

ASTRO Guidance on Shared and Incident To Billing of Evaluation and Management Services in Radiation Oncology

The Centers for Medicare and Medicaid Services (CMS) establishes Medicare policy for the payment of professional fees to physicians and qualified non-physician practitioners who furnish evaluation and management (E/M) services to Medicare beneficiaries. Non-physicians practitioners who are eligible to bill for services under their own National Provider Identifier (NPI) number include physician assistants and advanced practice nurses (e.g., nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and certified nurse-midwives).¹ For an E/M service furnished by a credentialed non-physician practitioner independently of a physician's participation, the non-physician practitioner may then bill under his or her NPI and CMS will reimburse at 85% of the physician fee schedule amount for that service.² For both physicians and non-physician practitioners, billing for these services is also subject to state licensure, scope of practice regulations and medical staff credentialing.

For E/M services where the work is shared between physician and non-physician practitioner and billed under the physician's NPI, Medicare has established billing requirements specific to the type of service and the clinical setting where the service is provided. Instructions regarding the reporting of shared E/M services are published in the Code of Federal Regulations, the Medicare Benefit Policy Manual and the Medicare Claims Processing Manual. These requirements and their application to common clinical settings are detailed in the following sections:

- 1. Shared E/M Services in a Hospital or Facility Setting**
- 2. "Incident To" E/M Services in a Physician Office Setting**
- 3. Additional Considerations for E/M Services Involving Teaching Physicians, Residents and Medical Students**

In the following sections, billing and documentation requirements for these E/M service categories are summarized. Citations and pertinent summaries of applicable Federal regulations are also provided.

Shared E/M Services in a Hospital or Facility Setting

Shared E/M services provided by physicians and non-physician practitioners to hospital patients are a covered Medicare benefit under Section 1861(s)(2)(B) of the Social Security Act. CMS guidance pertinent to billing and documentation for these services is provided in Chapter 12, Section 30.6 of the Medicare Claims Processing Manual. This

¹ 42 CFR §414.56 – 58

² 42 CFR §414.52(d) and 42 CFR §414.56(c)

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guidance applies to facility-based settings, which include on-campus and off-campus hospital outpatient departments, inpatient hospital units and emergency departments.

Medicare payment policy defines a shared E/M patient visit as a medically necessary encounter where the physician and qualified non-physician practitioner each personally perform a substantive portion of the visit face-to-face with the same patient on the same date of service. A substantive portion consists of all or some of the key history, physical examination or medical decision-making components of an E/M service. Medicare does not elaborate further on this definition of substantive. Medicare also requires that the physician and non-physician practitioner be in the same group practice or be employed by the same employer.³ If all the preceding conditions are met, then physician may bill for a shared E/M service under his or her NPI number.

Shared service billing is allowed for select facility settings and E/M services as specified by Medicare:

Shared E/M Services: Allowed and Non-Allowed Facility Settings and Professional Services

Facility Settings	Allowed	Place of Service Code
	hospital outpatient department, on campus	22
	hospital outpatient department, off campus	19
	hospital inpatient unit	21
	emergency department	23
	Non-Allowed	Place of Service Code
	skilled nursing facility	31
	nursing facility	32

Professional Services	Allowed	CPT Codes
	new patient visit, outpatient	99201 - 99205
	established patient visit, outpatient	99211 - 99215
	established patient visit with a new problem, outpatient	99211 - 99215
	initial hospital inpatient care, new or established patient	99221 - 99223
	subsequent hospital inpatient care, per day	99231 - 99233
	hospital discharge day management	99238 - 99239
	emergency department service, new or established patient	99281 - 99285
	Non-Allowed	CPT Codes
	consultation, outpatient*	99241 - 99245
	consultation, initial inpatient*	99251 - 99255
	critical care services	99291 - 99292

* consultations service CPTs have been retired from Medicare Physician Fee Schedule since 2010 but may be recognized by selected commercial payers

