NPP providing the service and countersigned by the physician under whose number the service will be billed, and;
      - Provided while the physician is present in the office suite.

   b. “Incident-to” services provided by auxiliary staff and other certain non-physician providers (i.e., nurses and pharmacists) cannot be billed higher than a 99211 (established patient visit).

   c. Incident-to” services are payable only with point of service code (POS) 11, free standing, not provider based clinics (POS 22).

   d. When billing incident to services, the claim should be submitted as if the physician personally performed the service.

   e. In some cases the physician or non-physician practitioner who performed an initial service and ordered the service that is subsequently performed by auxiliary personnel is not the same person who is supervising the service. Then the supervising physician must be identified on both the paper and electronic claim forms.

   f. When the paper Form CMS 1500 is used, follow the instructions for completing the form, found in Pub 100-04, chapter 26, §10.4:

   g. When a service is incident to the service of a physician or non-physician practitioner, the name and assigned UPIN (the NPI shall be used when implemented) of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in items 17 and 17a.

   h. When filing electronic claims with incident to services, supply the ordering physician information for each line of service in the 2420E loop and supply the supervising physician information in loop 2310E. If the supervising physician information differs for a specific detail line, then supply that detail line supervising physician information in loop 2420D.

   i. Do not list the name or position of the person performing the incident to service on the claim form.

F. **Implementation Guidance**

1. **Risk Areas for “Incident-to” Services/Billing**

   Many of the recent overpayment, audit, civil False Claims act and even criminal cases instituted by federal and Florida state agencies overseeing the Medicare and Medicaid programs involve allegations of improper billing for incident to services.

   Risk areas include:
- Failing to understand that the general supervision rule requirements for NPPs under Florida law will not satisfy the direct supervision requirements for “incident-to” billing under either the Medicare or Florida Medicaid program.

- Failing to ensure that NPPs practicing in Florida are licensed and certified in Florida and not another state.

- Applying “incident-to” billing regulations to the institutional settings (i.e. hospitals or skilled nursing facilities).

- Billing “incident-to” for new patients, or established patients with new chief complaints.

2. **Management Responsibility**

   Managers with responsibility for medical professional services should assure that services provided by auxiliary staff and NPPs that are billed as “incident-to” a physician’s services meet the criteria set forth above. Questions regarding this policy may be addressed to an Administrator or the Compliance Department.

3. **Update to Policy on 5/2/08, Rescinded 5/30/08 before it took effect.**

   On May 2, 2008 CMS released transmittal 87, CR5288 clarifying incident-to billing and stating that the following documentation should be available for medical review:

   - A reference to the initial problem and service to which the subsequent service is incidental. The medical record must clearly indicate that there was an initial service to which the subsequently provided and billed services are integral and incidental.

   - The physician’s or NPPs authorization for “incident-to” services must be recognizable in the medical record.

   - Identification of the physician/NPP who is overseeing the care of the patient.

   - Evidence that the supervisor was present and available throughout the time the service is delivered

   - The services are reasonable and necessary.

These revisions to the policy would have given carriers more power to determine whether or not the involvement of the physician in the service was significant enough for incident-to billing. However, **CMS rescinded this transmittal on May 30, 2008, and it will not be replaced at this time.**
G. References

3. CMS Medlearn Matter MM4246, released 01/06/06, effective 01/01/06: Provides the same information as CMS Pub 100.4,30.6.13H http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4246.pdf http://www.cms.hhs.gov/Transmittals/downloads/R808CP.pdf
5. CMS Transmittal 1776, CR 2321, October 25,2002 (addressing payment for E/M services provided by physicians and non physician practitioners (NPP) and also shared E/M services between a physician and NPP in the same group practice. http://www.cms.hhs.gov/transmittals/downloads/R1776B3.pdf

H. Related Policies

GB-420 Professional Services: Non-Physician Practitioners (NPPs)

I. Revision History

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<th>Date</th>
<th>Revision/Review</th>
<th>By</th>
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<tbody>
<tr>
<td>7/08/2007</td>
<td>Initial adoption</td>
<td>E. Baklid-Kunz</td>
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<tr>
<td>10/2/07</td>
<td>Added sections for services outside the office setting and services/supplies not covered under &quot;incident to&quot; rule.</td>
<td>G. Rousis</td>
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<td>08/17/08</td>
<td>Added sections: Limitation of Auxiliary Staff and Scribing. Policy update on 5/2/08, rescinded 5/30/08.</td>
<td>E. Baklid-Kunz</td>
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Get Ready for Big ICD-9-CM Changes

Kerin Draak, MS, APNP, CPC, CPC-E/M
Medicare’s Split/Shared Visit Policy

Rules for Medicare’s split/shared visit policy can be a lot to choke down. Here’s our simplified interpretation to make it easier to digest.

