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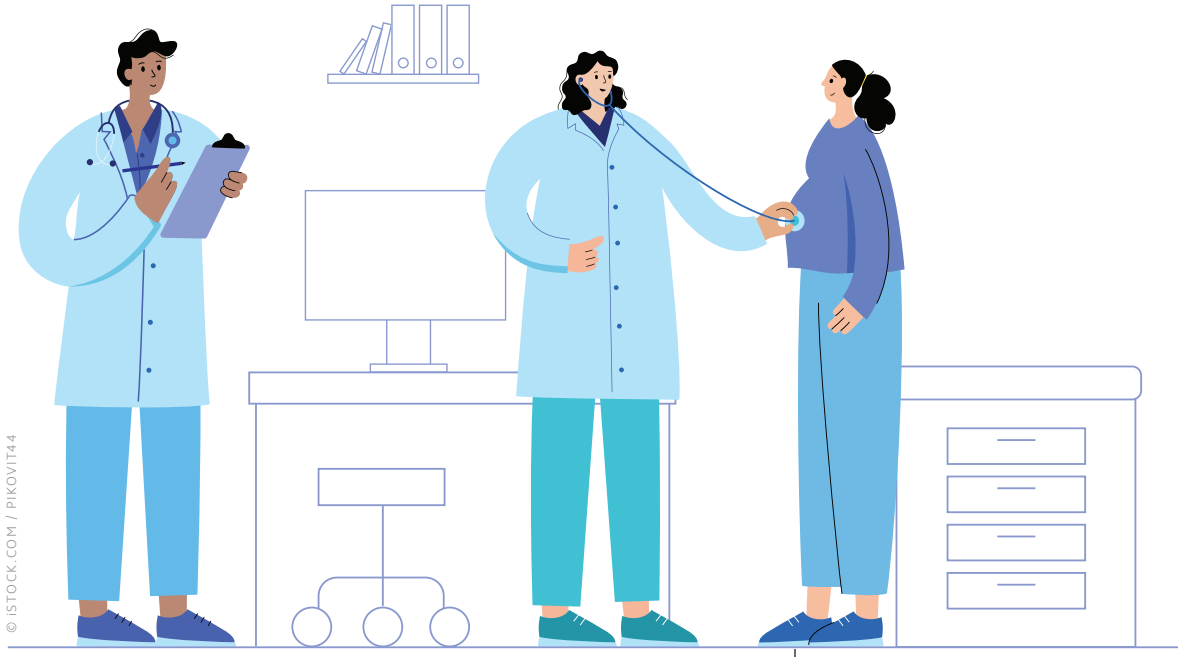
Billing for Non-Physician Provider Services to Support the Delivery of Physician Care



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Understanding the latest rules for incident-to and split/shared billing can help groups capture full reimbursement and work credit.

With the current shortage of physicians and the clinical demands on primary care due to the aging and growing population in the United States, a critical need for physician support is arising. The population aged 65 years or older is expected to grow by 45% over the next 15 years, and the general population is expected to increase by 10%.[1] One option to assist physicians in delivering care to patients is to add nurse practitioners (NPs) and physician assistants (PAs) to the clinical team.

Both professions originated in training programs around 1965.[2] Medicare billing, which initially revolved around physicians, had to morph to include these "non-physician providers" (NPPs) and allow payment for the services they delivered. Since NPP training was

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shorter in duration, less intense, and more generalized than physician training, reimbursement for their services was also less — set at 85% of the Medicare Physician Fee Schedule (MPFS). This reduced reimbursement rate still stands today for Medicare[3] and is commonly followed across other payers, most of which credential NPPs to allow payment for services delivered. Over the years, the NPP name has changed substantially to include qualified health care professionals, advance practice nurses, physician associates, doctors of nursing practice, advanced practice providers, and so on. For simplicity, we will use "NPPs" as an umbrella term for all these providers.

The scope of services NPPs can perform is dictated by the originating state governing body — the state Board of Nursing for NPs and the state Board of Medical Examiners for PAs. Though the two types of providers are closely aligned in scope, they are not identical, and rules can vary from state to state. Thus, before deploying this clinical collaboration in your practice setting, it is critical to investigate the scope of services allowed and the governing laws in place in your state. The specific credentialed services allowed need to be annotated in an agreement (Scope of Practice or Practice Agreement) updated on a set schedule to ensure all parties understand what care NPPs can deliver. Most states require the signed and dated document to be readily available at the time of a site visit if one were to occur. Twenty-two states currently allow NPs full (autonomous) practice authority,[4] and three states afford the same independence to PAs.[5]

KEY POINTS

- In the office setting, services furnished by a non-physician provider (NPP) can be paid at 100% of the Medicare physician fee schedule, rather than 85%, if they are provided "incident to" a physician service and meet certain requirements.
- In facility settings, split/shared billing occurs when a physician and NPP of the same group each perform portions of a visit on the same patient and on the same date of service; billing is allowed for the clinician who performs the substantive part of the visit based on key components or total time.
- Physicians risk being "left out" of receiving their part of the reimbursement (and work credit) if the total time option is followed.

