Billing Non-Physician Provider Services in 2024

Billing & Reimbursement Overview
and Changes in Split/Shared Visits

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Disclaimer Statement

* This program is not intended to provide reimbursement, legal or financial advice; it is for informational purposes only. Participants will need to do their own research and make their own decisions when making coding and reimbursement decisions.
* Regulations and policies concerning payer reimbursement are a rapidly changing area of the law. While we have made every effort to be current as of the issue date, the information may not be current or comprehensive when you review it or may contain inaccuracies or typographical errors.
* Please watch for announcements from CMS and commercials payers directly. Be aware that this presentation is focused on Medicare regulations and commercial insurances have their own rules and do not automatically adopt Medicare standards.
* Be sure to consult with your legal counsel for any specific reimbursement information.

For Medicare regulations visit:
www.cms.gov

Objectives

- Billing for NPP Services:
  - Review payer-specific rules and best practices for billing NP and PA services
- Understand 2024 Updates to Split/Shared Visits:
  - Examine key changes in coding and billing for Split/Shared visits for NPPs
- Modifier Usage in NPP Billing:
  - Learn when and how to apply modifiers appropriately to avoid billing errors

What is an NPP?

- Non Physician practitioner
  - A NPP is a healthcare provider who is not a physician but who practices in collaboration with or under the supervision of a physician

- NPPs generally include;
  - nurse practitioners (NP or APRN)
  - physician assistants - now - physician associates (PA)
  - clinical nurse specialists (CNS)

* NPPs are also known outside of the Medicare program by other names
  * advanced practice practitioners (APPs)
  * mid-level providers
  * physician extenders

NPPs must be working within their Scope of Practice

* However - Office of Inspector General (OIG) stated that:
  * *"State scopes of practice are broad and as a result provide little guidance that carriers can use to process claims."*
  * *"They most only contain only a general statement about the responsibilities, education requirements and non-specific list of allowed duties and do not identify services that are beyond their scope."*

Federal Regulations

* PA – Federal Regulations including Medicare:
  * A PA works under the supervision of one or more physicians, according to the Code of Federal Regulations (CFR), Title 42, **Section 410.74**

* NP & CNS – Federal Regulations including Medicare:
  * the NP or CNS must work "in collaboration with a physician." CFR, Title 42, spells this out in **Section 410.75** for NPs and in Section **410.76** for CNSs

Federal Regulations

* PA ***Qualifications***
  * Have graduated from a physician assistant educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs; or
  * Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants; and
  * Be licensed by the State to practice as a physician assistant.

Federal Regulations

* NP ***Qualifications***
  * Obtained Medicare billing privileges as a nurse practitioner for the first time on or after January 1, 2003, and meets the following requirements:
    * Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.
    * Possess a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree.

Federal Regulations

* PA Performs the services in accordance with state law and **state scope of practice rules for physician assistants in the state in which the physician assistant's professional services are furnished.**
  * Any state laws and scope of practice rules that describe the required practice relationship between physicians and physician assistants, including explicit supervisory or collaborative practice requirements, describe a form of supervision for purposes of section 1861(s)(2)(K)(i) of the Act.
  * For states with no explicit state law and scope of practice rules regarding physician supervision of physician assistant's services, physician supervision is a process in which a physician assistant has a working relationship with one or more physicians to supervise the delivery of their health care services.
    * Such physician supervision is evidenced by documenting at the practice level the physician assistant's scope of practice and the working relationships the physician assistant has with the supervising physician/s when furnishing professional services.

* ***Services and supplies furnished incident to a physician assistant's services*** Medicare Part B covers services and supplies incident to the services of a physician assistant if the requirements of § 410.26 are met.

Federal Regulations

* NP Performs them while working in collaboration with a physician.
  * **Collaboration** is a process in which a nurse practitioner works with one or more physicians to deliver health care services within the scope of the practitioner's expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by the law of the State in which the services are performed.
* In the absence of **State law** governing collaboration, **collaboration** is a process in which a nurse practitioner has a relationship with one or more physicians to deliver health care services.
  * Such collaboration is to be evidenced by nurse practitioners documenting the nurse practitioners' scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. Nurse practitioners must document this collaborative process with physicians.
* The collaborating physician does not need to be present with the nurse practitioner when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner.
* ***Services and supplies incident to a nurse practitioners' services.*** Medicare Part B covers services and supplies incident to the services of a nurse practitioner if the requirements of § 410.26 are met.

