

Evaluation & Mgt Scenarios (E/M)	Billing/ Reporting	Medicare Reimb	E & M Documentation Guidelines
Physician Performs (regardless of place of service)	Physician bills	100% of physician fee schedule	ROS and/or PFSH may be recorded by ancillary staff or form completed by patient. MD must document that they reviewed the information.
NP Performs (regardless of place of service)	NP bills	85% of physician fee schedule	ROS and/or PFSH may be recorded by ancillary staff or form completed by patient. NP must document that they reviewed the information.
<p><u>Split/Shared Encounter</u> Encounter between MD & NP Not applicable to medical students, nurses, residents Not applicable to consultations, procedures or critical care services Cannot be reported in SNF/NF setting *specialty/taxonomy must match and/or have crosswalk clarifying same specialty (CPT rules)</p>			<ul style="list-style-type: none"> • Service must be medically necessary. • Service must be within scope of practice/licensure of NP. • NP service & MD service may occur jointly or at independent times on same day calendar day. • Both must complete a face to face encounter in order to bill as a shared/split visit. • Both NP & MD should document what each personally performed. • Total documentation by both NP & MD should support the level of service reported.
<p><u>Hospital In-Patient/Out-patient/Hospital Observation/Hospital Disch/Emerg Dept Setting</u> Encounter is shared between MD and NP from same specialty and MD provides any face-to-face substantive portion of the E/M encounter with patient *specialty/taxonomy must match and/or have crosswalk clarifying same specialty (CPT rules)</p>	Can be billed under either MD or NP	Payment is made at the applicable physician fee schedule based on billing provider on claim (MD 100%, NP 85%)	<p>The ROS and/or PFSH may be recorded by ancillary staff or form completed by patient. To document the MD reviewed the information, there must be a notation supplementing or confirming the information recorded by others.</p> <p><u>Split/Shared Visit</u> If there is no face-to-face encounter between the patient and the MD (even if the MD participated in the service only by reviewing the patient's medical record) then the service may only be billed under the NP</p>
<p><u>Examples of Shared Visits (In-Patient Only)</u> If NP sees a hospital in-patient in the morning and the MD follows with a later face-to-face with the patient on the same day, the MD or NP can report the service.</p>			
<p><u>To bill Incident To in the free standing Office/Clinic Setting and patient is established patient.</u> Medicare Incident To Criteria</p> <ul style="list-style-type: none"> • MD must personally perform the initial service & remain actively involved in the course of treatment • MD must be present in the office suite and perform a face to face encounter. • MD is delegating work to the NP • MD and NP must be in the same specialty. Incident To applies to the office/clinic setting (not applicable in the hospital setting) 	Can be billed using the MD's or NP's NPI/name	100 of physician fee schedule if MD bills; 85% if NP bills	<p>The ROS and/or PFSH may be recorded by ancillary staff or form completed by patient. To document the MD reviewed the information, there must be a notation supplementing or confirming the information recorded by others.</p> <p>Incident to: If there is no face-to-face encounter between the patient and the MD (even if the MD participated in the service only by reviewing the patient's medical record) then the service may only be billed under the NP</p>
<p><u>Office/Clinic Setting – When Incident To is not met</u> NP should bill under their own name/number when:</p> <ul style="list-style-type: none"> • Seeing new patients • Seeing established patients with new problems • Physician not physically present in office suite • Physician not performing face to face encounter 	Must be billed using NP's NPI/name	85% of physician fee schedule	The ROS and/or PFSH may be recorded by ancillary staff or form completed by patient. To document the MD reviewed the information, there must be a notation supplementing or confirming the information recorded by others.