"Incident To," Shared Visits, Residents and Medical Students

Health Law Webinar

January 18, 2023

Fredrikson

Where Law and Business Meet®

Why is This So Messy?

- Services “incident to a physician’s professional services” have always been covered by Medicare.
- Designed to cover work that is initiated by the physician and normally included on the physician’s bill.
- “Incident to” services are not covered in the hospital.
- Complicated wording and really terrible instructions from contractors for decades have muddled the analysis. What is “Integral, though incidental….?”

Dictionary

Definitions from Oxford Languages · Learn more

in·te·gral

/ˈin(t)əgrəl,inˈtegrəl/

adjective

1. necessary to make a whole complete; essential or fundamental.
   "games are an integral part of the school's curriculum"

   Similar: essential | fundamental | basic | intrinsic | inherent | constitutive

in·ci·den·tal

/ˌinsəˈden(t)l/

adjective

1. accompanying but not a major part of something.
   "for the fieldworker who deals with real problems, paperwork is incidental"

   Similar: less important | of less importance | secondary | subsidiary | subordinate

2. liable to happen as a consequence of (an activity).
   "the ordinary risks incidental to a fireman's job"

   Similar: connected with | related to | associated with | accompanying | attending

noun

Incident To: SSA 1861(s)*

The term “medical and other health services” means any of the following items or services:

(1) physicians’ services;

(2) (A) services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician’s professional service, of kinds which are commonly furnished in physicians’ offices and are commonly either rendered without charge or included in the physicians’ bills (or would have been so included but for the application of section 1847B);

*Watch this space!!

Creating Confusion: SSA 1861(s)(2)

(B) hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to* physicians' services rendered to outpatients and partial hospitalization services incident to such services;

*Why, why, why did they have to use "incident to" here? Let's call them "outpatient therapeutic services."

Diagnostic Tests Are Different: SSA 1861(s)(3)

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act [398]),

Words Matter

- Note how “diagnostic tests” are a different benefit.
- HCFA thought of “diagnostic tests” as “incident to.” CMS sees it differently.
- There isn’t complete consistency. Prosthetics, are a separate benefit yet THEY can be incident to.
- It is often necessary to distinguish “therapeutic” from “diagnostic.”

Not Everything is Incident To…

"Rather, these services should meet the requirements of their own benefit category. For example, diagnostic tests are covered under §1861(s) of the Act. A/B MACs (A) and (B) must not apply incident to requirements to services having their own benefit category. For example, diagnostic tests are covered under §1861(s)(3) of the Act and are subject to their own coverage requirements.

Not Everything is Incident To…

Depending on the particular tests, the supervision requirement for diagnostic tests or other services may be more or less stringent than supervision requirements for services and supplies furnished incident to physician's or other practitioner's services. Diagnostic tests need not also meet the incident to requirement in this section. Likewise, pneumococcal, influenza, and hepatitis B vaccines are covered under §1861(s)(10) of the Act and need not also meet incident to requirements.

Not Everything is Incident To…

Physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists, clinical social workers, physical therapists and occupational therapists all have their own benefit categories and may provide services without direct physician supervision and bill directly for these services."

– *Medicare Benefit Policy Manual, Chapter 15 §60A.*

Why Do Incident To?

- For many services it pays more. (Reimbursed at 100% of Physician Fee Schedule vs. 85% when NPP bills independently.)
- Under the in-office ancillary exception, physicians may receive credit for DHS that are incident to.

Why Avoid Incident To?

- Adds a layer of requirements.
    - Supervision.
    - New patients/Initiating care.
    - Billing confusion.
- For some services (PT) no reimbursement benefit.

“Incident To” Billing

- Clinic can bill for “incident to” services only if:
  - Clinic pays for the expenses of the ancillary person.
  - Clinic is the sole provider of medical direction.
  - The first visit for the course of treatment is with a physician (later visits may be with the non-physician provider). Note the “new problem” myth.
  - The service is something typically done in an office.
  - The service is not in a hospital or nursing home (may be a “shared visit”).
  - A clinic physician must be in the “office suite.”
  - The services should be billed under the supervising physician.

42 C.F.R. § 410.26

Services and supplies incident to a physician's professional services: Conditions.

(a) Definitions. For purposes of this section, the following definitions apply:

(1) Auxiliary personnel means **any individual** who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased **employee, or independent contractor** of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner)…

42 C.F.R. § 410.26

…has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked, and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished.

MBPM Chapter 15 § 60.1.B

Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

Can one physician be incident to another?