By Elin Baklid-Kunz, MBA, CPC, CCS
On Oct. 25, 2002, the Center for Medicare & Medicaid Services (CMS) issued Transmittal 1776 giving non-physician practitioners (NPPs) and their supervising physicians increased latitude for hospital and office billing of evaluation and management (E/M) services. The instructions found at www.cms.hhs.gov/transmittals/downloads/R1776B3.pdf allowed NPPs and physicians who work for the same employer/entity to share patient visits on the same day by billing the combined work under the physician's provider number for 100 percent of the Medicare physician fee schedule (MPFS) reimbursement—although the NPP may have done the majority of the work. Medicare defines NPPs as physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs). These instructions are referred to as Medicare's Split/Shared Visit Policy. The policy is one of three billing options for NPPs:
- NPPs own provider number receiving 85 percent of the MPFS amount
- Incident-to the physician receiving 100 percent of the MPFS
- Split/shared service receiving 100 percent of MPFS

Billing using the NPP’s provider number is easy but can cause confusion about Medicare’s Split/Shared Visit Policy when it relates to new patient office or other outpatient visits (CPT® 99201–99205).

**Medicare’s Split/Shared Visit Policy**

The definition of split/shared visits can be found in the CMS Internet Only Manual (IOM): Medicare Claims Processing Manual Publication 100-04, chapter 12, section 30.6.1.H Split/Shared E/M Visit:

“A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer.”

**Different Rules for Different Settings**

The split/shared E/M visit policy applies only to selected settings: hospital inpatient, hospital outpatient, hospital observation, emergency department, and office and non-facility clinics. A split/shared E/M visit cannot be reported in the skilled nursing facility (SNF) or nursing facility (NF) setting.

When a non-hospital outpatient clinic or physician office E/M visit is split or shared between a physician and a NNP, the E/M encounter may be billed under the physician’s name and provider number if the patient is an established patient and the incident-to rules are met. (Note: Medicare clarifies that incident-to billing is not allowed for new patient visits).

Let’s look at an example. An established patient visits. The NPP performs the history and physical exam and the physician performs the medical decision-making. The “incident-to” requirements are met. In this same example, if the physician and the NPP shared the visit and it does not meet incident-to rules, the entire visit is billed under the NPP’s provider number.

When a hospital inpatient, hospital outpatient, or emergency department E/M visit is split or shared between a physician and a NPP from the same group practice, the E/M visit may be billed under the physician’s name and provider number if the physician provides any face-to-face portion of the E/M encounter (also applies to same day as the NPP’s portion) and the physician personally documents in the patient’s record the physician’s face-to-face portion of the E/M encounter with the patient. (Co-signatures are NOT sufficient).

An example of an E/M visit that may be billed under the physician’s name and provider number is hospital rounds at different times of the day on the same date of service. In a provider-based physician office (i.e., hospital outpatient department) or the emergency room, an example is a new or established patient visit where the NPP performs the history and physical exam, and the physician is the medical decision-maker.

**Rule Applies ONLY to Selected E/M Visits**

The split/shared E/M visit rule applies only to selected E/M visits such as these in the hospital settings:
Because incident-to criteria can be applied only in the office and non-facility clinic, the patient must be established.

- hospital admissions (99221-99223)
- follow-up visits (99231-99233)
- discharge management (99238-99239)
- observation care (99217-99220, 99234-99236)
- emergency department visits (99281-99285)
- prolonged care (99354-99357)
- hospital outpatient departments (provider-based visits) (99201-99215)

In a physician office setting, use codes 99211-99215 for an established patient with an established plan of treatment. Incident-to requirements must be met.

**Remember:** Split/shared visits do not apply to consultations (99241-99255), critical care services (99291-99292) or procedures.

