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PURPOSE

This guidance outlines the required qualifications and coverage criteria for the billing and payment of Medicare Services provided by non-physician practitioners in accordance with the Centers for Medicare and Medicaid Services (CMS).

NON-PHYSICIAN PRACTITIONER (NPP) TYPES

This guidance applies to Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs), specifically Nurse Practitioners (NPs), Certified Nurse-Midwives (CNMs), and Clinical Nurse Specialists (CNSs).

MEDICARE COVERAGE CRITERIA FOR NPP SERVICES

- NPP is legally authorized and qualified to furnish the services in the State where services are performed
- Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary
- Services are the type considered physicians' services if furnished by a medical doctor or a doctor of osteopathy
- When required, services are performed in collaboration with or under the supervision of a physician (see section below "Medicare Collaboration and Supervision Requirements")

Types of Billing NPPs may engage in:

1. **Direct Billing** -when an NPPs independently performs a service and bills under their own NPI (see "Direct Billing" section below for details)
2. **Split Shared Billing** between an NPP & Physician in a **hospital setting** (see "Split Shared Billing" section below for details)
3. **Incident-to Billing** encounters in an **office setting** conducted by an NPP incident to Physician services (see "Incident-to Billing" section below for details)
4. **Assistant-at-surgery services** furnished by an NPP may be covered

COLLABORATION AND SUPERVISION REQUIREMENTS FOR NPP SERVICES

Advanced Practice Registered Nurses (APRNs)

- **Supervision:** APRN billed services <u>do not require</u> physician supervision.
  - ➤ Exception: Incident-to-billing requires direct supervision (see "incident-to-billing" section below for details).

- **Collaborative Agreement:** Per Illinois' Nurse Practice Act, APRNs privileged to practice in a hospital, hospital affiliate, or ambulatory surgical center do not require a written collaborative agreement. *All other APRNs require such an agreement with the collaborating physician until they have completed the education/training hours mandated by the State.* The physician doesn't need to be present when the APRN furnishes and bills for services, but must be reachable by telephone or other electronic means.

Physician Assistants (PAs)

- **Supervision:** PA billed services **require** general supervision by an MD/DO (the supervising physician does not need to be physically present when the PA provides the service).
  - ➤ Exception: Incident-to-billing requires direct supervision (see "incident-to-billing" section below for details).

- **Collaborative Agreement**: Per Illinois' Physician Assistant Practice Act, PAs privileged to practice in a hospital, hospital affiliate, or a licensed ambulatory surgical treatment center may provide services without a written collaborative agreement. *All other PAs require such an agreement.* The collaborating physician does not need to be present when services are furnished so long as the physician can be reached for consultation by radio, telephone or other electronic means.

PAYMENT FOR SERVICES

When NPPs bill CMS using their National Provider Identification (NPI) number, they are paid at 80% of the lesser of a) the actual charge or b) 85% (for PAs, NPs, CNSs) of the Medicare Physician Fee Schedule (100% for CNMs). There is a separate payment policy assistant-at-surgery services.

PLACE OF SERVICE

Place of Service (POS) code is used on the professional claim to identify the setting where the beneficiary received the face-to-face encounter with the billing provider. Below is a list of some UCM facilities, their POS code, and the type of NPP billing permitted.
Note: For questions about the classification of a specific location, contact your Revenue or Billing Manager

Setting (not an exhaustive listing)	POS	Type of Billing
Inpatient (Comer, CCD, Mitchell)	21 (Inpatient Hospital)	Direct or Split-Shared with Physician
Outpatient On-Campus (DCAM, Comer)	22 (On Campus-Outpatient Hospital)	
Outpatient Off-Campus (i.e. South Shore Senior Ctr)	19 (Off Campus-Outpatient Hospital)	
Emergency Department (Comer, Adult)	23 (Emergency Room)	
Physician Offices (i.e., South Loop, River East)	11 (Office)	Direct or Incident-to Physician service

BILLING OPTIONS FOR NPP SERVICES

1. **DIRECT BILLING**: NPP personally provides services to the patient, independently documents the service, bills under their own NPI, and receives payment based on the physician fee schedule.   Medicare will reimburse 85% of the MPFS amount.