- Conventional wisdom seems to be no.
- As is often the case, the conventional wisdom appears mistaken. There is reason to doubt the conventional wisdom.
- Are physicians “any individual”?

Who Are Auxiliary Personnel?

“Comment: Many commenters wanted us to restrict the definition of auxiliary personnel so that only certain individuals may perform a given incident to service. For example, they want us to mandate that only audiologists may perform cochlear implant rehabilitation services as incident to services. Likewise, they want us to permit only physical or occupational therapists to perform physical or occupational therapy as incident to services. In support, they noted that section 4541(b) of the BBA amended section 1862(a)(20) of the Act and required that physical or occupational therapy furnished as an incident to service meet the same requirements outlined in the physical or occupational therapy benefit set forth in sections 1861(g) and (p) of the Act.”

Who Are Auxiliary Personnel?

Response: We have not further clarified who may serve as auxiliary personnel for a particular incident to service because the scope of practice of the auxiliary personnel and the supervising physician (or other practitioner) is determined by State law. We deliberately used the term any individual so that the physician (or other practitioner), under his or her discretion and license, may use the service of anyone ranging from another physician to a medical assistant. In addition, it is impossible to exhaustively list all incident to services and those specific auxiliary personnel who may perform each service. (emphasis supplied).

– *66 FR 55246, 55268 (Nov. 1, **2001**)*

No Need to Credential Physicians, Right?

- Interesting question.
- Must meet the requirements. New patient problem, and more.
- Note licensure issues!

42 C.F.R. § 410.26(a)

(2) Direct supervision means the level of supervision by the physician (or other practitioner) of auxiliary personnel as defined in §410.32(b)(3)(ii).

(3) General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service.

What is “Direct Supervision?”

- 410.32(b)(3)(ii): “Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.”
- Defined more by what it is NOT, rather than what it IS. Not “in the room.” But where?

Remote Direct Supervision During PHE

- 42 CFR 410.32 was amended to add “During a PHE…the presence of the physician includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider.”
- Must the link be open, or is availability enough?

What is “Direct Supervision?”

- 410.32(b)(3)(ii): “Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.”
- It would be weird to need to be MORE available during the pandemic.

Office “Suite” Office?

“We are not proposing that there must be any particular configuration of rooms for an office to qualify as an office “suite.” However, direct supervision means that a physician must be in the office suite and immediately available to provide assistance and direction. Thus, a group of contiguous rooms should in most cases satisfy this requirement. We have been asked whether it would be possible for a physician to directly supervise a service furnished on a different floor. We think the answer would depend upon individual circumstances that demonstrate that the physician is close at hand…

Office “Suite” Office?

…The question of physician proximity for physician referral purposes, as well as for incident to purposes, is a decision that only the local carrier could make based on the layout of each group of offices. For example, a carrier might decide that in certain circumstances it is appropriate for one room of an office suite to be located on a different floor, such as when a physician practices on two floors of a townhouse.”

– 63 Fed Reg. 1685, Jan 9, 1998

42 C.F.R. § 410.26(b)

Medicare Part B pays for services and supplies incident to the service of a physician (or other practitioner).

(1) Services and supplies must be furnished in a noninstitutional setting to noninstitutional patients.

MBPM § 60.1.B: Who Is Minding The Store?

Services provided by auxiliary personnel in an institution (e.g., 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 supervision. (See §70.3 of the Medicare National Coverage Determinations Manual for instructions used if a physician maintains an office in an institution.)

How to Mess Things Up 101

- Harmonize that with 410.26(b)(1): “Services and supplies must be furnished in a noninstitutional setting to noninstitutional patients.”

42 C.F.R. § 410.26(b)

(2) Services and supplies must be an integral, though incidental, part of the service of a physician (or other practitioner) in the course of **diagnosis** or treatment of an injury or illness.

The “New Problem” Problem

- Do you “diagnose” old problems??

“Course of Treatment*” MBPM Chapter 15 § 60.1.B

This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment*.

*What happened to diagnosis???

What is a “course of [diagnosis or] treatment?”

- Patient receiving chemo, develops an infection.
- Child has a series of ear infections. What if they now get strep throat?
- Is the course of diagnosis broader?
- **NEITHER THE REGS OF THE MANUAL MENTION “NEW PROBLEM.”**

42 C.F.R. § 410.26(b)

- (3) Services and supplies must be commonly furnished without charge or included in the bill of a physician (or other practitioner).
- (4) Services and supplies must be of a type that are commonly furnished in the office or clinic of a physician (or other practitioner).