Federal Regulations

* Both PA and NP:
  * ***Services and supplies incident to a nurse practitioners' services.*** Medicare Part B covers services and supplies incident to the services of a nurse practitioner if the requirements of § 410.26 are met.

  * ***Services and supplies furnished incident to a physician assistant's services.*** Medicare Part B covers services and supplies incident to the services of a physician assistant if the requirements of § 410.26 are met.

* More Information and Reference for Federal Regulations:
  * Code of Federal Regulations (CFR), Title 42
    * PA – Section 410.74
    * NP – Section 410.75

PA & NP
State Scope of Practice

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State Scope of Practice

* Who Governs PAs and NPs in New Jersey?
  * PA – New Jersey State Board of Medical Examiners
  * NP – New Jersey State Board of Nursing
    * Part of the Division of Consumer Affairs
    * The scope of practice outlines the duties, responsibilities, and limitations of registered nurses (RNs), licensed practical nurses (LPNs), and advanced practice nurses (APNs) in the state.

* Rx Authority
  * BOTH = Schedule II – V
    * NPs must complete a one-time, six hour course in controlled substance prescribing

State Scope of Practice - PA

* Physician Assistants
  * Physician assistants (PAs) in New Jersey must work under the supervision of a licensed physician, following regulations established by the New Jersey Board of Medical Examiners.
    * Key aspects of their scope of practice include:
      1. **Supervision:** PAs work under physician supervision but are not required to have direct physical supervision at all times. Supervision includes being available for immediate consultation via communication technologies like phone or telecommunication systems.
         1. Supervisory ratio is 4 to 1 MD/DO at any one time – no limit on delegation agreements
      2. **Practice Limitations**: PAs can perform medical services and procedures within their training and delegated by the supervising physician, including telemedicine and telehealth services.
      3. **Prescription Authority**: They are allowed to prescribe medications, including controlled substances from Schedules II-V, as long as they comply with supervisory guidelines.
      4. **Delegation Agreement**: PAs must file their supervising physician's details with the state and update any changes to the supervising physician within 30 days.

https://casetext.com/regulation/new-jersey-administrative-code/title-13-law-and-public-safety/chapter-35-board-of-medical-examiners/subchapter-2b-limited-licenses-physician-assistants

State Scope of Practice - PA

* Documentation – Signature Requirements
  * Question: Under the state regulation is the supervising physician required to countersign all medical services performed including prescribing and administering medications?
    * The paragraph below (NJ Admin Code 13:35-2B.10) is generally interpreted as **YES…. Or No???**
      * *"A determination of whether the supervising physician requires personal review of all charts and records of patients and countersignature by the supervising physician of all medical services performed under the delegation agreement, including prescribing and administering medication as authorized under N.J.A.C. 13:35-2B.12. This provision shall state the specified time period in which a review and countersignature shall be completed by the supervising physician. If no review and countersignature is necessary, the agreement must specifically state such provision"*

Show me…

N.J. Admin. Code § 13:35-2B.12

Download PDF

Current through Register Vol. 56, No. 19, October 7, 2024

Section 13:35-2B.12 - Requirements for issuing prescriptions for medications; special requirements for issuance of CDS

Previous Section
Section 13:35-2B.11 - Recordkeeping

Next Section
Section 13:35-2B.13 - Reserved

(a) A physician assistant may order, prescribe, dispense, and administer medications and medical devices to the extent delegated by a supervising physician only in accordance with the requirements contained in this section.

(b) A physician assistant shall provide the following on all prescription blanks:

1. The physician assistant's full name, professional identification ("PA-C," "PA," or "physician assistant"), license number, address, and telephone number. This information shall be printed on all prescription blanks;

2. The full name, age and address of the patient;

Show me…

(**a**) Licensees shall make contemporaneous, permanent entries into professional treatment records that shall accurately reflect the treatment or services rendered. To the extent applicable, professional treatment records shall reflect:

1. The dates and times of all treatments;

2. The patient complaint;

3. The history;

4. Findings on appropriate examination;

5. Any orders for tests or consultations and the results thereof;

6. Diagnosis or medical impression; and

7. Treatment ordered. If medications are ordered, the patient record shall include:

i. Specific dosages, quantities and strengths of medications;

ii. The physician assistant's full name, printed or stamped, and the license number; and

iii. The supervising physician's full name, printed or stamped.

Show me in writing??? Searching everywhere…

* According to New Jersey regulations, a supervising physician is **not required** to countersign every PA note; however, the supervising physician must review patient records and countersign medical services as outlined in a written delegation agreement, which can include specific requirements for countersignature depending on the situation and the PA's experience level.