2. **INCIDENT-TO BILLING (Physician Office POS 11):** Services that are furnished by an NPP incident to a physician's professional services. Medicare reimburses at 100% when an NPP provides services billed under the physician's NPI. Conditions include:
   - **Settings:** Applicable only in the office (POS 11) or in some cases, the patient's home.
   - **Direct supervision**: the physician must be present in the office suite (not necessarily in the treatment room) to render assistance while the NPP provides the service, if necessary. Another physician in the group who did not establish care may fulfill this requirement.
   - **Establishing Care:** Physician sees patient to establish care for the initial visit and must remain actively involved in the treatment course with periodic review and oversight of the plan of care.
     - **Return Visits:** NPP sees return patients as "Incident-to" the services of the Physician, but billed under the Physician's NPI.
     - **New or Worsening Problems:** If an established patient presents with a new or worsening problem, then incident-to billing does not apply. The visit would again require the direct participation of the Physician (i.e. pull into visit).
       - ➢ NPP may see the patient alone for the new problem, but would need to bill under their own NPI

   DOCUMENTATION:
   - NPP documentation should reference a supervising physician was present in the office or that direct supervision was provided and that they are providing follow-up care to the physician's established plan of care
     - *Example: I am providing follow-up care for this patient's conditions under the direct supervision of Dr. Jones who established the initial plan of care on ****. Dr. Jones was present and available in the office suite during today's visit.*
   - Physician must demonstrate periodic review and oversight (this may be achieved by participating in and/or reviewing follow-up visits)

3. **SPLIT-SHARED BILLING FOR EVALUATION AND MANAGEMENT (E/M) SERVICES**: *Split Shared Billing is not allowed in Physician Offices POS 11*
   Beginning January 1, 2022, a split-shared visit is a medically necessary E/M visit in the <u>facility</u> setting that is performed in part by both a physician and an NPP who are in the <u>same</u> <u>group</u>. One of the practitioners (not necessarily the one who bills) has to have seen the patient <u>face-to-face</u>. Whomever provides the substantive portion of the services bills with <u>Modifier FS</u> under their NPI.   Medicare will reimburse 100% of the fee schedule amount when billed by the physician, and 85% of the fee schedule amount when billed by the NPP.

   A. Same Group and Facility definition:
   - **Same Group Requirement**: Split Shared billing requires the NPP and Physician to belong to the same group (see below Employment Requirements)
   - **Facility Setting:** Split Shared billing is limited to Facility settings that are Hospital based (i.e. POS 19,21,22,23) [see Place of Service Descriptions above]
   - **Physician Office Ineligible**: as of Jan 1, 2022 Split Shared billing is no longer allowed in a Physician Office (POS 11). Incident-to billing may continue to be used in this setting (see Incident to Billing on page 3). APPs may also Direct Bill (see above section).

   B. Employment Requirements:
   - Physician and NPP must be employed by same entity (i.e., both BSD employees).
   - If the NPP is employed by the hospital, a service arrangement must be established between the UCMC/Care Network and the BSD department, and the UCMC/Care Network cost report must be updated.
   - In the absence of a service agreement, NPP documentation <u>*may not*</u> be used to support split-shared billing. Physicians must complete their own documentation and cannot rely on or refer to the NPP's documentation to support the E/M service.
     (Note: NPP lease agreements from UCMC to the BSD are in place on a section-by section basis or may be covered by a Master Agreement. For questions about existing service agreements in your section, consult your section administrator.)

   C. Eligible Services

E/M Services that may be split-shared billed	Split-shared does **NOT** apply to
• Outpatient visits (99201-99215) • Hospital admissions (99221-99223) • Subsequent visits (99231-99233) • Discharge (99238-99239) • Observation care (99217-99220, 99234-99236) • ED visits (99281-99285) • Prolonged care (99354-99359, G2212)* • Critical care services (99291-99292)* • Consultations (99241-99245, 99251-99255) *As of January 1, 2022	• Procedures *Note: The procedure must be performed by the billing practitioner. An APP may assist-at-surgery if appropriate for their scope of practice.*

D. Substantive Portion: Determining Who Bills *(Facility/Hospital Settings Only)*

1. Face-to-Face Requirement: One of the practitioners must have had seen the patient face-to-face. This does not necessarily have to be the practitioner that performs the substantive portion and bills for the visit (time may be with or without direct patient contact).