Shared E/M Services Involving Multiple Physicians

³ Medicare Claims Processing Manual, Chapter 12, Section 30.6.13.H

In a different shared service scenario, multiple physicians in a group practice may each provide E/M services to a patient on the same day. If more than one physician in the same specialty within a group practice furnishes E/M services on the same day to the same patient, then Medicare restricts reporting to a single E/M service as though performed by a single physician. However, if multiple same-day E/M services are furnished for unrelated problems that could not be managed within a single encounter, then each service may be reported separately. Likewise, physicians in the same group practice but in different specialties may bill for same-day E/M services separately with separate documentation.⁴

Determination of Appropriate CPT Code for Shared E/M Services

New Patient and Established Patient E/M Services

This section provides general guidance on the appropriate CPT code selection for common E/M services in radiation oncology.

Medicare retired outpatient (CPT 99241 – 99245) and inpatient (CPT 99251 – 99255) consultation codes from the Physician Fee Schedule in 2010, although some commercial payers continue to recognize these codes. For outpatient consultations of Medicare patients, physicians should now report from CPT 99201 – 99205 for new patients and CPT 99211 – 99215 for established patients. Medicare distinguishes a “new” from an “established” patient as a patient who has not received any professional services (e.g., an E/M service or other face-to-face service such as a surgical procedure) from the physician or physician’s group practice (limited to the same specialty) within the previous three years.⁵ For inpatient consultations of Medicare patients, providers should now report from CPT 99221 – 99223 for either new or established patients.

Shared E/M Service Level Determination

This section does not intend to provide comprehensive guidance on E/M service level determination but instead is limited to the appropriate selection of service level when a service is shared between a physician and a non-physician practitioner.

Briefly, the various code sets for reporting E/M services are organized into levels according to the complexity of the patient visit.⁶ The three key components considered when selecting the appropriate complexity level are history, examination and medical decision-making. However, visits that predominately consist of counseling and/or coordination of care (e.g., new outpatient visits and established outpatient visits with a

⁴ Medicare Claims Processing Manual, Chapter 12, Section 30.6.5

⁵ Medicare Claims Processing Manual, Chapter 12, Section 30.6.7.A

⁶ Medicare Learning Network (ICN 006764): Evaluation and Management Services. August 2016

new problem) are an exception to this rule. For these visits, time is the key factor to qualify for a particular level of E/M service, and the provider may attest that more than 50 percent of the face-to-face time (for outpatient services) or more than 50 percent of the floor time (for inpatient services) was spent providing counseling or coordination of care. The total face-to-face time or floor time may also be documented as well as a description of the coordination of care or counseling provided. For E/M services shared between physician and non-physician practitioner, face-to-face time refers only to the time spent by the physician interacting with the patient. Counseling by other staff is not considered to be part of the face-to-face physician-patient encounter time and is not considered in selecting the appropriate level of service.⁷

For multiple E/M services furnished to the same patient by the same physician or by multiple physicians in the same group practice (and of the same specialty) on the same day, the physician(s) should select a level of service representative of the combined visits and submit the appropriate code for that level. However and as described earlier, multiple same-day E/M services furnished by different physicians for unrelated problems may be reported separately by each physician.

“Incident To” E/M Services in a Physician Office Setting

E/M services provided by a non-physician practitioner to a patient in a physician’s office and incident to the physician’s professional services for that patient are a covered Medicare benefit under Section 1861(s)(2)(A) of the Social Security Act. Regulatory guidance pertinent to billing for E/M services in the office setting is provided under Section 410.26 of the Code of Federal Regulations, Title 42, and in Chapter 15, Section 60 of the Medicare Benefit Policy Manual.

