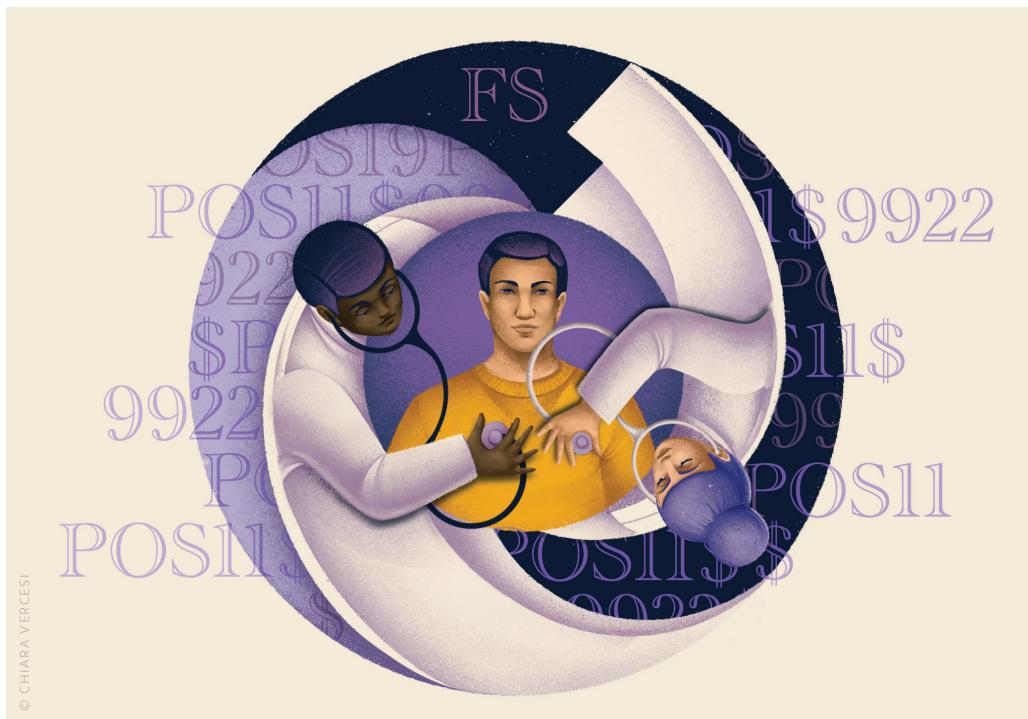


Incident-to and Shared Services: Demystifying Billing for Care Provided by Multiple Professionals



Knowing the rules can help practices receive payments that better reflect the work of the whole health care team.

Medical services are usually billed by the individual who performs the service. However, Medicare has two exceptions — “incident to” and “shared services.” These two rules essentially allow physicians to bill for care provided by clinicians and staff who work with them as if the physicians had done it themselves. They’re similar rules, but with key differences.

Incident-to services are performed in physician offices or patients’ homes, while shared services are performed in facilities such as hospitals or nursing homes. Incident-to services can be performed by either non-physician clinicians (NPCs) or clinical staff as part of the billing physician’s professional services, while shared

ABOUT THE AUTHOR

Betsy Nicoletti is a speaker and consultant in coding education, billing, and accounts receivable. She lives in North Andover, Mass. Author disclosure: no relevant financial relationships.

services must be performed by two clinicians (physicians or NPCs) who each could have billed the service on their own. (See “Incident-to vs. shared services comparison.”)

In either case, though, if the physician is billing, Medicare pays the full physician fee schedule rate, while services billed by NPCs are paid at 85% of that. Some private insurers also allow incident-to billing and

practitioners. They’re sometimes called “other qualified health care professionals” (QHPs) or “non-physician practitioners” (NPPs), but in this article we’ll refer to them as NPCs. Clinical staff are most often medical assistants or nurses, but could include other professionals who work under physicians’ supervision (see “Definitions” on page 12). Billing for incident-to services under the supervising physician’s name and National Provider Identifier (NPI) results in the full reimbursement rate.

NPCs may also use incident-to billing for services clinical staff provide under their supervision. As noted, though, Medicare will pay a lesser rate (85% of the physician fee schedule amount) for incident-to services billed using the NPC’s name and NPI on the claim form.

