Split/Shared Services Documentation & Billing

Jointly Presented by the Clinical Enterprise Compliance Department and the Department of Revenue Management

June 6, 2012
Disclaimer

This module is intended to provide educational information about CPT and Medicare documentation, coding, and billing standards, and corresponding UCSF policies. Links and source documentation have been provided within the document for reference.

These topics regularly evolve and change over time. Accurate documentation and the submission of correct claims is, ultimately, the responsibility of each provider of services.

Please contact the Clinical Enterprise Compliance Department or the Department of Revenue Management for information updates.
Reminder: Medical Necessity

Federal law requires that all expenses paid by Medicare, including expenses for Evaluation and Management (E&M) services, are “medically reasonable and necessary.”

- Medical necessity of E&M services is generally expressed in two ways: frequency of services and intensity of service (CPT level).
- Medicare’s determination of medical necessity is separate from its determination that the E&M service was rendered as billed.
- Medicare determines medical necessity largely through the experience and judgment of clinician coders along with the limited tools provided in CPT and by CMS.
- In the event of audit, Medicare will deny or downcode E&M services that, in their judgment, exceed the patient’s documented clinical needs.
Split/Shared Services Defined

- A “split/shared” service is a medically necessary patient encounter where both a physician **AND** a qualified NPP (non-physician practitioner) each perform a substantive portion of the E&M visit, face-to-face, with the same patient on the same date of service.

- The NPP, as defined by CMS regulations, for these visit types must be one of the following:
  - Physician assistant (PA)
  - Nurse practitioner (NP)
  - Clinical nurse specialist (CNS)
  - Certified nurse midwife (CNMW)

- The physician and NPP must be **from the same group practice** or be employed by the same employer where the physician in some way bears the cost of the NPP’s employment.
Split/Shared Services Defined

• The encounter can be performed (and billed) in the following settings:
  – Hospital inpatient
  – Hospital outpatient
  – Emergency department

* Note: Consultations, critical care services and procedures cannot be billed as split/shared services.
Split/Shared Services Criteria

- The NPP’s patient care service must be within their scope of practice, as defined by the applicable local, state or other governing body or licensure rules.

- The service must be provided by the physician and NPP on the same date of service. (The patient can be seen by both providers together or separately at different times of the day.)

- BOTH the physician and NPP must personally perform a portion of the visit.

- EACH provider must provide a face-to-face encounter with the patient.

- Each MUST personally document at least all or some portion of the history, exam or medical decision-making key components.

- UCSF requires that BOTH providers legibly sign the note.
Documentation & Billing

• Both the physician and NPP must document the part(s) of the visit he or she performed. * Note: Signing off (i.e. “seen and agree”) on the NPP’s note does not meet the criteria for a split/shared encounter.

• If the supporting documentation does not demonstrate both the physician and NPP “performed a substantive portion of the E&M visit face-to-face with the patient on the same date of service,” the visit should be billed under the NPI of the provider who provided a substantive portion of the E&M service, using only the documentation of this provider to support the level of E&M service billed.

Important!

• If there was no face-to-face encounter between the physician and the patient, the service may be submitted under the NPP’s NPI only.
• As a result, only the documentation of the NPP is used to determine the level of service supported.
Examples

Hospital Inpatient Example:

• The NPP sees the patient and writes a progress note in the morning during rounds.
• The physician follows up with the patient in a face-to-face encounter later the same day.
• The documentation is clear that each provider was present with the patient face-to-face and rendered a substantive portion of a medically necessary visit.
• Either the NPP or the physician may report the service with their NPI on the claim.

