Society for Maternal – Fetal Medicine

Incident to/Split –Shared Billing

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Non-Physician Providers (NPPs) are…

- Providers who are not physicians (M.D. or D.O.)
- Providers who typically can practice independently **OR** in collaboration with a physician
- Providers who may have their own provider identification number with third party payers

Non-Physician Practitioners (NPPs)

- **Non-Physician Providers:**
  - Clinical Nurse Specialists
  - Physician Assistants
  - Nurse Practitioners
  - Certified Nurse Midwives
- **Auxiliary Staff**
  - Examples: RN, RD, CDE, MA, Genetic Counselor

Auxiliary Staff

- RN, RD, CDE, MA, Genetic Counselor, etc.
- **Usually unable to bill directly (do not have provider number)**
- Examples of services provided
  - Injections
  - BP checks
  - **Patient education**
  - Blood sugar checks
  - Blood draws
  - Vitals

Ability to bill is very limited…

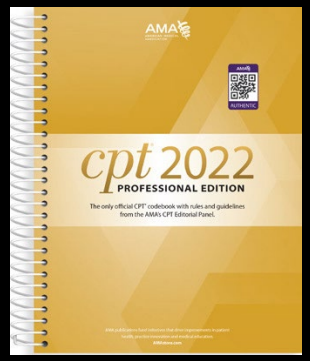
- 36415
- 36416
- 96372
- 99211

Identifying them…

- Medicare

- Non-physician providers (NPP)

- CPT



- Qualified healthcare providers (QHP)

- Common term

- Mid-level providers
- Physician extenders

Reporting Services Provided by Mid-Level Providers

- "Incident-to"
  - Billed under physician name with reimbursement at physician rate
- "Direct billing"
  - Provider's own billing number
  - May be paid at reduced rate
- Can bill for services of auxiliary staff
- Regardless of method, all supervision and documentation guidelines must be met

Supervision and Scope of Practice Guidelines

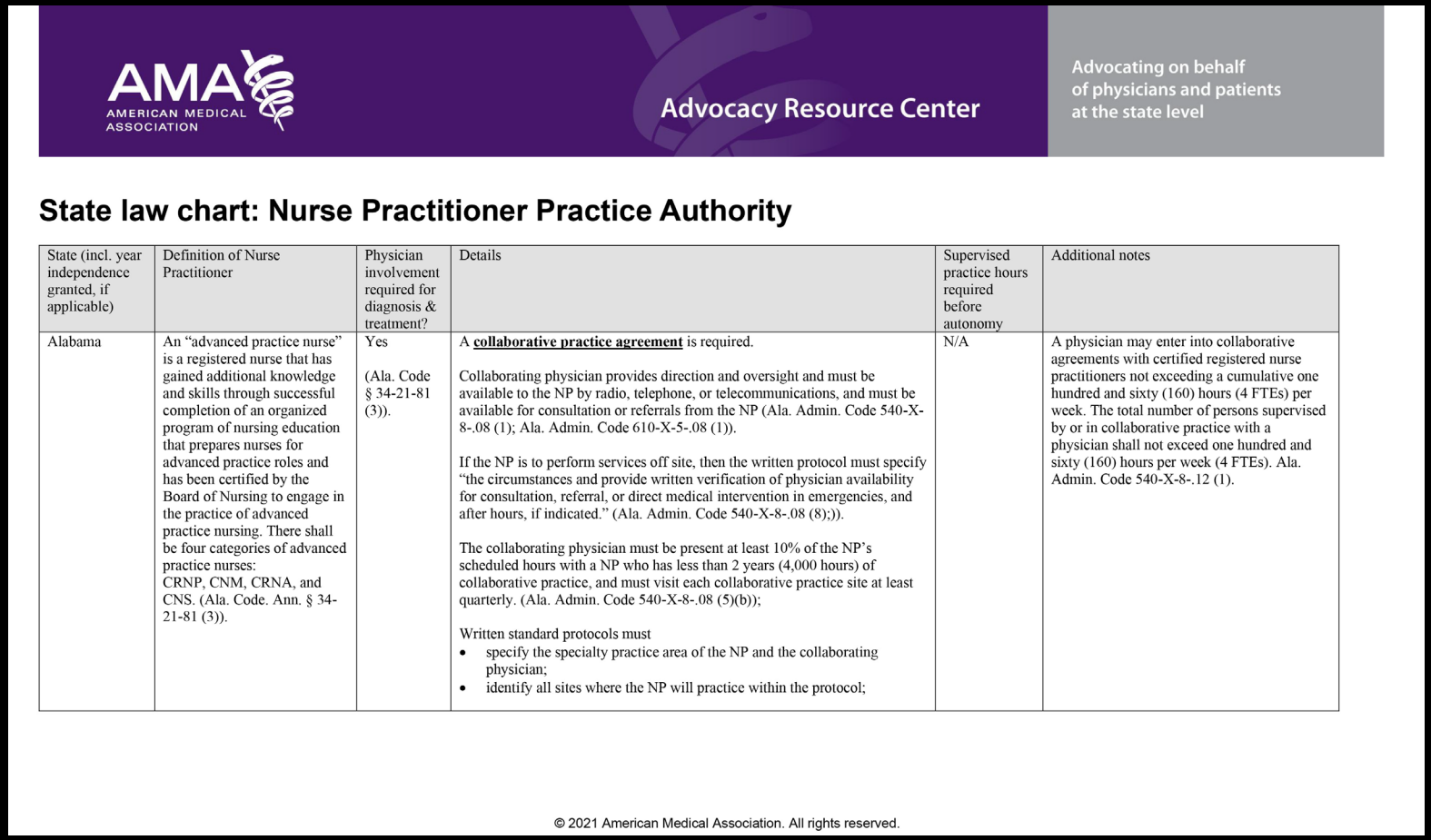
- Determined by State law
- Hospital credentialing requirements or
- Supervising/collaborative physician guidelines