E/M services shared between non-physician practitioners with a NPI number (i.e. physician assistants and advanced practice nurses) and physicians in an office are subject to Medicare’s “Incident To” requirements in order to be billed under a physician’s NPI. If “Incident To” requirements are not met for a shared E/M service, then the service must be billed under the non-physician practitioner’s NPI and payment will be made at 85% of the appropriate physician fee schedule payment.⁸ Briefly, these requirements include that such services must be part of an established patient’s normal course of treatment during which (1) the patient has a plan of care established by a physician following an initial visit, (2) that care plan is currently followed without change and (3) the physician remains actively involved in the course of treatment. Therefore, shared service billing is not allowed in the office setting for either new patient visits or established patient visits where a new problem is addressed. In these latter two scenarios, the non-physician practitioner is limited to functioning as ancillary office staff

⁷ Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.C

⁸ Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.B

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and may obtain and document the Review of Systems, Past Medical History, Family History and Social History.⁶ Alternatively, the non-physician practitioner may serve as a scribe and document additional E/M elements (e.g., Chief Complaint, History of Present Illness, Physical Examination and Medical Decision Making) obtained by the physician. Proper scribe attestations by both the non-physician provider and physician must be then documented.⁹ A sample attestation by the physician would be: “The documentation recorded by the scribe accurately and completely reflects the services I personally performed and the decisions made by me.”

Another requirement for “Incident To” billing is that the non-physician provider participating in the provision of E/M services is an employee, leased employee or independent contractor of the physician or billing legal entity.¹⁰ In all “Incident To” scenarios, services by non-physician personnel must be performed under the direct supervision of a physician – that is, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time other staff are providing services.¹¹ Please note that “Incident To” is a Medicare-only concept, although commercial payers may have similar billing requirements when midlevel providers render services.

In summary, Medicare billing for shared E/M services between a physician and non-physician practitioner in an office setting is subject to “Incident To” requirements and therefore allowed or not allowed for the following clinical scenarios:

"Incident To" E/M Services: Allowed and Non-Allowed Professional Services in the Office Setting (POS = 11)

Professional Services	<u>Allowed</u>	<u>CPT Codes</u>
	established patient visit, office	99211 - 99215
	<u>Non-Allowed</u>	<u>CPT Codes</u>
	consultation, office*	99241 - 99245
	new patient visit, office	99201 - 99205
	established patient visit with a new problem, office**	99211 - 99215

* consultations service CPTs have been retired from Medicare Physician Fee Schedule since 2010 but may be recognized by selected commercial payers

** note that CPT codes 99211 - 99215 may not be reported for "Incident To" E/M services for established patients with a new problem

⁹ Each Medicare Administrative Contractor (MAC) has the authority to issue its own documentation guidelines for all claims submitted within its jurisdiction, including guidelines on scribe use. In general, MAC guidelines follow the Joint Commission’s guidance on the use of scribes and allow scribes to document words and activities as the practitioner performs them during a patient encounter. (https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=1206)

¹⁰ 42 CFR §410.26(a)(1)

¹¹ Medicare Benefit Policy Manual, Chapter 15, Section 60.1.B

Additional Considerations for E/M Services Involving Teaching Physicians, Residents and Medical Students

Medicare has established specific billing requirements related to the responsibilities of a teaching physician when E/M services involve a resident in an approved Graduate Medical Education (GME) program. Further requirements apply when medical students are also involved. CMS guidance pertinent to the billing and documentation of E/M services furnished by teaching physicians is provided in Chapter 15, Section 30 of the Medicare Benefit Policy Manual and Chapter 12, Section 100 of the Medicare Claims Processing Manual. CMS regulatory guidance is provided under Section 415 of the Code of Federal Regulations, Title 42.

Medicare defines the following key terms related to this section¹²:

- Teaching Physician: A physician (other than another resident) who involves residents in the care of his or her patients.
- Resident: An individual who participates in an approved GME program (e.g., approved by the Accreditation Council for Graduate Medical Education or other accrediting bodies) or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting (e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools). This term also includes interns and fellows in approved programs.
- Student: An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program.
- Teaching Hospital: A hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.
- Teaching Setting: Any provider, hospital-based provider, or non-provider setting in which Medicare payment for the services of residents is made by the fiscal intermediary under the direct GME payment methodology.