* A determination of whether the supervising physician requires personal review of all charts and records of patients and countersignature by the supervising physician of all medical services performed under the delegation agreement, including prescribing and administering medication as authorized under N.J.A.C. 13:35-2B.12. **This provision shall state the specified time period in which a review and countersignature shall be completed by the supervising physician. If no review and countersignature is necessary, the agreement must specifically state such provision.**

But is is a good idea…

State Scope of Practice - NP

* **New Jersey Board of Nursing** website:
  * The Board of Nursing publishes the scope of practice and licensing requirements for RNs, LPNs, and APNs. Visit the New Jersey Board of Nursing website for information on regulations, practice standards, and rules.
    * (look on page 23 for Scope of Practice)
* **New Jersey Administrative Code** (NJAC) Title 13, Chapter 37:
  * This chapter provides the regulatory framework for nursing practice in New Jersey, outlining specific duties and functions allowed for different nursing roles.
    * The NJAC can be accessed through the state's legal database or consumer affairs website.
* **New Jersey Nurse Practice Act**:
  * The Nurse Practice Act (NJSA 45:11-23) governs nursing practice and provides the legal scope for nurses. It includes regulations for education, licensure, disciplinary actions, and practice boundaries.

State Scope of Practice - NP

* **Independent Practice:**
  * NPs can independently assess, diagnose, and manage patients within their area of certification.
  * They are responsible for advanced patient care, including physical examinations, diagnosis, and treatment.

* **Prescriptive Authority:**
  * NPs can prescribe medications, including **controlled substances (Schedule II-V)**, as long as they maintain a **collaborative agreement** with a licensed physician.
  * They can order diagnostic tests (e.g., lab work, imaging) and prescribe medical devices.

* **Collaborative Agreement with Physicians:**
  * While NPs can practice independently, they are required to have a **collaborative agreement** with a physician specifically for prescribing controlled substances. The agreement must outline the types of medications and circumstances under which the NP can prescribe.

State Scope of Practice - NP

- **Treatment & Management:**
  - NPs provide both primary and specialty care, manage chronic diseases, and offer preventative care services.
  - They can create and manage treatment plans, monitor patient progress, and make necessary adjustments to treatments.

- **Referrals and Consultations:**
  - NPs can refer patients to other healthcare professionals (specialists, therapists, etc.) and consult with physicians when complex or beyond their scope cases arise.

- **Patient Education & Advocacy:**
  - NPs provide patient education on managing health conditions, wellness, and prevention. They also advocate for patient needs within the healthcare system.

- **Advanced Procedures:**
  - Depending on certification and training, NPs may perform advanced clinical procedures such as suturing, wound care, and other specialized tasks within their clinical practice area.

- **Certification and Specialty Areas:**
  - NPs must be certified in a specific population focus (e.g., Family NP, Adult-Gerontology NP, Pediatric NP) and practice within that specialty.

- **Continuing Education:**
  - NPs are required to engage in ongoing education to maintain their certification and stay updated on medical advancements and regulatory changes.

Medicare Coverage and Reimbursement for NPPs

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CMS Coverage for NPPs

* Health care providers who practice either in collaboration with or under the supervision of a physician

* Allowed in all geographic areas and health care settings permitted under State licensing laws

* NPP services are reimbursed at 85% of the Physician Fee Schedule

* NPPs report their professional services to third-party payers using the same medical codes as physicians, such as CPT®, HCPCS Level II, and ICD-10-CM codes
  * scope of practice rules from a state, payer, or other source governing the NPP's work may affect which services the NPP may provide and how they report for payment

Direct Billing by NPPs

* Direct billing allows the NPP to bill a service using their national provider identifier (NPI) for Medicare
  * They can bill directly or have an employer or contractor bill services using the NPPs NPI for reassigned payment
* Because of some overlap in the plan of care, direct billing is a good substitute for incident-to services
  * which we discuss next
* NPP has own schedule of patients
* Medicare Reimbursement is 85% of the physician fee schedule

Collaborative Practice Models
changes reimbursement & how claim is billed

* Inpatient
  * NPP rounds (history exam and MDM) then updates physician before rounds
  * NPP rounds and then NPP and physician round together
  * NPP rounds and updates physician who then instructs the direction of care