42 C.F.R. § 410.26(b)

(5) In general, services and supplies must be furnished under the direct supervision of the physician (or other practitioner). Designated care management services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided incident to the services of a physician (or other practitioner). The physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) who is treating the patient more broadly. However, only the supervising physician (or other practitioner) may bill Medicare for incident to services.

We billed under the wrong person, we're SOL, right?

- Wrong!
- Medicare Claims Processing Manual Chapter 1, 30.2.2.1: "An otherwise correct Medicare payment made to an ineligible recipient under a reassignment or other authorization by the physician or other supplier does not constitute a program overpayment."

42 C.F.R. § 410.26(b)

- (6) Services and supplies must be furnished by the physician, practitioner with an incident to benefit, or auxiliary personnel.
- (7) Services and supplies must be furnished in accordance with applicable State law.
- (8) A physician (or other practitioner) may be an employee or an independent contractor.

So Why The Shared Visits?

42 CFR § 411.15 Particular Services Excluded from Coverage

(m) ***Services to hospital patients*** -

(1) ***Basic rule.*** Except as provided in paragraph (m)(3) of this section, any service furnished to an inpatient of a hospital or to a hospital outpatient (as defined in § 410.2 of this chapter) during an encounter (as defined in § 410.2 of this chapter) by an entity other than the hospital unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to the hospital's patients. As used in this paragraph (m)(1), the term "hospital" includes a CAH.

(2) ***Scope of exclusion.*** Services subject to exclusion from coverage under the provisions of this paragraph (m) include, but are not limited to, clinical laboratory services; pacemakers and other prostheses and prosthetic devices (other than dental) that replace all or part of an internal body organ (for example, intraocular lenses); artificial limbs, knees, and hips; equipment and supplies covered under the prosthetic device benefits; and services incident to a physician service.

42 CFR 410.26(b)

(b) Medicare Part B pays for services and supplies incident to the service of a physician (or other practitioner).

(1) Services and supplies must be furnished in a noninstitutional setting to noninstitutional patients.

(2) Services and supplies must be an integral, though incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness.

(3) Services and supplies must be commonly furnished without charge or included in the bill of a physician (or other practitioner).

(4) Services and supplies must be of a type that are commonly furnished in the office or clinic o a physician (or other practitioner).

(5) In general, services and supplies must be furnished under the direct supervision of the physician (or other practitioner). Designated care management services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided incident to the services of a physician (or other practitioner). The physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) who is treating the patient more broadly. However, only the supervising physician (or other practitioner) may bill Medicare for incident to services

The Original Solution

- Medicare Manual Language created “shared visits.”
- Note that the following language was all deleted in May 2021.

Medicare Claims Processing Manual, Chapter 12, § 30.6.1

SPLIT/SHARED E/M SERVICE

Office/Clinic Setting

In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician's UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient. If “incident to” requirements are not met for the shared/split E/M service, the service must be billed under the NPP’s UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

Medicare Claims Processing Manual, Chapter 12, § 30.6.1

When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

Medicare Claims Processing Manual, Chapter 12, § 30.6.1

1. If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.

Medicare Claims Processing Manual, Chapter 12, § 30.6.1

2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's UPIN/PIN.

The Florida Project

- Client says they've heard from the MAC the physician must perform a "substantive" portion of the visit, defined as one of the CPT's "key components," i.e. history, exam or medical decision making.
- Manual says "physician provides any face-to-face portion of the E/M encounter with the patient."
- Are those the same? Is "How are you?" sufficient? Is MDM face-to-face?

First Coast Website (Now Moot!)

Split and shared visits FAQ

Q: What is a split/shared visit? Can you provide an example?

A: A split/shared evaluation and management (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 non-physician practitioner (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 NPP both must be in the same group practice or employed by the same employer.

The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non-facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to critical care services or procedures.

Common split/shared visit scenarios

- **Hospital inpatient/outpatient/emergency room setting:**
- When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's National Provider Identifier(NPI).
- If there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's NPI.
- Payment will be made at the appropriate physician fee schedule rate based on the Provider Transaction Access Number (PTAN) entered on the claim.

EXAMPLE: If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.

EXAMPLE: In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's NPI.