In general for physician services furnished in teaching settings, payment is made under the Medicare Physician Fee Schedule to the teaching physician only if the teaching physician is physically present during the key portion of any service or procedure performed by the resident. Medicare considers the teaching physician as “physically present” if located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service. Also per Medicare, it is the teaching physician who determines that part of the service as the critical or key portion. When a resident provides an E/M service without teaching physician presence, the teaching physician must repeat the key portions of the visit and have his or her own documentation in order to get reimbursed.

¹² 42 CFR §415.152

For E/M services specifically, the teaching physician must be present during the portion of the service that determines the level of service billed. However, Medicare allows for an exception to this requirement for E/M services of lower and mid-level complexity furnished in certain primary care centers, and carriers may make physician fee schedule payment for a service furnished by a resident without the presence of a teaching physician.¹³ This exception does not apply to a radiation oncology teaching setting or any other specialty teaching setting where patient care is limited by organ system or diagnosis.

Documentation and Billing Requirements

Billing for an E/M service shared by teaching physician and resident must be supported with documentation attesting to the presence of the teaching physician at the time the service is furnished. Medicare requires that the teaching physician personally document his or her participation in the service in the medical record.¹⁴ Documentation by the resident of the presence and participation of the teaching physician is not sufficient for supporting teaching physician billing. When determining the appropriate level of E/M service for billing under a teaching physician's NPI, the combined documentation by both the resident and the teaching physician are considered and must together support the medical necessity of the service. For the purposes of payment, E/M services billed by a teaching physician require that he or she personally document, at a minimum, the following:

- his or her participation in the management of the patient; and
- that he or she personally performed the services or were physically present during the key or critical portion(s) of the service when performed by a resident.¹⁵

The Medicare Claims Processing Manual provides examples of appropriate supporting documentation using common scenarios where teaching physicians work with residents to furnish E/M services.¹⁵ In one such scenario, the resident performs the elements required for an E/M service in the presence of the teaching physician and documents the service. In this case, the teaching physician must document that he or she was present during the performance of the critical or key portion of the service and that he or she was directly involved in the management of the patient. The teaching physician's note should reference the resident's note, with the following sample statement considered acceptable per Medicare: "I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note." Medicare provides other acceptable sample statements as well for this and other scenarios presented in the Manual.

¹³ 42 CFR §415.174

¹⁴ 42 CFR §415.172

¹⁵ Medicare Claims Processing Manual, Chapter 12, Section 100.1.1.A

Per Medicare, examples of unacceptable documentation to support billing for teaching physician E/M services performed jointly with a resident include the following: “Agree with above”; “Rounded, Reviewed, Agree”; “Discussed with resident – agree”; “Seen and agree”; “Patient seen and evaluated”; or a legible countersignature or identity alone. Such documentation is not acceptable as it cannot be determined whether the teaching physician was present, evaluated the patient or had any involvement with the plan of care.

Claims for teaching physician services that meet the requirement for physical presence during the key portion of the service must include a GC modifier (“This service has been performed in part by a resident under the direction of a teaching physician.”¹⁶) for each service.¹⁷

Participation of Medical Students in E/M Services

Medicare does not pay for any service furnished by a student, but students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the Review of Systems, Past Medical History, Family History and Social History. The teaching physician may not refer to a student’s documentation of the History of Present Illness, Physical Exam or Medical Decision Making in his or her personal note but rather must verify and re-document the History of Present Illness and re-perform and re-document the Physical Exam and Medical Decision Making.¹⁸

If you have questions regarding this summary please contact the ASTRO Health Policy Department at 1-800-962-7876 or at healthpolicy@astro.org.

¹⁶ Medicare Learning Network (ICN 006347): Guidelines for Teaching Physicians, Interns and Residents. March 2017

¹⁷ Medicare Claims Processing Manual, Chapter 12, Section 100.1.8.B.1

¹⁸ Medicare Claims Processing Manual, Chapter 12, Section 100.1.1.B