* Outpatient
  * NPP obtains history then physician and NPP perform exam and MDM together
  * NPP performs history and exam and discusses with physician to determine plan
  * Physician has an established plan of care and the NPP provides follow up care within that plan

Billing for Evaluation and Management Services

* Office Setting – New guidelines 2021
  * Code based on Time or Medical Decision Making (MDM)
  * Split/Shared services not allowed in office setting
    * When requirements are met - bill “incident to”

* Hospital (facility) Setting – New Guidelines 2023
  * Code based on Time or MDM
  * Split/Shared Billing is Allowed
    * No “incident to”

Incident-To

Found in Medicare Benefit Policy Manual, Chapter 15, sections 60.1 and 60.2

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Incident-To

* Applies **only** in a noninstitutional setting setting
  * (CMS) defines as “all settings other than a hospital or skilled nursing facility
* NPP must be an employee of the physician/group
* Supervising physician must be “within the suite and readily available”
  * Supervising physician does not need to be the ordering physician
  * NPPs can be supervision providers of ancillary staff as long as they are working within their scope of practice

Incident-To

* The physician must provide a direct, personal, professional service to initiate the course of treatment the NPPs service
    * No new patient visits
    * Addressing any new problems or worsening condition disqualifies "incident to" and must be billed by the NPP directly
        * Expected problems w/standing order's – ok (Document!)
* There must be subsequent services by the physician frequent enough to show the physician continues to actively participate in the management of the course of treatment
* Bill claim under **supervising provider NPI**
    * NPPs NPI does not need to be on the claim for Medicare
* Paid at 100% of the physician fee schedule
* **Documentation – Needs to be CLEAR!**
    * **SIGNATURES OF NPP PERFORMING SERVICES AND SUPERVISING PHYSICIAN**
* Use SA Modifier for some Commercial Payers

Virtual Direct Supervision

* Allowed during COVID and extended through 2024
  * the physician providing virtual direct supervision **does not need to be continuously utilizing real-time communication technology for the entire duration** that the patient is receiving services, such as chemotherapy or other prolonged infusion services.
    * However, the physician or non-physician practitioner must be **immediately available to intervene** via the technology, should their assistance or direction be needed.

Virtual Direct Supervision CMS Clarifications

* **"Immediately Available" Requirement**: The key requirement for direct supervision, whether provided physically or virtually, is that the supervising physician must be "immediately available." This does **not** mean they must be continuously observing the patient or be in direct communication the entire time. Instead, they must be able to intervene quickly if necessary.

  1. **Real-Time Technology**: For virtual supervision, the supervising physician must be available through **real-time audio and video** technology, so they can respond to issues or provide direction as needed during the course of care.
  2. **Prolonged Services (e.g., Chemotherapy)**: In the case of chemotherapy or other infusion services that occur over a period of time, as long as the physician or NPP is immediately available via audio-video communication (i.e., not attending to other duties that would make them unavailable), the supervision requirement is considered met. They do **not** need to be actively monitoring the patient for the entire duration of the infusion.

* **Example:**
  - A patient is receiving chemotherapy that lasts for several hours.
    - The supervising physician, who is providing virtual direct supervision, is working remotely but is connected via real-time audio-video technology.
    - The physician does **not** need to stay on the video call continuously but must be available to respond immediately if an issue arises during the treatment.
    * Thus, for services like chemotherapy, Medicare allows virtual direct supervision as long as the supervising physician or NPP is immediately accessible, even if they are not actively engaged in continuous communication with the patient or clinical staff throughout the entire session.

Split/Shared Visits– Since 2022

2024 Medicare in Physician Fee Schedule Final Rule

Rules were projected to change Significantly in 2024

Slight Changes Occurred

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Definition of Split/Shared

* Medicare defines split/shared visits in the following way;
  * "A split (or shared) visit is an evaluation and management (E/M) visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner (NPP)
    * who are in the same group,
    * in accordance with applicable law and regulations
      * such that the service could be could be billed by either the physician or NPP if furnished independently by only one of them.
  * Payment is made to the practitioner who performs the **substantive** portion of the visit."