Documentation for split/shared visits should follow the documentation guidelines 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 and legibly sign and date the record. The documentation must support the combined service level reported on the claim

Comprehensive Error Rate Testing (CERT) Finding: Split/Shared Evaluation & Management Services

Provider Types Affected: Physicians and Non Physician Practitioners (NPP)

Background: A Split/Shared service is an encounter in which a physician and an NPP, such as a Nurse Practitioner (NP), Physician Assistant (PA), Clinical Nurse Specialist (CNS), or Certified Nurse Midwife (CNM), each personally perform a substantive portion of an Evaluation/Management (E/M) visit face-to-face with the same patient on the same date of service.

OTHER CONSIDERATIONS

SPLIT/SHARED SERVICES

A split/shared service is an encounter where a physician and an NPP each personally perform a portion of an E/M visit. Below are the rules for reporting split/shared E/M services between physicians and NPPs:

- In the office or clinic setting:
  - For encounters with established patients who meet incident to requirements, use either practitioner's National Provider Identifier (NPI); and
  - For encounters that do not meet incident to requirements, use the NPP's NPI.
- Hospital inpatient, outpatient, and ED setting encounters shared between a physician and a NPP from the same group practice:
  - When the physician provides any face-to-face portion of the encounter, use either provider's NPI; and
  - When the physician does not provide a face-to-face encounter, use the NPP's NPI.

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Evaluation and Management Services

Where Did This “Substantive Portion” Stuff Originate???

- Hint: It wasn’t in the regulation. Or even in the portion of the Manual discussing shared visits.

Medicare Claims Processing Manual, Chapter 12, § 30.6.13 – Nursing Facility Services

H. Split/Shared E/M Visit **A split/shared E/M visit cannot be reported in the SNF/NF setting.** 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…**

Medicare Claims Processing Manual, Chapter 12, § 30.6.13 – Nursing Facility Services

…The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to critical care services or procedures.

Florida Project Lessons

- Don’t assume you know the answer.
- Make them show you the rule. (And Manuals are NOT the rule. See below.)
- The Medicare program is so complicated that the people running it don’t understand it.
- Just because it’s on government/MAC letterhead doesn’t mean it’s a rule.

U. S. Department of Justice

Office of the Associate Attorney General

The Associate Attorney General

Washington, D.C. 20530

January 25, 2018

MEMORANDUM FOR: HEADS OF CIVIL LITIGATING COMPONENTS
UNITED STATES ATTORNEYS

CC: REGULATORY REFORM TASK FORCE

FROM: THE ASSOCIATE ATTORNEY GENERAL

SUBJECT: Limiting Use of Agency Guidance Documents
In Affirmative Civil Enforcement Cases

On November 16, 2017, the Attorney General issued a memorandum ("Guidance Policy") prohibiting Department components from issuing guidance documents that effectively bind the public without undergoing the notice-and-comment rulemaking process. Under the Guidance Policy, the Department may not issue guidance documents that purport to create rights or obligations binding on persons or entities outside the Executive Branch (including state, local, and tribal governments), or to create binding standards by which the Department will determine compliance with existing statutory or regulatory requirements.

The Guidance Policy also prohibits the Department from using its guidance documents to coerce regulated parties into taking any action or refraining from taking any action beyond what is required by the terms of the applicable statute or lawful regulation. And when the Department issues a guidance document setting out voluntary standards, the Guidance Policy requires a clear statement that noncompliance will not in itself result in any enforcement action.

The Brand Memo

- Gives voice to the principle “Manuals are not binding.”
- Has been withdrawn by AG Garland, but…
- The regulatory hierarchy is key. Binding: Constitution, statute, regs, NCD. Non-binding: Fed. Reg. preamble, manuals, carrier guidance.
- The Allina Supreme Court Case articulates the same idea.

Azar v. Allina, 139 S.Ct. 1804, 1809 (2019)

"Notably, Congress didn't just adopt the APA's notice-and-comment regime for the Medicare program. That, of course, it could have easily accomplished in just a few words. Instead, Congress chose to write a new, Medicare-specific statute. The new statute required the government to provide public notice and a 60-day comment period (twice the APA minimum of 30 days) for any "rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under [Medicare]." 42 U.S.C. § 1395hh(a)(2)."

SSA 1871(a)(2)

“No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).”

Former Process To Challenge Manuals

- HHS Good Guidance Practices Regulation, 85 Fed. Reg. 78,770 (Dec. 7, 2020)/45 C.F.R. § 1.5(a)(1).
- Was used January 2021:

  https://www.cms.gov/files/document/enf-instruction-split-shared-critical-care-052521-final.pdf
- The Manual was withdrawn in May 2020.
- CMS withdrew the Good Guidance Practices Regulation!! 87 Fed. Reg. 44002 (July 25, 2022).

