PPAC PRESENTATION ON
"SPLIT" or SHARED EVALUATION AND MANAGEMENT (E/M) SERVICE

Concerns have been raised in recent "open door" meetings about current payment policies for E/M services when they are jointly provided by a physician and a non-physician practitioner. These visits are commonly referred to as "split or shared visits". Currently, the physician and non-physician practitioner must each document and bill for the portion of the E/M service that he/she individually provided. This policy is burdensome to both clinicians and contractors. To address these concerns, we have drafted revised language for the Medicare carrier manual (MCM) as provided below.

CURRENT LANGUAGE AT MCM §15501.B

The physician or any non-physician practitioner with the ability to bill Medicare services must submit his/her bill to reflect the actual service or portion of a service he/she performed. When a service performed is less than the CPT description of the level of the service, the physician and/or the non-physician practitioner must document and bill the service he/she individually provided. A claim for a service must always reflect the service actually provided. A physician and/or non-physician practitioner may submit a claim for CPA code 99499, Unlisted Evaluation and Management Service with a detailed report stating why the covered service was medically necessary and describing what service(s) was provided. The carrier has the discretion to value the service when the service does not meet the full terms of the CPT description (e.g., only a history is performed). The carrier will also determine the payment based on the applicable percentage of the physician fee schedule depending on whether the claim is paid at the physician rate or the limited licensed practitioner rate. CPT modifier -52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier -52 for this purpose.

DRAFT LANGUAGE AT MCM §15501.B FOR CLEARANCE

The physician or any non-physician practitioner (NPP) with the ability to bill Medicare services should submit his/her bill for the service he/she performed. The service will be paid by the carrier at the appropriate physician fee schedule amount based on the rendering UPIN/PIN.

"Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met (see §§ 2050.1, 2050.2 and 15501.G).

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

Hospital Inpatient Setting.--When a hospital inpatient E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the

physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (even if the physician participated in the service) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

Examples of Shared Visits:

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

2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met the service may be billed using either the physician's UPIN/PIN or the NPP's UPIN/PIN. If the "incident to" requirements are not met then the service should be reported using the NPP's UPIN/PIN.

In the rare circumstances when a physician (or NPP) provides a service that does not reflect a CPT code description then the service should be reported as an unlisted service with CPT code 99499. A description of the service provided should accompany the claim. The carrier has the discretion to value the service when the service does not meet the full terms of a CPT code description (e.g., only a history is performed). The carrier will also determine the payment based on the applicable percentage of the physician fee schedule depending on whether the claim is paid at the physician rate or the non-physician practitioner rate. CPT modifier -52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier -52 for this purpose.