Rules about Nurse Practitioners

- The rules are less consistent than those of PAs
  - Varying definitions
  - Different physician involvement requirements
  - Some with independent practice—some not

Rules about Nurse Practitioners

https://ama-assn.org/system/files/2020-02/ama-chart-np-practice-authority.pdf



AMA AMERICAN MEDICAL ASSOCIATION

Advocacy Resource Center

Advocating on behalf of physicians and patients at the state level

State law chart: Nurse Practitioner Practice Authority

State (incl. year independence granted, if applicable)	Definition of Nurse Practitioner	Physician involvement required for diagnosis & treatment?	Details	Supervised practice hours required before autonomy	Additional notes
Alabama	An "advanced practice nurse" is a registered nurse that has gained additional knowledge and skills through successful completion of an organized program of nursing education that prepares nurses for advanced practice roles and has been certified by the Board of Nursing to engage in the practice of advanced practice nursing. There shall be four categories of advanced practice nurses: CRNP, CNM, CRNA, and CNS. (Ala. Code. Ann. § 34-21-81 (3)).	Yes (Ala. Code § 34-21-81 (3)).	A **collaborative practice agreement** is required. Collaborating physician provides direction and oversight and must be available to the NP by radio, telephone, or telecommunications, and must be available for consultation or referrals from the NP (Ala. Admin. Code 540-X-8-.08 (1); Ala. Admin. Code 610-X-5-.08 (1)). If the NP is to perform services off site, then the written protocol must specify "the circumstances and provide written verification of physician availability for consultation, referral, or direct medical intervention in emergencies, and after hours, if indicated." (Ala. Admin. Code 540-X-8-.08 (8);)). The collaborating physician must be present at least 10% of the NP's scheduled hours with a NP who has less than 2 years (4,000 hours) of collaborative practice, and must visit each collaborative practice site at least quarterly. (Ala. Admin. Code 540-X-8-.08 (5)(b)); Written standard protocols must • specify the specialty practice area of the NP and the collaborating physician; • identify all sites where the NP will practice within the protocol;	N/A	A physician may enter into collaborative agreements with certified registered nurse practitioners not exceeding a cumulative one hundred and sixty (160) hours (4 FTEs) per week. The total number of persons supervised by or in collaborative practice with a physician shall not exceed one hundred and sixty (160) hours per week (4 FTEs). Ala. Admin. Code 540-X-8-.12 (1).

Rules about Physician Assistants Vary by State

- Co-signature: 20 state require a certain percentage or number of charts to be signed
- Ratio: 39 states put a limit on the number of PAs that can be supervised/collaborated with
- Prescriptions: 44 states—authorized to prescribe Schedule II-V
- Supervision: 47 states—PAs supervised by physician
- Regulation: 43 states—regulated by medical board
- Scope of Practice: 47 states—defined by physician/practice

https://ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/state-law-physician-assistant-scope-practice.pdf

Why have NPPs?