Hospital Outpatient Example:

• The NPP performs and documents a portion of the visit while the physician is present in the clinic.
• The physician completes the visit (face-to-face) and personally documents their portion.
• Either the NPP or the physician may report the service with their NPI on the claim.
Examples

Emergency Department Example:

- The NPP performs and documents a portion of the visit when the physician is present in the ER and may make the initial determination or start care.
- The physician completes the visit (face-to-face) and documents their portion.
- Either the NPP or the physician may report the service with their NPI on the claim.
When Counseling Dominates the Visit…

Documentation Guidelines

When Counseling and/or Coordination of Care time dominates (more than 50%) of the visit, the documentation guidelines for the NPP and the physician depend on how the services are provided: Separate Visits or Overlapping Visits

**SEPARATE VISITS** by the NPP and Physician where **counseling** dominates both visits - BOTH the NPP AND the physician need to independently document a time statement:

**NPP:** “I spent 20 minutes with the patient, the majority of which was spent counseling the patient regarding _____.”

**Physician:** “I spent 15 minutes with the patient, the majority of which was spent counseling the patient regarding _____.”

- **Coding:** The visit would be based on 35 minutes combined total time, with the majority of time (25 minutes) counseling the patient.
Documentation and Coding when Counseling Time is a Factor

**OVERLAPPING VISITS** by the NPP and Physician where **counseling** dominates both visits:

- **Example:** *The NPP sees the patient for a total time of 20 minutes, 15 minutes of which was spent counseling. The NPP then discusses the patient with the physician and both providers see the patient for a total of 15 minutes, with 10 minutes counseling time by the physician dominating the visit.*

**Important! DO NOT double count the time you work together!** If the physician is going to bill, he/she will count overlapping time in his/her totals (total time and counseling time).
Documentation and Coding when Counseling Time is a Factor

- **Documentation:**
  - **NPP:** Only the NPP’s time alone with the patient can be counted towards the NPP time: 20 minutes total time and 15 minutes counseling time, both of which must be documented as well as the content of discussion.
  
  “I spent 20 minutes with the patient, 15 minutes of which was spent counseling the patient regarding _______.”

  - **Physician:** The entire total time and entire counseling time that the physician documents will be counted.
  
  “I spent 15 minutes with the patient, 10 minutes of which was spent counseling the patient regarding _______.”

- **Coding:**
  - The visit would be based on 35 minutes combined total time with 25 minutes counseling time.
FAQ’s

1) What can be billed if the physician forgets to document her/his time statement, but the NPP does document a time statement?

Answer: Bill the visit based on the history, exam, and decision making (3 key components) documented by the Physician and NPP. Do not use the time statement because the physician did not document his/her time.

Example: If the NPP documented a visit with an appropriate time statement and the physician documented his/her portion of the service but did not include any mention of time, the visit could be billed as a Split/Shared visit under the physician’s name based on the 3 key components found in both the NPP’s and physician’s documentation.
FAQ’s

2) How is a charge abstracted if the NPP forgets to document a time statement (or note the total visit time), but the physician does document an appropriate time statement? 
Answer: The service would usually be billed in the physician’s name, based only on his/her documentation.

Example: For an established patient visit, if the NPP did not document an appropriate time statement and the physician documented that he/she spent “10 minutes with the patient all of which was spent counseling the patient regarding ________,” the visit would be billed as a level 2 established patient visit (99212) under the physician’s name. The NPP’s documentation would not be considered.

However, if it is advantageous to bill based on the 3 key components from the NPP’s documentation, the service could be billed under the NPP’s name using the NPP’s history, exam, and medical decision making documentation (physician did only counseling).
Resources:

- Medicare Claims Processing (PUB. 100-04); Chapter 12 - Physicians/Nonphysician Practitioners; 30 - Correct Coding Policy; Sections 30.61, 30.6.12, 30.6.13
- Palmetto GBA Website; Can an evaluation and management (E/M) service be performed as a split/shared service?; [Website Link Palmetto GBA]; updated 3/30/12
- Palmetto GBA Website; E/M Weekly Tip, Inpatient, Hospital Outpatient and Emergency Department Setting-Split/Shared Visits; [Website Link Palmetto GBA]; updated 5/24/12
- Palmetto GBA Website: Medicare Medical Records: Signature Requirements, Acceptable and Unacceptable Practices; [Website Link Palmetto GBA]; updated 2/27/12
Questions?

For compliance questions:

For revenue, coding or billing support questions:

Compliance Hotline (anonymous reporting)
415-502-8448