Shared Visits: 42 CFR § 415.150 (was 140)

- Replaces guidance with a regulation.
- Applies where “incident to” billing is prohibited.
- Requires a modifier (FS) on the claim.
- Only the professional doing the “substantive portion” may bill.

42 CFR 415.150

Facility setting for purposes of this section means institutional settings in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under § 410.26(b)(1) of this subchapter.

Split (or shared) visit means an evaluation and management (E/M) visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or nonphysician practitioner if furnished independently by only one of them.

42 CFR 415.150

Substantive portion means more than half of the total time spent by the physician and nonphysician practitioner performing the split (or shared) visit, except as otherwise provided in this paragraph. For visits other than critical care visits furnished in calendar year 2022 ***and 2023***, substantive portion means one of the three key components (history, exam or medical decision-making) or more than half of the total time spent by the physician and nonphysician practitioner performing the split (or shared) visit.

42 CFR 415.150

(b) *Conditions of payment*. For purposes of this section, the following conditions of payment apply:

(1) *Substantive portion of split (or shared) visit*. In general, payment is made to the physician or nonphysician practitioner who performs the substantive portion of the split (or shared) visit.

(2) *Medical record documentation*. Documentation in the medical record **must** identify the physician and nonphysician practitioner who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) **must** sign and date the medical record.

(3) *Claim modifier*. The designated modifier must be included on the claim to identify that the service was a split (or shared) visit.

Shared Visits: Substantive Portion

- 2023 remains more flexible for all but Critical Care.
- In 2023, “substantive portion” of the visit means the professional performed any one of the three key components (history, exam or medical decision-making) or more than 50 percent of the time.
- In 2024, absent another change, only whoever does the most time may bill. (CMS has indicated informally that if both professionals are there, they may decide which gets the time.)

Shared Visit Critical Care Technical Correction

- The preamble said that you could bill 99292 with 75 minutes of critical care. They meant to say 104, because you need a full 30 minutes of additional time.
- Note that CMS differs from CPT.

Semantics Matter

- NPP work in the clinic is “incident to” or billed independently by NPP.
- NPP work in the hospital is “shared visit” or billed independently.
- 2 professionals in the clinic: don’t call it shared! Co-visit? Joint visit? Combined visit?

Critical Care: 99291 / 99292

- Split and shared critical care is allowed. When two professionals provide care, only one of their time counts.

The Teaching Physician Rule

- Medicare pays hospitals for training residents. When there is Graduate Medical Education (GME) payment, pretend the resident didn't exist.
- When the resident is "off" the GME clock, if they are licensed, they are just a physician.
- Most other payors don't pay for GME, so there isn't an equivalent limit on billing.
- For Medicare, there is a documentation requirement!

42 CFR § 415.172(b)

- The medical records must document that the teaching physician was present at the time the service (including a Medicare telehealth service) is furnished. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by the physician or as provided in § 410.20(e) of this chapter.

42 § 410.20 Physicians' Services

- Medical record documentation. The physician may review and verify (sign/date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team including, as applicable, notes documenting the physician's presence and participation in the services.

Can A NPP Supervise A Resident?

- If we're talking billing, it is the wrong question.
- Remember Fruit Loops! Can we DO it and can we BILL for it are different.
- Billing is about the billing professional's WORK, not supervision.

Primary Care Exception: 42 CFR § 415.174

- E/M level 3 or below (except during PHE).
- Outpatient department or ambulatory setting where resident time counts for GME.
- Resident in program at least six months.
- Teaching physician oversees four or fewer residents.
- Teaching physician has no other responsibilities at the time, assumes management responsibility for patients, reviews with each resident during or immediately after each visit the beneficiary's history, exam, diagnosis and tests and therapies.

Primary Care Exception: 42 CFR § 415.174

- Clinic must perform: 1) acute care for undifferentiated problems or chronic care for ongoing conditions, 2) coordination of care furnished by other physicians and providers and 3) comprehensive care not limited by organ system or diagnosis.
- Patients must be an identifiable group of individuals who consider the center to be the continuing source of their healthcare.
- Medical records document teaching physicians' review and direction.
- Outside of an MSA, and during PHE, teaching physician review can be through audio/visual real time communication technology.

Medical Students

- Like a medical assistant or other unlicensed individual.
- They can document. Their exam doesn’t count.
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Medical Students

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Presenter

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Thank you!

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