The Centers for Medicare & Medicaid Services (CMS) has developed pathways to use NPPs that allow 100% of the MPFS, which we will discuss below, but the nuances of these pathways can be complex. The rules for how NPPs interface clinically with physicians for billing purposes were redefined in 2022.[6] Following the guidelines can allow physicians to extend their clinical reach through team expansion while maintaining full payment (and full work credit) for services delivered by an NPP collaborating with them on a plan of care. In this article, we will explore incident-to and split/shared billing and see how NPP billing differs for each in various clinical settings.

INCIDENT-TO BILLING FOR OFFICE OR HOME VISITS

As "incident to," services furnished by an NPP must be an integral, although incidental, part of the physician's personal professional services during diagnosis or treatment of an injury or illness.[7] For a service to be incident to, there must first be a physician service to which the incident-to service relates. The physician must perform the initial service and devise a plan of care, which the NPP then follows in subsequent visits. Thus, incident-to services are more appropriate for established patients and established problems. Incident-to billing uses the physician's national provider identifier (NPI) even though the physician did not perform the subsequent face-to-face visit with the patient.

Sometimes, it is not clear whether a problem is new, such as a patient presenting with the latest in a series of upper respiratory infections. In general, if the NPP is following the course of care that the physician previously established, then the visit qualifies as incident to. However, if a new course of care is needed (especially when dealing with multi-system problems) and the physician is not involved, then the visit would *not* be incident to. A best practice is if the treatment needs to be adjusted (more than just a "tweak" of blood pressure medication to get the patient to goal, for example), then the NPP should discuss this with the supervising physician, who may want to do a quick face-to-face visit with the patient. The visit could

SUMMARY OF REQUIREMENTS

	Incident to	Split/shared
Place of service	Office 11 Home 12	Inpatient 21 Emergency 23 Outpatient 19, 22 SNF 31, 32, 54, 56
Modifier	None	FS
Who performs the service	NPP	NPP and physician in same group on same day, employed by same entity
Whose NPI is billed	Physician's	NPP's or physician's, depending on who performed the substantive portion of the service
Requirements	Direct supervision: a physician must be present in the office suite to render assistance if necessary. Established care: Physician has previously seen patient to establish plan of care for the problem. Oversight: Physician must demonstrate periodic review and oversight.	Substantive portion may be based on key component (history, exam, or medical decision making) or time spent. Times from both clinicians can be combined for billing. One of the clinicians (not necessarily the one who bills) must have seen the patient face-to-face.

then be billed under the physician's NPI at 100% of the MFPS.

For compliant billing, a supervising physician in the group must be on site, in the office suite, and immediately available to the NPP should an issue arise (known as "direct personal supervision").[7] The supervising physician is the physician of record at the state office that the NPP is working under/collaborating with. Other physicians (deemed an "alternate") can supervise as well. When they supervise an NPP delivering incident-to services, their NPI is used for billing.

Incident-to services can be delivered in a physician's office (place of service [POS] 11) or in a patient's home (POS 12). If done correctly, Medicare reimbursement is 100%, not the traditional 85%. As always, check the availability of using incident-to billing and related reimbursement levels for each commercial payer.

Though no strict physician documentation is required for incident-to billing, a best practice is for the NPP to note that "Dr. X is on site and available" as part of the visit documentation. Including a statement such as this on the routing report/charge sheet or in the progress note helps the biller assign the charge correctly — as incident-to under the physician's NPI at 100% of the MPFS, instead of 85%. Additionally, the overseeing (billing) physician could document an addendum to the note indicating that they reviewed the note and agree with the treatment plan outlined. This addendum/attestation is not mandated by CMS. The scope of practice for some NPPs may require a certain number of chart audits for supervision of services, but those requirements do not extend to NPP billing.

SPLIT/SHARED VISIT BILLING FOR VISITS OUTSIDE THE OFFICE

Outside the office, the NPP-physician billing relationship is called "split/shared" and is allowed in hospital inpatient (POS 21), hospital outpatient (POS 19 and 22), emergency department (POS 23), and nursing facility (POS 31-32) settings. These encounters occur when a physician and NPP of the same group each perform portions of a visit on the same patient and on the same date of service. Split/shared services can involve new or established patients, initial or subsequent visits, or prolonged services. Both clinicians must document their respective work in the clinical record to support claims for split/shared billing, identified with modifier FS.