- They can provide many services otherwise performed by a physician
  - Which expands the physician's capacity
- They are less costly to the practice
  - $111,903 for a PA per salary.com
  - $115,005 for an NP per salary.com
  - $115,341 for a CNM per salary.com

Billing for NPPs

Medicare's policy

- Physicians are paid 100% of the Medicare fee schedule
- NPPs are paid 85% of the Medicare fee schedule
- BUT…NPPs are paid at 100% of the Medicare fee schedule if they bill "incident to" or in a "split/shared" fashion

So there are three approaches…

- Bill all NPP services directly
- ~~Bill all services "incident to"~~
- Bill some directly, some "incident to"

- The most conservative approach
- Results in a 15% reduction by many payers for all services
- This is a highly risky approach
- It means the doctor is always in the office
- It means there is never a new patient or a new problem
- The best approach, but requires awareness of guidelines
- Don't be committed to *maximizing* reimbursement

However…

- There are some very specific guidelines that must be met…


Incident to

Incident To Guidelines

- “Incident to” services are services that are furnished incident to physician professional services **in the physician’s office** (whether located in a separate office suite or within an institution) or in a patient’s house.

Incident To Guidelines

- “Incident to” is a **Medicare** concept intended to allow the physician in an office setting to bill for ancillary-type services and some E/M services performed by a non-physician practitioner (NPP).
- Frees the physician to see other patients at the same time.
- Some payers require an identifying modifier (e.g. SA for nurse practitioners, SB for nurse midwife)

(See MCR IOM, Pub. 100-02, Chap 15, Section 60 and Pub. 100-04, Chap 12, Section 30.6.4).

Non-Physician Practitioner Requirements

1. Includes NP, PA, CNM, CNS and CRNA.
2. Require licensing and certification by the state and national agencies.
3. Scope of practice may include a defined level of diagnosing and treatment.
4. May provide services independent of direct physician involvement with the patient.

Non-Physician Practitioner Requirements

5. Physician supervision required in most cases
   - "Direct" supervision—in the office suite, but does not have to see the patient
   - During COVID PHE, supervision can be by telemedicine (audio/visual)
6. **Permitted (or required) by an increasing number of payers to bill under their own name.**
7. Typically receive a reduction from the physician fee schedule rates.

Non-Physician Practitioner Requirements

- Eligible for enrollment (own provider number)
  - Can bill directly for services they personally perform
  - Services can be billed “incident to” physician service
  - Can bill for services of auxiliary staff

Incident To Requirements

- Services must be performed in an ***office/clinic*** **setting**
- **Physician must:**
  - Provide ***initial evaluation*** and *establish plan of care for the problem/condition*
  - See patient ***intermittently*** during course of treatment
  - ***Be in the office*** and available to assist
  - Have ***financial responsibility*** for the NPP providing services (i.e., W-2, leased employee, contractor, or under same cost center)

“Incident To”

Can “incident to” services be billed when provided in a hospital setting?

“Incident to” applies to services that are furnished in a physician’s office or clinic. Services provided in the inpatient or outpatient hospital setting **do not qualify** for “incident to” billing.

“Incident To”

The physician spends 15 minutes with the patient. The NP then spends 30 minutes with the patient on the same day. Can the times of both providers be combined to select the E/M level?

In order to qualify as “incident to”, the services of two providers cannot be combined. The shared/split visit guidelines would apply if the service occurred in a facility setting.

“Incident To”

Can a mid-level provider bill “incident to” another mid-level provider?

Since mid-level providers (NP, CNM, PA, etc.) can have their own provider numbers, it would not be appropriate for one mid-level to bill under another.

“Incident To”

Can a mid-level provider bill for “incident to” services performed by auxiliary staff?

Yes, a mid-level provider can bill under their provider number for services provided by auxiliary personnel, provided all “incident to” criteria are met.

“Incident To”

Does the billing provider need to co-sign the NPP’s note for “incident to” services?

For most payers, billing provider co-signature is **not a requirement** for “incident to” services. However, the billing provider is responsible for the accuracy of any claim submitted under his/her name. Therefore, **it is recommended** that the billing provider co-sign all medical record entries made by the NPP for “incident to” services.

“Incident To”

Patient comes in for a blood pressure check only, which is performed by an RN (auxiliary staff). Can the service be billed?

This service may be billed using CPT code **99211**, which is commonly referred to as a “nurse visit”.

Acceptable “incident to” circumstances

- Gestational diabetic previously seen by the physician presents to the clinic for ultrasound. NP reviews glucose log—answers patient questions.
- Pregnant patient with chronic hypertension presents for blood pressure check and log review by PA.
- Patient with known oligohydramnios presents for follow up ultrasound. NP reviews findings and discusses delivery plans, as originally developed by the physician.