2. Substantive Portion (Key Component or Time): The substantive portion determines which provider (the APP or Physician) may bill for the visit. In 2022, the substantive portion can be defined by either:

- **A) Key Component** *or*
- **B) Time**

*Note: **Beginning in 2024** the substantive portion for **all services** will **solely be based on Time** (whomever spent more time)*

Outpatient (99202-99215)	Key Component	Time
Substantive Portion Method	Whomever performs the MDM in its entirety*may bill for the service. 1) ***Use MDM as the key component:*** MDM is the sole component that determines billing levels for OP E/M Both practitioners may contribute to the MDM but the billing practitioner must have performed all portions or aspects required to select the visit billed*. *Ex. 99213: at least 2 of 3 MDM elements personally performed must have resulted in an overall "Low" complexity (i.e. Low Problem, Limited Data, Mod Risk)* *If MDM elements by the other clinician support a higher level, the billing provider needs to review and note the additional elements and acknowledge they have been incorporated into the assessment of MDM complexity. *For example:* "APP Jones reviewed 3D images from the ER last night, I agree with the assessment of the images, the fragment injury would require a repair. I am scheduling the pt. for open surgery to avoid strictures. Also discussed the lack of success with only casting."	Whomever spends more than half of the total visit time performing the service may bill for the service. 1) The time of both practitioners must be totaled to determine who provided more than half of the total visit time. 2) If joint time was spent discussing or seeing the patient, only one practitioner should count that time
Leveling:	Leveling may be based on **MDM or Time** regardless of the substantive method used (Key Component or Time). →*For leveling by MDM or Time, see* Outpatient Tip Sheet	

Inpatient, Obs, Consults,ED ref here for CPTs	Key Component	Time
Substantive Portion Method	Whomever performs one of the key components in its entirety* (History, Exam, or MDM) may bill for the service. 1) History, Exam, or Medical Decision Making may be used as the key component. 2) Both practitioners may contribute to the key component but the billing practitioner must have performed all portions or aspects required to select the visit billed*. *Ex. 99223: If MDM is used as substantive portion, MDM personally performed must have been "High".* *If visit elements by the other clinician support a higher level, the billing provider needs to review and note the additional elements and acknowledge they have been incorporated into the assessment of MDM complexity. *For example:* "I reviewed APP Jones exam from this a.m. and note the new 2 x 5 area of redness and induration. To avoid bed sores I recommend the patient start on a more frequent turning schedule. I am ordering Tylenol prn to deal with any local discomfort in the interim."	Whomever spends more than half of the total visit time performing the service may bill for the service. 1) The time of both practitioners must be totaled to determine who provided more than half of the total visit time. 2) If joint time was spent discussing or seeing the patient, only one practitioner should count that time
Leveling:	Leveling is based on a combination of **History, Exam, and MDM** unless otherwise specified: ***3 of 3 Components***: i.e. Initial Hospital/Obs, ED **|** ***2 of 3 Components***: Subs Hosp/Obs →*For leveling by Hx, Exam and MDM see* E/M Tip Sheet	

Critical Care (99291-99292)	Time	
Substantive Portion Method	Whomever spends more than half of the total combined Critical Care time of both practitioners, may report the cumulative Critical Care units.	
Leveling:	Critical Care units are based solely on Time. →*For Critical Care time increment billing, see* Critical Care Tip Sheet Use *.SPLITSHARED_CRITICALCARE* SmartPhrase	

"SUBSTANTIVE PORTION" EXAMPLES *(n/a for Physician Office POS 11)*

KEY COMPONENT AS SUBSTANTIVE PORTION:

APP: Performs History & Exam, discusses findings with Physician. *History & Exam = Expanded Problem Focused*

Physician: Reviews and verifies history and exam performed by APP. Discusses problems with patient. Performs MDM (e.g. orders tests & makes management decisions addressing the patient's presenting problems) *MDM = Moderate*

► *OUTPT:* MDM is the billable key component for Outpatient E/M to meet the substantive portion. The physician completed all MDM elements to bill a Level 4 (i.e. 99214) as 2 out of the 3 elements of MDM performed by the physician met a Moderate complexity.