Breaking Down Split/Shared Visits

* Allowed in the facility setting only
  * Includes;
    * 19 - off campus outpatient hospital
    * 21 - inpatient hospital
    * 22 - on campus outpatient hospital
    * 23 – emergency department of hospital
    * And some others, Skilled nursing, rehab, etc
      * So 19 & 22 – outpatient visit can be billed as split shared!
* E/M visits which are jointly performed by MD/DO & NPP **employed by the same group**
  * CMS does not define group
    * Usually same tax ID but not required
* Either could perform and submit the service on their own
* Beginning in 2021 – allowed for **new** and established patients, initial and subsequent, some critical care patients and certain E/M services in a skilled nursing facility (SNF)
* Beginning in 2022 prolonged services can be billed split shared
  * Bill under provider which provides the most **time**
* Submit claim under the professional performing the substantive portion of the service

Substantive Portion

* Substantive portion is either
  * Medical Decision Making

OR *(your have the choice!)*

  * Time (follow CPT Guidelines) – provider who spends more than ½ of total time
    * Qualifying Time – List of activities that count towards time to determine substantive portion
      * Preparing to see the patient (reviewing tests)
      * Obtaining or reviewing separately obtained history
      * Performing a medically appropriate exam and/or evaluation
      * Ordering tests, medications, procedures
      * Referring and communicating with other healthcare professionals (when not separately reported)
      * Documenting the medical record
      * Independently interpreting results (not separately reported),
      * Communicating results to the patient/family/caregiver
      * Care Coordination

OF NOTE: when NPP and Physician meet jointly to discuss the patient – time can only be counted once!

OF NOTE: This year's proposed rule made no mention of any change to the Split (or Shared) Visit billing policies implemented in last year's rule, suggesting the finalized policy from the 2024 fee schedule will remain in place.

Substantive MDM

* In order to document substantive portion of MDM, the physician or QHP must do both of the following, according to CPT:
  * Make or approve 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.

Substantive MDM Example

* NPP – performs a complete history, exam and also documents medical decision making
* MD/DO – INDEPENDENTLY performs and documents medical decision making in its entirety

* This visit can be billed under EITHER the NPP or the MD/DO
  * If billed under the MD/DO, then the level of service chosen must be based on what the billing provider personally performed, documented, signed, and dated within the medical record

AMA CPT vs CMS

* The good news for 2024 is that CPT and CMS are now aligned in their definitions for split/shared services.
  * However, there are two key differences in utilization between CMS's and CPT's interpretations.
    * CMS allows split/shared billing **only in the facility setting** (outpatient hospital, inpatient hospital, or emergency department), and CMS also requires modifier FS to be appended to identify the practitioner who provided the substantiative portion of the split/shared service.
    * CPT does not define the sites of service or service types that may use this methodology, and it does not specify a modifier for use when billing for split/shared services.

Face-to-Face Requirement

* Effective in 2022 – Per Physician Fee Schedule Final Rule
  * ONE practitioner must have a face to face with the patient
    * CMS STATES – it does NOT have to be the practitioner who performs the substantive portion and bills for the visit! (“Game Changer!”)

Face to Face Requirement Example

* The NPP could see the new/established patient in the hospital, perform and document the history, exam and MDM.
* From home the MD/DO could discuss the patient with the NPP, review the documentation, test results, etc., perform medical decision making and document the medical record, and bill for the service receiving 100% of the physician fee schedule.
  * **Number and complexity of problems**: The number of diagnoses or management options that need to be considered
  * **Amount and complexity of data**: The amount and complexity of medical records, diagnostic tests, and other information that needs to be reviewed and analyzed
  * **Risk of complications**: The risk of complications, morbidity, or mortality associated with the patient's problem(s)

Below is an excerpt from the Medicare online manual;

"For all split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit."

Claims and Payment

- Use FS modifier indicating split/shared E & M visit

Modifier FS

Split (or shared) evaluation and management visit

Instructions

This modifier is used to indicate the service was a split or shared evaluation and management (E/M) visit.

Correct Use

- For E/M services split or shared between a physician and a non-physician practitioner (NPP) in a facility setting
- Physician and NPP in same group

Incorrect Use

- May not be used in an office or other setting outside of a facility setting defined as hospital or skilled nursing facility

- NPP Services - Claims paid at 100% of the physician fee schedule
- Now that the claims are clearly recognizable – be prepared to see audits!!

Documentation

* **Identify** the MD/DO & NPP and what THEY individually performed
  * Both must document to support medical necessity of the visit and level of service
  * When billing on time, time spent by the physician and NPP must be documented and summed to define total visit time or
  * Documentation must reflect that the billing practitioner individually performed MDM

* REMINDER - Individual who performed substantive portion must **sign** an date the medical record

Of Note: Hospitals have their own rules and may have additional or more restrictive requirements!