Unacceptable “incident to” circumstances

- Pregnant patient presents with new vaginal bleeding
- Oligohydramnios is revealed to be substantially worse
- Chronic hypertensive now has evidence of pre-eclampsia
- Patient at 22 weeks 3 days has a newly confirmed fetal demise
- Non-physician providers can bill for these services…but not “incident to.”

Medicare: Incident-To Services General Requirements

- Integral, although incidental, part of the physician's professional service
- Type commonly furnished in physician's office or clinic
- Physician *must perform initial service* and on-going services at frequency that demonstrate active involvement

Medicare: Incident-To Services
General Requirements

- Charges are included in physician's bill
- Furnished under the physician's direct personal supervision
  - Immediately available (in office suite)
  - Face-to-face contact with patient not required

Medicare: Key Incident-To Restrictions

- Applies *only* to services provided in a physician office
- Does not apply to:
  - New patient encounters, *OR*
  - Evaluation/treatment of new problems
- Requires presence of physician in office suite (or telemedicine)
- Must meet business relationship requirements

Reporting Methodologies: Medicaid

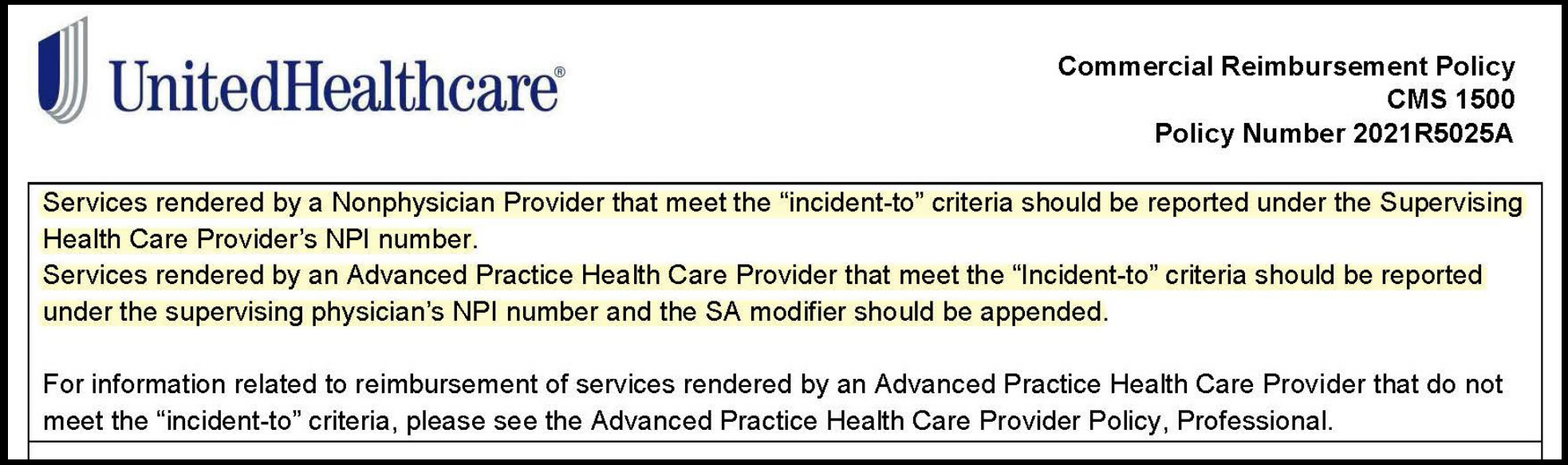
- Most State Medicaid programs cover services provided by PA/NPs
- Reporting may be “incident-to” or “direct bill” depending on the *specific State*
- If “incident-to” billing allowed, supervision guidelines may vary from those of Medicare
- Check individual State requirements before billing.

Reporting Methodologies: Other Third-Party Payers

- Coverage and reporting guidelines vary by payer
- Supervision guidelines for “incident-to” billing may vary from Medicare’s requirements
- Always check the payer’s guidelines
- Professional organizations for PA/NPs often have general information available.