**Relationship to Incident-to**

To bill a split/shared visit in the physician office setting, the visit must meet incident-to rules. For the services of a NPP to be covered as incident-to the services of a physician, the services must meet all the requirements for coverage specified in the CMS IOM: Medicare Benefit Policy Manual Publication 100-02, chapter 15 §60-61:

- The service or supplies are an integral, although incidental, part of the physician’s or practitioner’s professional services
- The services or supplies are of a type that are commonly furnished in a physician’s office or clinic
- The services or supplies are furnished under the physician’s/practitioner’s direct supervision
- The service is part of the patient’s normal course of treatment, during which a physician personally performs an initial service and remains actively involved in the course of treatment

According to the Medicare Benefit Policy Manual, incident-to apply only to non-institutionalized settings (i.e., not hospital or SNF settings); section 60.1B of the Medicare Claims Processing Manual states:

“For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians’ services under 279H§1861(s)(2)(A) of the Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a Medicare intermediary.”

**Can New Patients Office or Other Outpatient Visits (99201–99205) be Split/Shared?**

Because incident-to criteria can be applied only in the office and non-facility clinic, the patient must be established. A hospital outpatient clinic/office is considered a hospital or facility setting, and not a non-institutional setting. Incident-to regulations do not apply and New Patient Office or Other Outpatient Visits (99201–99205) can be reported as a split/shared visit in the hospital outpatient clinic/office (POS 22). The physician must perform some aspect of the E/M service with the patient face-to-face and both the NPP and the physician must personally document what he/she performed.

**Remember:** Exclude the NPP’s salary and benefits from the hospital’s cost report when the NPP performs professional services. If the NPP does both facility and professional services, keep time sheets so the expense for professional services can be excluded from the facility’s cost report.

In a provider-based clinic/office, the cost for the hospital staff is reported in the facility’s cost report and reimbursement for the service is received through the facility payment. If the NPP performs professional services, remember to exclude the NPP’s salary and benefits from the cost report. If the NPPs perform both hospital and professional services, keep track of the time spent on professional services so this component can be excluded from the cost report.

The cost report manuals are paper based manuals found at:

[www.cms.hhs.gov/Manuals/PBM/list.asp](http://www.cms.hhs.gov/Manuals/PBM/list.asp)

(publication 15: Provider Reimbursement, Provider Reimbursement Manual Part 1 chapter 21: Cost Related to Patient Care, section 2108: Reimbursement For Services by Provider-Based Physicians)
Provider-based regulations can be found in Transmittal A03-030, CR 2411, April 18, 2003: [www.cms.hhs.gov/transmittals/downloads/A03030.PDF](http://www.cms.hhs.gov/transmittals/downloads/A03030.PDF)

**Documentation of Split/Shared Visits**

Documentation for split/shared visits should follow the documentation guidelines for any E/M Service, and you must follow these documentation requirements:

- Each physician/NPP should personally document in the medical record his/her portion of the E/M split/shared visit.
- The physician’s documentation must clearly indicate that a face-to-face visit took place. (i.e., documenting an exam component to substantiate the physician had a face-to-face visit with the patient, is recommended.)
- Documentation must support the combined service level reported on the claim.
- Auxiliary staff may document the review of systems, past family history, and social history. The physician and NPP must personally review this documentation and confirm and/or supplement it in the medical record.

If the physician does not personally perform and document a face-to-face portion of the E/M encounter with the patient, then the E/M encounter is not billed under the physician’s name and provider number and is billed only under the NPP’s name and provider number.

If the physician’s participation is only reviewing the patient’s medical record, the service is billed under the NPP’s name and provider number. Payment will be made at the appropriate physician fee schedule based on the provider number entered on the claim.

**Acceptable Physician Documentation**

Because teaching physician services involving residents is somewhat analogous to split/shared visits, these examples from the CMS material on teaching physician services (CMS Pub.100-4, Chapter 12, Section 100.1.1.A General Documentation Instruction and Common Scenarios), help establish acceptable documentation for split/shared visits:

- “I saw and evaluated the patient. I reviewed the NPP’s note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs.”
- “I saw and evaluated the patient. Agree with NPP’s note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

Examples of unacceptable documentation by a physician:

- “Agree with above,” followed by legible countersignature or identity.
- “Rounded, Reviewed, Agree,” followed by legible countersignature or identity.
- “Discussed with NPP. Agree,” followed by legible countersignature or identity.
- “Seen and agree,” followed by legible countersignature or identity.
- “Patient seen and evaluated,” followed by legible countersignature or identity.
- A legible countersignature or identity alone.