Incident-to services include evaluation and management (E/M) and other services and supplies commonly furnished in medical practices, such as applying a splint, doing an injection, or checking blood pressure at a nurse visit. Incident-to billing does not apply to services with their own statutory benefit categories (i.e., groups of services health plans are legally required to cover), including wellness visits, clinical diagnostic tests, and pneumococcal, influenza, and hepatitis B vaccines.

To bill for a service that an NPC performed under the physician’s NPI (at the full physician rate), these requirements must be met:

- **The service must be part of a physician’s plan of care.** The physician sees the patient at a prior encounter and establishes the plan of care. After that, the NPC may see the patient as part of the physician’s treatment. (If a subsequent E/M service can be performed entirely by clinical staff, rather than an NPC, the supervising physician may still bill for it as an incident-to service at the full physician rate using E/M code 99211 — the lowest level of E/M. Higher level E/M services must be performed by an NPC or physician.) E/M services for new patients, or new problems for existing patients, aren’t eligible for incident-to billing because they are not part of the physician’s preexisting plan of care. If an NPC provides these services, they must bill for them under their own NPI (at the 85% rate).

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shared services billing under rules similar to Medicare’s, but this varies by payer.

Shared services rules have changed recently, as CPT has published new definitions (which Medicare has largely adopted, for now). The requirements for incident-to billing haven’t changed, but they can be confusing, and because family physicians tend to use incident-to billing more often, a refresher is useful. This article provides that refresher on incident-to billing, as well as an explanation of the changes to shared services billing, and has a set of questions and answers with specific scenarios to help physicians understand when and how to use each of them.

INCIDENT-TO REFRESHER

Incident-to rules allow a supervising physician to report services performed by NPCs or auxiliary clinical staff as if the physician personally provided them. NPCs are most often physician assistants or nurse

KEY POINTS

- Medicare allows supervising physicians to bill for services that other members of the health care team provide in office or home settings (“incident-to” billing) and bill for services they provide jointly with other clinicians in facility settings (“shared services”).
- Some private payers also allow incident-to billing and shared services billing, and CPT has released definitions for shared services.
- Shared services are billed by the physician or other clinician who performed the “substantive portion” of the E/M visit, which is easier to determine when using total time.

INCIDENT-TO VS. SHARED SERVICES COMPARISON

	Incident to	Shared
Service performed by	NPC* or clinical staff	Both physician and NPC
Type of service	E/M, supplies, injections, minor procedures such as splint application	E/M services only
Place of service (POS)	Physician office (POS 11) or patient's home (POS 12)	Facilities (e.g., hospital inpatient or outpatient, emergency department, nursing home)
Supervision	Direct (physician in suite of offices)	Not applicable
New patients or new problems allowed?	No	Yes
Billed by	Supervising physician (at 100%) or NPC (at 85%)	Clinician who performs substantive portion of service
Signature	Co-signatures not required	Billing clinician signs and dates

*Non-physician clinician, sometimes called non-physician practitioner or other qualified health care professional

- **The service requires direct supervision.** The physician, or the physician's covering partner, is in the suite of offices (or patient's home) and immediately able to assist if needed when the NPC performs the service. Medicare rules are generally interpreted as requiring the supervising physician to be in the same or a similar specialty as the NPC performing the service, although the Centers for Medicare & Medicaid Services (CMS) doesn't specifically say this. Likewise, CMS does not specifically define supervision beyond the physician being "in the suite of offices," but some payers interpret it to mean not separated by a set of stairs or elevator.

- **The NPC must be an expense to the practice,** either employed, leased, or contracted.

- **The physician must stay involved in the plan of care,** but CMS does not describe exactly what this entails. It could mean alternating visits with the NPC or periodically seeing the patient. Simply signing off on the record alone is less compelling as documentation, and there is no Medicare requirement for co-signature. NPCs can provide documentation that supports incident-to billing by noting in their assessment that the visit was part of the physician's plan of care and that the physician was in the office. But CMS does not specifically require this.