The MPFS 2023 Final Rule released Nov. 1, 2022, clarified that billing for this service is allowed for the clinician who 1) performs the substantive part of the encounter based on key components or 2) spends more than 50% of the total time.[8] This split/shared billing guidance originally went into effect Jan. 1, 2022. ➤

Using the *substantive part of the visit based on key components* option, the clinician who performs/documents one of the key components (history, exam, or medical decision making [MDM]) of the encounter can bill for the service. The key component is determined by the clinician, and any of the three components can be used. However, that key component must be fully performed to meet the level of the charge assigned for the visit. Clinically, it makes sense for the physician to use the MDM aspect of the encounter as the driver of the charge, as long as clinical documentation supports this.

The prior method of using an "attestation" comment, such as "saw patient and agree with above," will no longer suffice for adequate capture of the MDM level of billing. Documentation such as "seen and agree"[9] is no longer acceptable because it is not possible to determine whether the physician was present, evaluated the patient, or had any involvement with the plan of care. The physician must "think in ink" and fully note the problems assessed and any active management that is ongoing to care for the condition. A clinician can do this by commenting on continuation of medication or stating a "next steps" plan in the management. Pertinent documentation specific to the patient is ideal and would help avoid a denial of payment due to lack of medical necessity to support the evaluation and management (E/M) level of the encounter.

To help billers know who provided the substantive portion of the visit based on key components, groups will need to figure out a workflow. For example, a group may decide to bill these visits based on the physician's documentation of MDM, because that is what physicians are trained in and MDM drives the charge much more than the history or exam components. However, if there is no documentation of MDM by the physician, then the group could decide that the visit would be billed under the NPP who made the rounds and documented in the chart. Since CMS has not standardized which key component is deemed the substantive part when using the key components option for the billing level, groups can decide.

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Using the *total time* option, the clinician who spends more than 50% of the total time performing the service on that calendar day would bill for the service. Total time includes time personally spent doing anything pertinent to care for the patient: review of records, coordination of care, outside report/communication review, taking the history, performing the exam, performing documentation in the record, etc. The specific amount of time (number of minutes) needs to be documented to show that the clinician performed more than 50% of the total time of the encounter. The bill would be submitted under the name of this clinician; however, the times spent by each clinician would be added together to assign the charge for the visit.

The following time-based billing example highlights a potential problem area when billing based on time. Consider a situation where an NPP spends 17 minutes in the care of a hospitalized patient and then the physician spends 10 minutes later in the day to round on the same patient. Since the NPP spent "more than 50% of the total time" (17 of 27 minutes), the split/shared service (hospital rounding, 99231) would be billed for the PA, not the physician. This scenario may cause concern for physicians and is currently being debated through national societies with CMS. A final decision on the billing rules surrounding this is expected by the end of 2023.

There are times when split/shared billing should be used rather than incident-to billing. Incident-to billing is not permitted in outpatient hospital departments, as the services are defined by Medicare as "commonly furnished in physician offices."[7] This affects physicians in ambulatory sites that have been classified as off-campus (POS 19) or on-campus (POS 22) outpatient departments of a hospital. The clinical setting may look like a physician's office, but some institutions have reclassified these offices as "outpatient hospital departments" for financial reasons, thus making incident-to billing not allowed.

For split/shared critical care services,

the 2022 guidelines[6] allowed physicians and NPPs to have their time in critical care delivery added for billing purposes. Previously, only one clinician could track time, and if the minimum threshold of time was not surpassed, they could not bill for critical care services. With the updated guidelines, the minimum threshold may be more easily reached. Multiple clinicians in the same specialty or group can furnish critical care services concurrently to a patient on a single day, and their total time can be aggregated.[10] However, the guidelines indicate that the clinician who delivers the substantive portion of critical care, or more than 50% of the total time, should bill for the service. Therefore, physicians risk being "left out" of receiving their part of the reimbursement (and work credit) if the total time option is followed.

NPPs also assist physicians in the delivery of post-acute care in nursing facilities. This includes short-term skilled care facilities (POS 31) and long-term residential care facilities (POS 32). For short-term care in a skilled nursing facility, the physician must make the initial assessment to arrange the rehab plan of care for a patient. After that, the physician and NPP can alternate visits if allowed by state law or regulation. With long-term residential care, the physician/NPP cadence is less regulated, with NPPs able to perform initial comprehensive nursing facility visits, per state law or regulation.

Clinicians should bill for services delivered in these settings following the 2023 split/shared guidelines unless the visit is required to be performed by the physician alone. Additionally, there is a special situation whereby physicians can establish a separate stand-alone area within a facility and designate it as their medical office. Visits performed within this specific discrete area can be billed as though they were performed within the physician's office (POS 11). As such, the incident-to rules would apply for services performed within that specific site.

EXPANDING PHYSICIAN REACH AND REIMBURSEMENT

NPPs are key members of the clinical dyad team and integral to successful delivery of care, given the complex patient load shouldered by primary care physicians today. The addition of these professionals in various practice settings will help expand physicians' reach and can go a long way in helping address physician burnout. Optimizing the economics of this approach will ensure physicians avoid compliance issues and receive maximum reimbursement and work credit for the services delivered. FPM

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