Such documentation is not acceptable as it is not possible to determine whether the physician was present, evaluated the patient, and/or had any involvement with the plan of care.

**Scribing is Not a Billable Service**

A scribe’s role is to document in the medical record a physician’s visit with the patient. In a hospital setting, a scribe makes rounds with the physician and documents the visit. Scribing is not a billable service and is not always straightforward. For example, it is no longer considered scribing if the NPP adds an opinion to the progress note.

If your hospital or office uses scribes, establish a protocol that clearly outlines scribes to not render any opinions and to provide an accurate transcription of physicians’ comments. Watch out for scribes who improve documentation to facilitate optimization of the claim to maximize revenue.

Guidelines for scribes published by First Coast Service Option, the Part B carrier for Florida and Connecticut in the third quarter 2006 Part B update (www.floridamedicare.com/Part_B/Medicare_B_Update/Archive/106399.pdf) are:

- The physician must perform some aspect of the E/M service with the patient face-to-face and both the NPP and the physician must personally document what he/she performed.
If a nurse or NPP acts as a scribe for the physician, the individual writing the note, history, discharge summary, or any entry in the record; should note “written by X, acting as scribe for Dr. Y.” Dr. Y should co-sign, indicating the note accurately reflects work and decisions made.

It is inappropriate for an employee of the physician to make rounds and write entries in the record, and then for the physician to make rounds several hours later and note “agree with above,” unless the employee is a licensed, certified provider (PA, NP) billing Medicare for services under his/her own name and number.

Scribes should record entries upon dictation by the physician, and should clearly document the level of service provided at that encounter. This requirement is no different from other encounter documentation requirements.

Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to deliver services and create the record. There is no carrier Part B incident-to billing in the hospital setting (inpatient or outpatient). The scribe should only write what the physician dictates and does, acting independently there is no payment for this activity.

Understand Private Payer Differences

There is a distinction between Medicare regulations and private payers’ policies. Medicare rules do not necessarily impact private payers. Some payers may defer to state law, so understand your state’s scope of practice. Follow the requirements set out by private payers. Some hospitals query private payers to see what their rules are. An alternative to querying the private payers is to send the private plans a certified letter advising the hospital’s procedures plan for billing NPP service, unless the plan advises the hospital otherwise, in writing. When querying payers about policies, ask how to report services such as critical care and consultations.

Most private payers do not issue numbers to NPPs and request that billing occur under a supervising physician. Some payers may only ask to follow state law when NPPs deliver care. For such cases, it might be appropriate for the NPP to provide care without a physician face-to-face encounter in the emergency room and bill the private payer under the physician’s number.

Follow Medicaid’s State Rules

Medicaid also has different rules from Medicare when it comes to NPPs. Check your local state Medicaid Web site for your state’s rules. Medicaid pays NPPs on a separate fee schedule and has a separate limitation and coverage book for NPPs.

In Florida, NPP services under the direct supervision of a physician may be billed using the physician’s provider number instead of the NPPs provider number with some exceptions. Florida Medicaid direct supervision means the physician is on the premises when the services are rendered and he/she reviews, signs, and dates the medical record.

Get on Target with Split/Share Visits Compliance

In January’s incident-to article, Robert Pelaia Esq., CPC identified incident-to billing as completely transparent to the payer. This transparency exists for split/shared visit billing as well. When a claim for a split/shared visit is received for reimbursement, it looks just like a claim for a physician service and the provider usually gets paid for the claim even if it did not comply with the split/shared visit policy. Although transparent to the payer, non-compliance with the split/shared visit policy could be an easy target for Recovery Audit Contractors (RACs) when the permanent RAC program starts. In the revised scope of work released on Nov. 7, 2007, E/M codes were added to the services list that RAC can review. The RAC will also have hospital and provider specific medical record request limits and they may only send the provider one review result per claim. This may lead to auditors checking for multiple issues before sending denial letters. Because the RACs have the complete medical record and the claims submitted, it will be very easy to identify a progress note documented by the NPP and merely signed by the physician.

With the permanent RAC program near, now is a good time to a review a few internal progress notes for compliance with the split/shared visit policy. You may discover your physicians are not aware of the face-to-face requirement for billing split/shared visits, do not realize incident-to rules do not apply in emergency room and provider-based offices, or are using the split/shared visits for consultations.