Documentation

- ***Directly from the Code of Federal Regulations***
- 42CFR410.20(e)
  - **"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."
- The best practice is for the practitioner to document his/her services. This leaves little doubt as to who performed what portion of the service.

Scribe services

Scribed services are those in which the physician utilizes the services of ancillary personnel to document/record the work performed by that physician, in either an office and other outpatient or a facility setting. The scribe does not act independently, but simply documents the physician's dictation and/or activities during the visit in the patients chart or Electronic Health Record (EHR).

Scribes are not providers of items or services. When a scribe is used by a provider in documenting medical record entries (e.g. progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician's/non-physician practitioner's (NPP's) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided. Reviewers are only required to look for the signature (and date) of the treating physician/non-physician practitioner on the note. Reviewers shall not deny claims for items or services because a scribe has not signed/dated a note.

Documentation of a scribed service must clearly indicate:

- Who performed the service
- Signed and dated by the treating physician or non-physician practitioner (NPP) affirming the note adequately documents the care provided
    - I agree with the above documentation' or 'I agree the documentation is accurate and complete' *

If an NPP is utilized and acting as a scribe for the physician, the medical record should clearly indicate the NPP is acting as a scribe. This applies to all scribed encounters, whether scribing was performed by licensed clinical staff or other ancillary staff.

Examples*

- Billing provider's note: '________________, acted as scribe for this encounter on __________",
- Billing provider's note: "______________(scribes name) scribing for ____________(physician/non physician provider name)

It is recommended to include the identity of the scribe within the medical record documentation as the recorder of the service performed. It is expected that the use of a scribe to be clinically appropriate for each situation and in accordance with applicable state and federal laws governing the relevant professional practice, hospital bylaws and any other relevant regulations.

Some Frequent Questions

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Question…

* Do you need to use the FS modifier every time you bill for an NPP?

  - No. Use Modifier FS anytime the physician and NPP share a split/shared visit.

Question…

* The billing practitioner must perform the E/M MDM component in its entirety. Does performing a MDM component "in its entirety" mean that a physician cannot use the NPP notes?
  * The billing provider MUST meet the guidelines for the component used to decide the substantive portion. The billing provider would not simply state "reviewed" but would instead provide and document the component.

Question…

* NPP provides 20 minutes of time, MD, separately provides 30 minutes. Then, they meet and discuss patient for 10 minutes. Should total time be 60 min or 70 for overlapping NPP and MD?

  * Overlapping is not allowed. Count joint practitioner time only once. Total time would be 60 min.
  * Substantive portion would be MD
  * NOTE: Clearly Document!

Question…

- The NPP and physician provide an initial inpatient service. The NPP documents a comprehensive history and exam and high-complexity medical decision making. The physician documents a moderate complexity MDM. How should we submit this?

  * This is a split/shared visit. You would have a choice. You can choose the level based on the NPP or the physician. Medicare would accept either

Question…

- If the NPP sees a new patient at the hospital, documents history, exam and medical decision making. Then, the physician (from home) reviews the notes of the NPP and performs and documents medical decision making, can we bill under the physician?
  - Yes. Only one provider is required to have a face-to-face visit with the patient and it does not have to be the billing provider.

Question…

* The NPP provides an incident to service in the office. The physician also sees the patient. How would we submit this to Medicare?

  * You cannot have a split shared visit in the office. Use the medical record of one of the providers. You cannot combine the notes. Submit under the provider most advantageous to you.

References

- 2022 Physician Fee Schedule Final Rule
- 2023 Physician Fee Schedule Final Rule
- 2024 Physician Fee Schedule Final Rule

- Medicare Claims Processing Manual
  - Chapter 12 – Physicians/Nonphysician Practitioners
    - *Section 30.6.18 – Split (or Shared) Visits*

- CMS Transmittal #R11288CP and MM12543

- Three helpful sources for understanding Medicare's NPP rules are the MLN Booklet *Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants*; Medicare Benefit Policy Manual, Chapter 15; and Medicare Claims Processing Manual, Chapter 12.

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev. 11288, 03-04-22)
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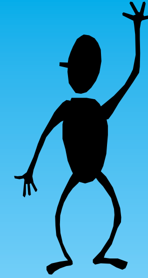
References

- Medicare's NPP rules are the MLN Booklet *Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants*; Medicare Benefit Policy Manual, Chapter 15; and Medicare Claims Processing Manual, Chapter 12.

Questions??



Contact:

Michelle Weiss

Weiss Oncology Consulting

www.weissconsulting.org

Email: michelle@weissconsulting.org