- **The NPC must be enrolled in Medicare,** whether billing directly or incident to the physician, according to U.S. Department of Health and Human Services guidance.¹

SHARED SERVICES

Until recently, only Medicare defined shared services. But CPT added its own definition in 2021 and expanded it in 2024. (See "CPT vs. CMS shared services comparison" on page 13.)

Shared services are E/M services that a physician and NPC perform jointly in a facility setting, such as inpatient and outpatient hospital buildings, emergency departments, and nursing homes. Shared services may not be performed in physician offices that are not part of a facility setting. The place of service (POS) code is

Shared services are E/M services that a physician and NPC perform jointly in a facility setting.

key to shared services billing.² For example, hospital outpatient clinics that use POS 19 (on campus) or 22 (off campus) can bill for shared services, whereas physicians' offices that use POS 11 cannot. (It's the opposite with incident-to services, which can be billed with POS 11, but not POS 19 or 22.)

Both clinicians must be enrolled in Medicare and able to perform E/M services on their own (a physician may not share E/M services with a social worker or dietitian, for example, because those professionals don't have E/M in their scope of practice).³

To bill for E/M as a shared service, both clinicians must participate in the patient's care on the same calendar day. The identity of both clinicians must be included in the encounter note, but only the billing clinician is required to sign and date the medical record. That clinician then submits the

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claim using HCPCS modifier FS ("split [or shared] evaluation and management visit") for Medicare.

Remember that when the physician bills for the shared service, Medicare pays 100% of the physician fee schedule allowance, but when an NPC bills, it results in payment of only 85%. So, it makes sense to bill under the physician's NPI when possible. But under both Medicare and CPT rules, physicians may only do this if they perform the "substantive portion" of the service.

Billing based on time. If you're billing for E/M based on total time, determining who provided the substantive portion of the visit is pretty straightforward: The

clinician who accounted for more than half the visit's total time (face-to-face and non-face-to-face time combined) performed the substantive portion of the service. Thus, both clinicians should document their own time, and if the physician's time is greater than half, the service should be billed under the physician's NPI. The only complicating factor with time-based coding is that if the physician and other clinician meet to discuss the patient, or see the patient together, only one of them can count those minutes — they can't double-count them.

Billing based on MDM. If you're using medical decision making (MDM) to code an E/M service, determining who performed the substantive portion is significantly more complicated. There's no quick and clear way to do it, but here is some guidance based on both CPT and CMS rules.

MDM is defined by three elements: the number and complexity of problems addressed, the amount and/or complexity of data reviewed and analyzed, and the risk of morbidity and/or mortality from additional diagnostic testing or treatment. In 2024, CPT added this instruction: "performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) who made or approved the management plan for the number and complexity of problems addressed at the encounter take responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM. If a practice codes the visit based on medical decision-making (MDM), the practitioner who performs the problems addressed and risk portions of the visit reports the service."

The key takeaways are this:

- The physician or NPC who evaluates the problems and determines and takes on the risk of the additional testing and treatment of those problems (two of the three MDM elements) meets the "substantive portion" threshold to qualify as the billing clinician.
- CPT states that the billing clinician "made or approved the management plan." It does not state that the billing clinician

DEFINITIONS

Non-physician clinicians (NPCs) or non-physician practitioners (NPPs): Physician assistants and a variety of advance practice registered nurses (e.g., clinical nurse specialists, certified nurse midwives, nurse practitioners, and certified registered nurse anesthetists) who are allowed to bill Medicare directly.

Other qualified health care professional: According to CPT, "A physician or other qualified health care professional is an individual who by education, training, licensure/regulation, and facility privileging (when applicable) performs a professional service within his/her scope of practice and independently reports a professional service. These professionals are distinct from clinical staff." This includes the NPCs/NPPs above, but also other professionals such as physical therapists and clinical social workers.

Clinical staff member: According to CPT, this is "a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service." This includes medical assistants and nurses.