Recent Controversy

- 3/1/21 United Healthcare says, “No” to “incident-to”
- 8/1/21 United Healthcare changes their mind
  - Adopts Medicare language and requirements
  - Requires the application of an SA modifier



UnitedHealthcare®

Commercial Reimbursement Policy
CMS 1500
Policy Number 2021R5025A

Services rendered by a Nonphysician Provider that meet the “incident-to” criteria should be reported under the Supervising Health Care Provider’s NPI number.
Services rendered by an Advanced Practice Health Care Provider that meet the “Incident-to” criteria should be reported under the supervising physician’s NPI number and the SA modifier should be appended.

For information related to reimbursement of services rendered by an Advanced Practice Health Care Provider that do not meet the “incident-to” criteria, please see the Advanced Practice Health Care Provider Policy, Professional.

“Incident To”

- Patient self-management codes (98960-98962) and nutritional therapy codes (97802-97804) are non-physician codes.

  - If the auxiliary staff has their own provider number, these services can be billed under their name. If they do not have their own provider number, the services can be billed “incident to” using CPT code 99211.

Split/Shared Services

Split/Shared Visit

- An encounter with a patient where the physician and a qualified non-physician practitioner each *personally* perform a portion of an E/M visit with the same patient on the same date of service.
- Services can be provided jointly or at different encounters as long as they occur on the same calendar date.

Split/Shared Visit

- The physician and NPP are from the same group (tax ID#)
- Each provider documents what he/she personally did
- Must be
  - Medically necessary
  - Within NPP scope of practice

Split/Shared Visit

- **Locations**
  - Hospital (inpatient/outpatient)
  - Emergency Department

Split/Shared Visit

- To report under the physician's name:
  - Must have face-to-face encounter
  - Physician must document that patient was seen and any care that was provided (history or exam elements or MDM component)
  - Physician must sign the medical record
- Incident-to guidelines do not have to be met

A new rule for 2022…

- Before 2022: The service could be billed under the name of the physician.
- In 2022: The service is billed by the person who supplied the substantive portion of the visit…
  1. The provider who documents the support of the history, exam, or medical decision making, OR
  2. Provides more than 50% of the service time
- In 2023 and beyond: Under the name of the individual who provides more than 50% of the visit time.

CMS clarified…

- Split-shared can be…
  - New or established
  - Initial or subsequent
  - Prolonged services
- When split-sharing critical care, only time can be used to select the billing provider.

- Split-shared visits require an **FS** modifier
- Split-shared can’t be done in a teaching setting

Split/Shared Visit

- **Does not apply to**
  - Non-E/M procedures
  - E/M services in nursing facility
  - Services provided by auxiliary staff

Split/Shared Visit

- **Outpatient clinic/office setting:**
  - Established patient
  - “Incident to” rules must be met to bill under the physician’s billing number
  - If “incident to” guidelines are not met, must be billed under NPP
  - Each provider documents their own separate service

Split/Shared Visit

2021

- An NP rounds on a patient in the morning. The physician sees the patient in the afternoon of the same day and documents in the chart.
  - The service can be reported under the physician's billing number.
  - According to the split/shared visit guidelines, both providers must be from the same group practice.

Split/Shared Visit

2021

- An NP rounds on a patient in the morning. The physician sees the patient in the afternoon of the same day and documents in the chart.
  - The service can be reported under the physician's billing number.
  - According to the split/shared visit guidelines, both providers must be from the same group practice.

Split/Shared Visit

2022

- An NP rounds on a patient in the morning. The physician sees the patient in the afternoon of the same day and documents in the chart.
  - Who did the primary work?
  - Who spent the most time?

Split/Shared Visit

2023

- An NP rounds on a patient in the morning. The physician sees the patient in the afternoon of the same day and documents in the chart.
  - Who spent the most time?

Split/Shared Visit

- An mid-level who works for the hospital rounds on a patient in the morning. The physician in a stand-alone private practice see the patient in the afternoon of the same day and documents in the chart.
  - According to the split/shared visit guidelines, both providers must be from the same group practice to combine services
  - However, the physician can bill a service based on what she/he personally performed.

Using split/shared services

Appropriate usage:

- NP rounds in the morning, physician rounds in the afternoon

Inappropriate usage

- NP sees patient in the morning, physician does *not* see the patient that day, but service is billed under physician name
  - First day: NP bills; no physician bill
  - Physician bills for services provided the date that she/he sees the patient either as individual service or shared/split visit if requirements met.

Considerations

- Billing for medical services provided by a mid-level provider under the name of the physician (for example, under “incident to” or shared visit provisions) creates a lack of transparency that may impact quality measures
- Makes mid-level productivity difficult to assess
- Poses compliance risks

QUESTIONS?

about Incident to/Split-Shared Billing?