► *INPT SUBS HOSPITAL:* Both practitioners completed one key component in its entirety. The MDM performed by the physician meets the Moderate complexity associated with 99232. The collective APP/Physician work also meets the criteria for the level (Hx = EPF interval, Exam = EPF, MDM = M).

TIME AS SUBSTANTIVE PORTION:
OUTPATIENT E/M:
APP: Performs Hx & Exam *25 mins*
Physician: Performs MDM *20 mins*

Total Combined Time = 45 mins

► APP Lane bills 99204 as more than half of the total visit time was provided (approx 55% of total time).

CRITICAL CARE:
APP: Does *40 mins critical care*
Physician: Does *80 mins critical care*

Total Combined Time = 120 mins

► Dr. Lee bills 99291 & 99292 because more than half of the total Critical Care time was provided (over 65% of time) *.SPLITSHARED_CRITICALCARE*

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E. Split Sharing Prolonged Services
- **Time as Substantive Portion:**
    1. The time threshold for reporting a prolonged service must first be met.
    2. The Physician and NPP must document and sum their time together
    3. Whomever furnished more than half of the total time, including prolonged time, would bill for both the primary service and the prolonged service code

- **Key Component as Substantive Portion (2022 only)**
    ❖ **Outpatient E/M Same Day G2212:**
    1. The combined time of both practitioners must meet the threshold for reporting G2212 (at least 15 minutes beyond the maximum time of 99205 or 99215)
    2. The practitioner who provided a substantive portion of the service using the key component method may bill both the primary service and prolonged service code
    3. Note that for leveling purposes 99205 & 99215 may still only be leveled by time when adding on prolonged service G2212).

    ❖ **Other prolonged service codes (i.e. 99354-99359)** (prolonged is n/a for Critical Care/ED):
    1. The combined time of both practitioners must meet the threshold for reporting prolonged E/M services (typically *60 minutes beyond* the typical time of the Primary Service)
    2. The practitioner who provided a substantive portion of the service using the key component method may bill both the primary service code and the prolonged service code

F. Documentation Requirements: Split Shared

Medical Necessity: Documentation should support the medical necessity of the involvement of both practitioners and the level of service billed.

1. **Document Personal Contributions:** Each practitioner should document their own separate contributions to the visit.
   ►Physicians may separately document within an addendum to the note or within the *.splitsharednppvisit* statement. There must be enough information detailed to support the substantive portion and/or level billed, as applicable.

   - ▪ *Note:* if the APP identifies elements of the visit that support a higher level of coding, the billing provider would need to review and note the additional elements and acknowledge that they have been incorporated into his/her assessment of MDM complexity.

VISIT COMPONENT	NPP DOCUMENTATION	PHYSICIAN DOCUMENTATION
HISTORY & EXAM *Elements:* OUTPATIENT Medically Appropriate History & Exam INPATIENT **History:** HPI, ROS, PFSH **Physical Exam:** 95 or 97	See EPIC Note Workflow Document the medically necessary History & Exam elements of the visit you personally performed and contributed to.	See EPIC Note Workflow ***Use "*.splitsharednppvisit*" or addendum* 1. Document unique history & exam elements you captured: • If you did not personally perform any history & exam elements, review and verify what the APP captured 2. **Note and acknowledge** if any History & Exam elements from the APP were used in Medical Decision Making (note your review and detail how used)

MEDICAL DECISION MAKING
 	
Elements:
OUTPATIENT
1. **Problems Addressed** (& Complexity)
2. **Data** (reviews, orders, interpretation, discussion, independent historian, etc)
3. **Management Risk**
 	
INPATIENT
1. **Presenting Problem**
2. **Diagnostic Procedures Ordered**
3. **Management Options Selected**
	Document the medically necessary MDM elements you personally performed and contributed to, including any Data Elements you contributed to or Diagnostic Procedures Ordered.	1. Document the Medical Decision Making you personally performed:
		   • **Problems** addressed & **Management** recommended
		   problem complexity should be clear if not already inherent
		
		   • **Data** elements you performed or **Diagnostic Procedures** ordered
		
		2. **Note and acknowledge** if any MDM elements from the APP were used in Medical Decision Making (note your review and detail how used)