CPT VS. CMS SHARED SERVICES COMPARISON

	CPT	CMS	Comments
Definition	"Physician(s) and other qualified healthcare professional(s) may act as a team in providing care for the patient, working together during a single E/M service."	"E/M services furnished in a facility setting ..." "a split or shared visit refers to an E/M visit performed by both a physician and an NPP in the same group practice."	CMS explicitly says "same group," while CPT says "act as a team." Both should be interpreted as requiring the same or similar specialty for physicians and NPCs.
Location	CPT doesn't mention location.	Facility settings only.	Use split/shared only in facility settings for Medicare patients (in office, use incident-to). Commercial payers may adopt their own location policies.
Substantive portion of E/M based on time	The clinician who spent the majority of time on the E/M service does the billing.	The clinician who spent the majority of time on the E/M service does the billing.	CMS has said it intends to require time-based billing for shared E/M services, but so far has not.
Substantive portion of E/M based on number and complexity of problems and risk	The physician or NPC who "made or approved the management plan" for the problems addressed at the encounter and takes responsibility for the risks of that plan has performed two of the three elements used in the selection of the code level.	"... whoever performs the MDM and subsequently bills the visit would appropriately document the MDM in the medical record to support the billing of the visit" (CMS 2024 Physician Fee Schedule final rule, page 475).	CPT: Billing clinician performs any two of the three MDM elements. "Made or approved" suggests signing off on other clinician's documentation is OK. CMS: Largely agrees with CPT but implies billing clinician should do documentation.
MDM data	Either clinician can review Category 1 data (unique test results or notes, using an independent historian), but billing clinician must review Category 2 data (an independent interpretation of an image or tracing) or Category 3 data (discussion with an external health care professional about management or test interpretation).	Doesn't comment specifically on data or the other individual elements of the MDM in determining the substantive portion, but quotes CPT in the final rule.	Default to CPT if using data to select the level of service. This means the billing clinician does not have to personally order and review tests or documents, or use an independent historian, but does have to personally interpret image or tracing or personally discuss patient with external health care professional.
Documentation	Either clinician can document, but billing clinician must at least sign off ("made or approved").	The billing clinician, who performed the "substantive portion" of the visit, should do the documentation.	Check with your Medicare Administrative Contractor (MAC). Avoid using attestation statements unless your MAC specifically allows it.

must personally document the plan.

There is one twist. If you use data to select the level of E/M service and include Category 2 data (an independent interpretation of an image or tracing) or Category 3 data (discussion with an external health care professional about management or test interpretation), the billing clinician must perform that portion of the service.⁴

Category 1 data (ordering and/or reviewing unique test results, reviewing notes, or using an independent historian) does not need to be performed by the billing clinician because this work is included in the formulation of the diagnosis and plan.

Because of the complicated nature of determining who should be the billing clinician using MDM, CMS has said that in

the future it intends to require that clinicians only use time to determine who performed the substantive portion of shared services. But CMS delayed that change for the third year in a row in its 2024 Physician Fee Schedule final rule, instead

saying it would follow the new CPT definition for now.

CMS also said this about shared services: "Although we continue to believe there can be instances where MDM is not easily attributed to a single physician or NPP when the work is shared, we expect that whoever performs the MDM and subsequently bills the visit would appropriately document the MDM in the medical record to support the billing of the visit."

CMS does not explicitly say what the billing physician needs to document and what the NPP (or NPC) could document instead. Therefore, although CPT's guidance seems to indicate that an attestation statement is acceptable ("made or approved the management plan"), it would be prudent for physicians to personally document MDM when billing Medicare for shared services under their NPI.

PAYMENTS THAT BETTER REFLECT THE WHOLE HEALTH CARE TEAM

Clearly, the rules governing incident-to billing and shared services billing are not always simple. But the list of questions and answers on the left should help clarify some common scenarios.

Having a basic understanding of when shared services and incident-to rules apply allows physicians to receive payments that better reflect the actual work their practices are doing, especially as team-based care increases. **FPM**

1. Advanced practice registered nurses, anesthesiologist assistants, and physician assistants. Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network. MLN901623; March 2022.

2. Place of service code set. CMS. Updated September 2023. Accessed March 13, 2024. <https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets>

3. Medicare Claims Processing Manual, Ch. 12, Sec. 30.6.18A. CMS 100-04; rev. 12461. Jan. 18, 2024. Accessed March 14, 2024. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

4. *CPT 2024 Professional Edition*. American Medical Association; 2023.

5. CMS-1784-F. CMS. Nov. 16, 2023. Accessed March 14, 2024. <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f>

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