Each clinician (at minimum billing provider) should note the visit was "done or performed" in conjunction with the other clinician **Sign & Date:** Each practitioner must sign and date to authenticate their documentation See EPIC Note Workflow **Modifier FS:** Billing practitioner must add Modifier FS instructions here		

Time Based: *In addition to the above steps*, the distinct time spent by *both* the Physician and NPP must be documented and summed to define total visit time. If there is shared time, the time of only one individual should be counted for that period.
- **APP:** Insert **".TIMEATTEST"** smartphrase when leveling by time. Only include time independent of the provider.
- **Physician:** Fill out the optional time statement in the ".splitsharednppvisit" smart phrase to level by time or demonstrate that you spent "substantive time".

G. Modifier FS Requirements (n/a for physician office)

Beginning Jan 1, 2022 Modifier FS should be appended to charges involving Split Shared services. Add Modifier FS when selecting the charge unless otherwise instructed by your Department:

Steps to Add Modifier FS

A. Add Modifier FS at time of charge selection:

1. In Level of Service area select charge button (i.e. NEW3)
2. Next to "Modifiers" click the + button
3. Search for FS and hit Accept (in the future it will show up in Recent tab)

B. "Wrenching-In" Modifier Button for Future Use

1. Click the Wrench Icon in the Level of Service Area
2. Click on empty serrated modifier box and select "+ Add"
3. Under Modifier select FS, Under Caption add "FS" or "FS-shared"
4. Hit Accept, Modifier FS will now be a option to choose in Modifiers
5. To undo click "Restore Defaults" while in Wrench editing

H. SmartPhrases

Whether in a separate addendum or detailed within the "*.splitsharednppvisit"* SmartPhrase, the documentation of your contribution must be detailed enough to support the substantive portion and/or level of service billed, as applicable.

- The billing practitioner is encouraged to use the smart phrase *".splitsharednppvisit"*. Other acceptable exams are listed.
- If the Physician is adding an addendum to the NPP's note, the physician should describe any contribution to the service that is not described in the NPP's note.

Note: The use of Teaching Physician attestation statements is never acceptable.

ACCEPTABLE PHYSICIAN DOCUMENTATION EXAMPLES:

.splitsharednppvisit: This encounter was done in conjunction with APP ***. I provided the substantive portion of this visit by personally performing the {History/Exam/MDM} component in its entirety. I verify that the notes documented by the APP are correct. Additionally, I am documenting that **** *(note unique elements you contributed, including history, exam, data).* Finally, my impression and plan related to this encounter is *** *(document problems addressed and their management).*

ATTEST TIME (Optional) {:221517}: I spent a total of *** minutes of non-overlapping time on the visit. The total APP/MD visit time was *** minutes. Substantive Time: I {did/did not} spend more than half of the total visit time.

Acceptable Phrase Example: I performed the visit in conjunction with APP***. I saw and evaluated the patient and performed the MDM as documented in my note. Agree with NPP's physical exam as documented, in addition it should be noted that lower extremities are weaker, now 3/5; Therefore, I am recommending an MRI of L/S spine today. I reviewed the orders and have incorporated them into my management of the patient.

►For Critical Care Split Shared services use "*.SPLITSHARED_CRITICALCARE"*. See Critical Care Tip Sheet for detail & documentation.

UNACCEPTABLE PHYSICIAN DOCUMENTATION EXAMPLE:

X   Agree with above, followed by legible countersignature or identity.
X   Rounded, Reviewed, Agree, followed by legible countersignature or identity.
X   Discussed with NPP. Agree, followed by legible countersignature or identity

.TIMEATTEST (to document APP time)

I spent a total of *** minutes (excluding separately reportable procedure time) in care of this patient on @ED@. *[Only include your time independent of physician time]*

REFERENCES

- Illinois Nurse Practice Act (225 ILCS 65/): http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1312&ChapterID=24
- Illinois Physician Assistant Practice Act of 1987 (225 ILCS 95/) http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1320&ChapterID=24
- MLN Matters "Incident to" Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf
- Medicare Benefit Policy Manual, Chapter 15-Covered Medical and Other Health Services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Medicare Claims Processing Manual, Chapter 12-Physicians/NonphysicianPractitioner: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf