



## Physician Services Version

### KEY CONCEPTS OUTLINE

#### **Module 10: Physicians Aren't the Only Ones that Can Expect Compensation; Non-Physician Practitioner Services**

##### I. Scope of this Module

A. This module addresses Medicare coverage, billing, and payment for the following types of non-physician practitioners:

1. Nurse Practitioners (NPs)
2. Physician Assistants (PAs)

B. For purposes of this module, the term "NPP" is used to refer to NPs and PAs.

##### II. Non-Physician Practitioners (NPPs)

###### A. Coverage of NPP Services

###### 1. How NPP Services are Potentially Covered by Medicare

a. In general, there are three different ways under which Medicare will potentially cover NPP services.

###### (i) Separate Enrollment

(a) NPPs may separately enroll in Medicare and have their services covered independently of any physician service. <Medicare Benefit Policy Manual, Chapter 15 §§ 190, 200, 210>

(b) As discussed below, the manner in which NPP services are billed and paid depends on how the services are performed.

###### (ii) "Incident To"

(a) NPP services may be covered under Medicare's so-called "incident to" coverage provisions. <Medicare Benefit Policy Manual, Chapter 15 § 60.2>

(iii) Split/Shared Services

(a) A split/shared service is a service where both an NPP and a physician see a patient. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1>

2. Coverage of NPP Services for Separately Enrolled NPPs

a. In General

(i) NPPs who are separately enrolled in Medicare and issued a billing number may have his or her professional services compensated if they are legally authorized to provide services in the state where the services are performed. <Medicare Benefit Policy Manual, Chapter 15 §§ 190 and 200>

(a) As discussed below, there are different enrollment requirements applicable to NPs and PAs.

b. Coverage for Separately Enrolled NPs

(i) In order for Medicare to cover the services of a separately enrolled NP, the following requirements must be satisfied:

(a) The "Licensure" Requirement

(1) The NP must be a registered professional nurse authorized to practice as a nurse practitioner under applicable state law. <42 CFR § 410.75(b); Medicare Benefit Policy Manual, Chapter 15 § 200(A)>

(b) The "Certification" Requirement

(1) The NP must be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners. <42 CFR § 410.75(b); Medicare Benefit Policy Manual, Chapter 15 § 200(A)>

(2) Certifying Agencies – the following organizations are recognized national certifying bodies:

- a. American Academy of Nurse Practitioners,
- b. American Nurses Credentialing Center,

- c. Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses),
- d. National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties,
- e. AACN Certification Corporation,
- f. National Board on Certification of Hospice and Palliative Nurses, and
- g. Oncology Nurses Certification Corporation. <Medicare Benefit Policy Manual, Chapter 15 § 200(A)>

### (3) Exception to Certification Requirement

- a. NPs who meet the licensure requirement do not need to meet the certification requirement if the NP was enrolled in Medicare as a nurse practitioner on or before December 31, 2000. <42 CFR § 410.75(b); Medicare Benefit Policy Manual, Chapter 15 § 200(A)>

### (c) The "Master's Degree" Requirement

- (1) After January 1, 2003, NPs enrolling for the first time are also required to have a Master's degree. <42 CFR § 410.75(b)(4); Medicare Benefit Policy Manual, Chapter 15 § 200(A)>

### (d) The "Physician Services" Requirement

- (1) The services furnished by the NP must be of a type that would be covered if furnished by a physician. <42 CFR § 410.75(c); Medicare Benefit Policy Manual, Chapter 15 § 200(B)(1)>

### (e) The "Scope of Practice" Requirement

- (1) The services furnished by the NP must be of a type that a NP is authorized to furnish under applicable state law. <42 CFR § 410.75(c)(1); Medicare Benefit Policy Manual, Chapter 15 § 200(B)(1)>

### (f) The "Physician Collaboration" Requirement

- (1) The NP must practice in “collaboration” with an MD/DO. <42 CFR § 410.75(c)(3); Medicare Benefit Policy Manual, Chapter 15 § 200(D)>
- (2) Collaboration is defined by Medicare as a process in which a NP works with one or more physicians to deliver health care services, with physician medical direction and appropriate supervision as required by state law. <42 CFR § 410.75(c)(3)(i); Medicare Benefit Policy Manual, Chapter 15 § 200(D)>
  - a. In the absence of state law governing collaboration, Medicare requires NPs to document their scope of practice and the relationships that the NP has with physicians to deal with issues outside their scope of practice. <42 CFR § 410.75(c)(3)(ii); Medicare Benefit Policy Manual, Chapter 15 § 200(D)>
- (3) The collaborating physician does not need to be present with the NP when services are furnished or to make an independent evaluation of each patient who is seen by the NP. <42 CFR § 410.75(c)(3)(iii); Medicare Benefit Policy Manual, Chapter 15 § 200(D)>

c. Coverage for Separately Enrolled PA Services

- (i) In order for Medicare to cover the services of a separately enrolled PA, the following requirements must be satisfied:
  - (a) The “Licensure” Requirement
    - (1) The PA must be licensed by the state to practice as a physician assistant. <42 CFR § 410.74(c); Medicare Benefit Policy Manual, Chapter 15 § 190(A)>
  - (b) The “Accreditation/Certification” Requirement
    - (1) The PA must meet one of the following conditions:
      - a. The PA must have graduated from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant, or

- b. The PA must have passed the national certification examination administered by the National Commission on Certification of Physician Assistants. <42 CFR § 410.74(c); Medicare Benefit Policy Manual, Chapter 15 § 190(A)>

(c) The "Physician Services" Requirement

- (1) The services furnished by the PA must be of a type that would be covered if furnished by a physician. <42 CFR § 410.74(a)(1); Medicare Benefit Policy Manual, Chapter 15 § 190(B)(1)>

(d) The "Scope of Practice" Requirement

- (1) The services furnished by the PA must be of a type that a PA is authorized to furnish under applicable state law. <42 CFR § 410.74(a)(2); Medicare Benefit Policy Manual, Chapter 15 § 190(B)(1)>

(e) The "General Physician Supervision" Requirement

- (1) The PA's services must be furnished under the general supervision of a physician.
- (2) General supervision requires that PA services be performed under the overall direction and control of the physician. <Medicare Benefit Policy Manual, Chapter 15 § 190(C)>
  - a. While the supervising physician must be immediately available to the PA for consult, this does not mean the supervising physician must be physically present when the PA is furnishing services. <42 CFR § 410.74(a)(2) ;>
  - b. Telephone consultations are permissible by Medicare unless prohibited by state law or regulation. <Medicare Benefit Policy Manual, Chapter 15 § 190(C)>

(f) Beginning January 1, 2022, Medicare is now authorized through the Consolidated Appropriations Act to make direct payment to PAs for professional services furnished under Medicare Part B.

- (1) Allowing PAs to bill Medicare directly, reassign benefits and incorporate with other PAs.

(2) Replacing the previous "Employer Billing" Requirement

a. The PA's services must be billed by the PA's employer.  
<42 CFR § 410.74(a)(2); Medicare Benefit Policy Manual, Chapter 15 § 190(D)>

b. The employer may not be a group of PAs.

d. Billing for Separately Enrolled NPP Services

(i) NPP services covered as the services of a separately enrolled NPP are billed under the NPP's NPI. <Medicare Benefit Policy Manual, Chapter 15 § 200>

(ii) In essence, the services are billed in the exact same manner as they would have been billed had the NPP been a physician.

e. Payment for Services Billed Under an Enrolled NPP's NPI

(i) The Medicare allowable for services billed under an NPP's NPI is determined based on 85% of the applicable Physician Fee Schedule amount. <42 CFR §§ 414.52(d), 414.56(c); Medicare Claims Processing Manual, Chapter 12, §§ 110.2 and 120.1>

3. "Incident To" Coverage of NPP Services

a. Definition

(a) "Incident to" coverage means that the NPP's services are covered as a component part in the diagnosis or overall course of treatment being furnished by a physician or other practitioner. <Medicare Benefit Policy Manual, Chapter 15 § 60.1>

(b) For the incident to discussion, the term physician includes other practitioners such as nurse practitioners and physician assistants.

b. "Incident To" Coverage Requirements

(i) The "Integral, Although Incidental" Requirement

(a) The "incident to" services must have been an "integral, although incidental" part of a physician's professional services in diagnosing or treating a Medicare beneficiary. <42 CFR § 410.26(b)(2); Medicare Benefit Policy Manual, Chapter 15 § 60.1>

(1) This means that:

- a. There must have been a “direct, personal, professional service” furnished by the physician to initiate the course of treatment, and
- b. There must be subsequent services provided by the physician of a frequency that reflects his or her continuing active participation in and management of the course of treatment. <Medicare Benefit Policy Manual, Chapter 15 § 60.1 (B)>
- c. However, the physician does not need to personally see the patient every time the patient sees the NPP.  
<Medicare Benefit Policy Manual, Chapter 15 § 60.1 (B)>

(ii) The “Direct Supervision” Requirement

- (a) “Incident to” services must be furnished under the “direct supervision” of a physician or NPP.

(1) What Constitutes Direct Supervision?

- a. Direct supervision in the office setting does not mean that a physician or NPP must be present in the same room when auxiliary personnel furnish services. However, a physician/NPP must be present in the office suite and immediately available to provide assistance and direction. <42 CFR §§ 410.26(b)(5), 410.32(b)(3)(ii); Medicare Benefit Policy Manual, Chapter 15 § 60.1 (B)>
- b. The availability of the physician by telephone is not sufficient. <Medicare Benefit Policy Manual, Chapter 15 § 60.1(B)>
- c. CMS has never clearly defined the term “office suite.”

(2) Direct Supervision in a Group Practice Setting

- a. If the physician who initiated the course of treatment is a member of a group practice, another physician in the group may provide the direct supervision for incident to services. <Medicare Benefit Policy Manual, Chapter 15 § 60.3)>

- b. However, effective January 1, 2016, the physician providing supervision MUST be the provider billing Medicare for the services, not the one that initiated treatment <42 CFR § 410.26(b)(5)>

(iii) The "Included in the Physician's Bill" Requirement

- (a) To be covered as "incident to" services, the services must be of a type that are commonly included in the bill of a physician/practitioner (or furnished without charge). <42 CFR § 410.26(b)(3); Medicare Benefit Policy Manual, Chapter 15 § 60 (A)>

- (1) The implications of this requirement have always been somewhat unclear. Presumably, it simply means that the attending physician (i.e., the physician to whom the NPPs services are "incident to") must bill for the services ("incident to" billing is discussed below).

(iv) The "Physician Expense" Requirement

- (a) To be covered as "incident to" services, the NPP services must represent a direct financial expense to the physician or billing entity. <Medicare Benefit Policy Manual, Chapter 15 § 60.1(E)>

- (1) This means that the physician (or practice) must be paying for the services of the NPP. <Medicare Benefit Policy Manual, Chapter 15 § 60.1(A)>

- (2) However – the NPP need not be a "W-2" employee. "Incident to" coverage is also available for leased employees and independent contractors. <42 CFR § 410.26(a)(1); Medicare Benefit Policy Manual, Chapter 15 § 60.1(B)>

(v) The "Commonly Furnished in a Physician's Office" Requirement

- (a) To be covered as an "incident to" service, the service must be of a type that is commonly furnished in a physician's office or clinic. <42 CFR § 410.26(b)(4); Medicare Benefit Policy Manual, Chapter 15 § 60.1(A)>

(b) The "Institutional Patients" Limitation on "Incident To" Coverage

- (1) "Incident to" coverage is not available for services furnished in a hospital or skilled nursing facility or for services furnished (presumably in any setting) to a hospital or SNF



patient. <42 CFR §§ 410.26(b)(1), 410.26(a)(5); Medicare Benefit Policy Manual, Chapter 15 § 60.1(B)>

(c) Provider-Based Clinics

- (1) Although not entirely clear, it appears that the “institutional patients” limitation precludes incident to coverage in a clinic (or any other entity) that is treated as “provider-based” for Medicare purposes.

(vi) The “Eligible Provider” Requirement

- (a) To be covered as an “incident-to” service, the provider providing that service must be eligible for payment under the Medicare program, meaning that they have not been excluded from the Program by the Office of Inspector General or had his or her Medicare enrollment revoked <42 CFR § 410.26(a)(1)>
- (b) Service must be within the scope of practice imposed by the licensure of the provider within the state in which they are practicing <42 CFR § 410.26(a)(1)>

c. Billing for “Incident To” NPP Services

- (i) NPP services furnished “incident to” the services of a physician are billed as follows:
- (a) When the “incident to” services were supervised by a physician other than the attending physician (i.e., the physician to whom the NPP’s services are “incident to”), the supervising physician’s NPI is reported in Item 24J. <Medicare Claims Processing Manual, Chapter 26 § 10.4, Item 24J>
- (1) Although not stated in the Claims Processing Manual, if the attending physician personally supervised the NPP, presumably, the attending physician’s NPI would be reported in Item 24J.
- (2) The group NPI should be reported in Item 33a when the attending physician is in a group practice. <Medicare Claims Processing Manual, Chapter 26 § 10.4, Item 33a>
- (ii) Interestingly, for “incident to” claims there is no way to tell from the claim itself that the services were actually furnished by a NPP rather than the attending physician.

d. Payment for "Incident To" NPP Services

- (i) Medicare pays for "incident to" services at the same rate that it would have paid for the services if the attending physician had personally furnished the services.

4. Split/Shared Services

a. Definition

- (i) A split/shared service is a service where both a NPP and a physician from the same group practice see a patient. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.B>

b. Coverage of Split/Shared" Services

- (i) Although not considered an "incident to" service, Medicare covers split/shared visits in a hospital if the NPP and physician are "from the same group practice" and "the physician provides any face-to-face portion of the E/M encounter." <Medicare Claims Processing Manual, Chapter 12 § 30.6.1>

- (a) Interestingly, the Medicare Claims Processing Manual indicates that the physician's "face-to-face" visit with the patient may occur later in the day from the NPP portion of the encounter. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1 (Examples of Shared Visits>

- (1) Although not entirely clear, it appears that only evaluation and management ("E/M") services qualify for coverage as a split/shared encounter.

(ii) Billing for Split/Shared Encounters Furnished in a Hospital

- (a) Split/shared services are billed by the practitioner performing the substantive portion of the visit.
- (b) Eligible places of service for split/shared services include hospital inpatient, hospital outpatient, certain nursing facility services, and emergency department settings
- (c) As of January 1, 2022, the split/shared E/M policy does apply to critical care services and prolonged services.

Intentionally

Blank

Version 02/15/2023  
Check for Updates

# **Medicare Benefit Policy Manual**

## **Chapter 15 – Covered Medical and Other Health Services**

**Table of Contents**  
*(Rev.11771, 12-30-22)*  
*(Rev.11769,12--30-22)*

Version 02/15/2023  
Check for Updates

**60 - Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service**  
**(Rev. 1, 10-01-03)**  
**B3-2050**

**A - Noninstitutional Setting**

For purposes of this section a noninstitutional setting means all settings other than a hospital or skilled nursing facility

Medicare pays for services and supplies (including drug and biologicals which are not usually self-administered) that are furnished incident to a physician's or other practitioner's services, are commonly included in the physician's or practitioner's bills, and for which payment is not made under a separate benefit category listed in §1861(s) of the Act. A/B MACs (A) and (B) must not apply incident to requirements to services having their own benefit category. Rather, these services should meet the requirements of their own benefit category. For example, diagnostic tests are covered under §1861(s)(3) of the Act and are subject to their own coverage requirements. Depending on the particular tests, the supervision requirement for diagnostic tests or other services may be more or less stringent than supervision requirements for services and supplies furnished incident to physician's or other practitioner's services. Diagnostic tests need not also meet the incident to requirement in this section. Likewise, pneumococcal, influenza, and hepatitis B vaccines are covered under §1861(s)(10) of the Act and need not also meet incident to requirements. (Physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists, clinical social workers, physical therapists and occupational therapists all have their own benefit categories and may provide services without direct physician supervision and bill directly for these services. When their services are provided as auxiliary personnel (see under direct physician supervision, they may be covered as incident to services, in which case the incident to requirements would apply.

For purposes of this section, physician means physician or other practitioner (physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, and

clinical psychologist) authorized by the Act to receive payment for services incident to his or her own services.



To be covered incident to the services of a physician or other practitioner, services and supplies must be:

- An integral, although incidental, part of the physician's professional service (see §60.1);
- Commonly rendered without charge or included in the physician's bill (see §60.1A);
- Of a type that are commonly furnished in physician's offices or clinics (see §60.1A);
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision (see §60.1B).

## **B - Institutional Setting**

Hospital services incident to physician's or other practitioner's services rendered to outpatients (including drugs and biologicals which are not usually self-administered by the patient), and partial hospitalization services incident to such services may also be covered.

The hospital's A/B MAC (A) makes payment for these services under Part B to a hospital.

### **60.1 - Incident To Physician's Professional Services**

(Rev. 1, 10-01-03)

**B3-2050.1**

Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

#### **A - Commonly Furnished in Physicians' Offices**

Services and supplies commonly furnished in physicians' offices are covered under the incident to provision. Where supplies are clearly of a type a physician is not expected to have on hand in his/her office or where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the incident to provision.

Supplies usually furnished by the physician in the course of performing his/her services, e.g., gauze, ointments, bandages, and oxygen, are also covered. Charges for such

services and supplies must be included in the physicians' bills. (See §50 regarding coverage of drugs and biologicals under this provision.) To be covered, supplies, including drugs and biologicals, must represent an expense to the physician or legal entity billing for the services or supplies. For example, where a patient purchases a drug and the physician administers it, the cost of the drug is not covered. However, the administration of the drug, regardless of the source, is a service that represents an expense to the physician. Therefore, administration of the drug is payable if the drug would have been covered if the physician purchased it.

## **B - Direct Personal Supervision**

Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel.

Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

However, the physician personally furnishing the services or supplies or supervising the auxiliary personnel furnishing the services or supplies must have a relationship with the legal entity billing and receiving payment for the services or supplies that satisfies the requirements for valid reassignment. As with the physician's personal professional services, the patient's financial liability for the incident to services or supplies is to the physician or other legal entity billing and receiving payment for the services or supplies. Therefore, the incident to services or supplies must represent an expense incurred by the physician or legal entity billing for the services or supplies.

Thus, where a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment. (However, the direct supervision requirement must still be met with respect to every nonphysician service.)

Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than hospital or SNF), their services are covered incident to a physician's service only if there is direct supervision by the physician. For example, if a nurse accompanied the physician on house calls and administered an injection, the nurse's services are covered. If the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician) since the physician is not providing direct supervision. Services provided by auxiliary personnel in an institution (e.g., nursing, or convalescent home) present a special problem in determining whether direct physician supervision exists. The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct supervision. (See §70.3 of the Medicare National Coverage Determinations Manual for instructions used if a physician maintains an office in an institution.) For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under §1861(s)(2)(A) of the Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a A/B MAC (A). (See §80 concerning physician supervision of technicians performing diagnostic x-ray procedures in a physician's office.)

## **60.2 - Services of Nonphysician Personnel Furnished Incident To Physician's Services**

(Rev. 1, 10-01-03)

**B3-2050.2**

In addition to coverage being available for the services of such auxiliary personnel as nurses, technicians, and therapists when furnished incident to the professional services of a physician (as discussed in §60.1), a physician may also have the services of certain nonphysician practitioners covered as services incident to a physician's professional services. These nonphysician practitioners, who are being licensed by the States under various programs to assist or act in the place of the physician, include, for example, certified nurse midwives, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists. (See §§150 through 200 for coverage instructions for various allied health/nonphysician practitioners' services.)

Services performed by these nonphysician practitioners incident to a physician's professional services include not only services ordinarily rendered by a physician's office staff person (e.g., medical services such as taking blood pressures and temperatures, giving injections, and changing dressings) but also services ordinarily performed by the physician such as minor surgery, setting casts or simple fractures, reading x-rays, and other activities that involve evaluation or treatment of a patient's condition.



Nonetheless, in order for services of a nonphysician practitioner to be covered as incident to the services of a physician, the services must meet all of the requirements for coverage specified in §§60 through 60.1. For example, the services must be an integral, although incidental, part of the physician's personal professional services, and they must be performed under the physician's direct supervision.

A nonphysician practitioner such as a physician assistant or a nurse practitioner may be licensed under State law to perform a specific medical procedure and may be able (see §§190 or 200, respectively) to perform the procedure without physician supervision and have the service separately covered and paid for by Medicare as a physician assistant's or nurse practitioner's service. However, in order to have that same service covered as incident to the services of a physician, it must be performed under the direct supervision of the physician as an integral part of the physician's personal in-office service. As explained in §60.1, this does not mean that each occasion of an incidental service performed by a nonphysician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment. In addition, the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.

Note also that a physician might render a physician's service that can be covered even though another service furnished by a nonphysician practitioner as incident to the physician's service might not be covered. For example, an office visit during which the physician diagnoses a medical problem and establishes a course of treatment could be covered even if, during the same visit, a nonphysician practitioner performs a noncovered service such as acupuncture.

### **60.3 - Incident To Physician's Services in Clinic** (Rev. 1, 10-01-03) **B3-2050.3**

Services and supplies incident to a physician's service in a physician directed clinic or group association are generally the same as those described above.

A physician directed clinic is one where:

1. A physician (or a number of physicians) is present to perform medical (rather than administrative) services at all times the clinic is open;
2. Each patient is under the care of a clinic physician; and
3. The nonphysician services are under medical supervision.

■ 14. Section 405.2463 is amended by revising paragraph (c)(4) introductory text to read as follows:

**§ 405.2463 What constitutes a visit.**

(c) \* \* \*  
(4) For FQHCs billing under the PPS, and grandfathered tribal FQHCs that are authorized to bill as a FQHC at the outpatient per visit rate for Medicare as set annually by the Indian Health Service—

■ 15. Section 405.2464 is amended by—  
■ a. Revising the heading of paragraph (a), paragraphs (a)(1), (2), and (5), the heading of paragraph (b), and paragraph (b)(1).  
■ b. Adding paragraphs (c) and (d).  
The revisions and additions read as follows:

**§ 405.2464 Payment rate.**

(a) *Payment rate for RHCs that are authorized to bill under the reasonable cost system.* (1) Except as specified in paragraph (c) of this section, a RHC that is authorized to bill under the reasonable cost system is paid an all-inclusive rate that is determined by the MAC at the beginning of the cost reporting period.

(2) The rate is determined by dividing the estimated total allowable costs by estimated total visits for RHC services.

(5) The RHC may request the MAC to review the rate to determine whether adjustment is required.

(b) *Payment rate for FQHCs billing under the prospective payment system.* (1) Except as specified in paragraph (c) of this section, a per diem rate is calculated by CMS by dividing total FQHC costs by total FQHC daily encounters to establish an average per diem cost.

(c) *Payment for chronic care management services.* Payment to RHCs and FQHCs for qualified chronic care management services is at the physician fee schedule national average payment rate.

(d) *Determination of the payment rate for FQHCs that are authorized to bill as grandfathered tribal FQHCs.* This rates is paid at the outpatient per visit rate for Medicare as set annually by the Indian Health Service for each beneficiary visit for covered services. There are no adjustments to this rate.

**§ 405.2467 [Amended]**

■ 16. Section § 405.2467 is amended by removing paragraph (b) and redesignating paragraphs (c) and (d) as paragraphs (b) and (c), respectively.

■ 17. Section 405.2469 is amended by revising paragraphs (a) and (b)(2) and adding paragraph (b)(3) to read as follows:

**§ 405.2469 FQHC supplemental payments.**

(a) *Eligibility for supplemental payments.* FQHCs under contract (directly or indirectly) with MA organizations are eligible for supplemental payments for FQHC services furnished to enrollees in MA plans offered by the MA organization to cover the difference, if any, between their payments from the MA plan and what they would receive under one of the following:

(1) The PPS rate if the FQHC is authorized to bill under the PPS; or  
(2) The Medicare outpatient per visit rate as set annually by the Indian Health Service for grandfathered tribal FQHCs.

(b) \* \* \*  
(2) Payments received by the FQHC from the MA plan as determined on a per visit basis and the FQHC PPS rate as set forth in this subpart, less any amount the FQHC may charge as described in section 1857(e)(3)(B) of the Act; or

(3) Payments received by the FQHC from the MA plan as determined on a per visit basis and the FQHC outpatient rate as set forth in this section under paragraph (a)(2) of this section, less any amount the FQHC may charge as described in section 1857(e)(3)(B) of the Act.

**PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS**

■ 18. The authority citation for part 410 continues to read as follows:

**Authority:** Secs. 1102, 1834, 1871, 1881, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, 1395rr, and 1395ddd).

■ 19. Section 410.15, paragraph (a), is amended by—

■ a. In the definition of “First annual wellness visit providing personalized prevention plan services”, revising paragraph (x) and adding paragraph (xi).

■ b. In the definition of “Subsequent annual wellness visit providing personalized prevention plan services”, revising paragraph (viii) and adding paragraph (ix).

The revisions and additions read as follows:

**§ 410.15 Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage.**

(a) \* \* \*

First annual wellness visit providing personalized prevention plan services  
\* \* \*

(x) At the discretion of the beneficiary, furnish advance care planning services to include discussion about future care decisions that may need to be made, how the beneficiary can let others know about care preferences, and explanation of advance directives which may involve the completion of standard forms.

(xi) Any other element determined appropriate through the national coverage determination process.

\* \* \* \* \*

Subsequent wellness visit providing personalized prevention plan services  
\* \* \*

(viii) At the discretion of the beneficiary, furnish advance care planning services to include discussion about future care decisions that may need to be made, how the beneficiary can let others know about care preferences, and explanation of advance directives which may involve the completion of standard forms.

(ix) Any other element determined appropriate through the national coverage determination process.

\* \* \* \* \*

■ 20. Section 410.26 is amended by revising paragraphs (a)(1) and (b)(5) to read as follows:

**§ 410.26 Services and supplies incident to a physician's professional services: Conditions.**

(a) \* \* \*

(1) *Auxiliary personnel* means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner), has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked, and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished.

\* \* \* \* \*

(b) \* \* \*

(5) In general, services and supplies must be furnished under the direct supervision of the physician (or other practitioner). Services and supplies furnished incident to transitional care management and chronic care

management services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided by clinical staff. The physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) who is treating the patient more broadly.

However, only the supervising physician (or other practitioner) may bill Medicare for incident to services

\* \* \* \* \*

■ 21. Section 410.41 is amended by revising paragraph (b) to read as follows:

**§ 410.41 Requirements for ambulance suppliers.**

\* \* \* \* \*

(b) *Vehicle staff.* A vehicle furnishing ambulance services must be staffed by at least two people who meet the requirements of state and local laws where the services are being furnished, and at least one of the staff members must, for:

(1) *BLS vehicles.* (i) Be certified at a minimum as an emergency medical technician-basic by the State or local authority where the services are furnished; and

(ii) Be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle;

(2) *ALS vehicles.* (i) Meet the requirements of paragraph (b)(1) of this section; and

(ii) Be certified as a paramedic or an emergency medical technician, by the State or local authority where the services are being furnished, to perform one or more ALS services.

\* \* \* \* \*

■ 22. Section 410.78 is amended by adding paragraph (b)(2)(ix) to read as follows:

**§ 410.78 Telehealth services.**

\* \* \* \* \*

(b) \* \* \*

(2) \* \* \*

(ix) A certified registered nurse anesthetist as described in § 410.69.

\* \* \* \* \*

■ 23. Section 410.160 is amended by revising paragraph (b)(8) to read as follows:

**§ 410.160 Part B annual deductible.**

\* \* \* \* \*

(b) \* \* \*

(8) Beginning January 1, 2011, for a surgical service, and beginning January 1, 2015, for an anesthesia service, furnished in connection with, as a result of, and in the same clinical encounter as a planned colorectal cancer screening test. A surgical or anesthesia service

furnished in connection with, as a result of, and in the same clinical encounter as a colorectal cancer screening test means—a surgical or anesthesia service furnished on the same date as a planned colorectal cancer screening test as described in § 410.37.

\* \* \* \* \*

**PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT**

■ 24. The authority citation for part 411 continues to read as follows:

**Authority:** Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

■ 25. Section 411.351 is amended by—

■ a. In the definition of “Entity”, revising paragraph (3).

■ b. Revising the definitions of “‘Incident to’ services or services ‘incident to’”, “List of CPT/HCPCS Codes”, and “Locum tenens physician”.

■ c. In the definition of “Parenteral and enteral nutrients, equipment, and supplies”, revising paragraphs (1) and (2).

■ d. Revising the definition of “Physician in the group practice”.

■ e. In the definition of “Remuneration”, revising paragraph (2).

The revisions read as follows:

**§ 411.351 Definitions.**

\* \* \* \* \*

*Entity* \* \* \*

(3) For purposes of this subpart, “entity” does not include a physician’s practice when it bills Medicare for the technical component or professional component of a diagnostic test for which the anti-markup provision is applicable in accordance with § 414.50 of this chapter and Pub. 100–04, Medicare Claims Processing Manual, Chapter 1, Section 30.2.9.

\* \* \* \* \*

“Incident to” services or services “incident to” means those services and supplies that meet the requirements of section 1861(s)(2)(A) of the Act, § 410.26 of this chapter, and Pub. 100–02, Medicare Benefit Policy Manual, Chapter 15, Sections 60, 60.1, 60.2, 60.3, and 60.4.

\* \* \* \* \*

*List of CPT/HCPCS Codes* means the list of CPT and HCPCS codes that identifies those items and services that are DHS under section 1877 of the Act or that may qualify for certain exceptions under section 1877 of the Act. It is updated annually, as published in the **Federal Register**, and is posted on the CMS Web site at [http://](http://www.cms.gov/)

[www.cms.gov/PhysicianSelfReferral/11\\_List\\_of\\_Codes.asp#TopOfPage](http://www.cms.gov/PhysicianSelfReferral/11_List_of_Codes.asp#TopOfPage).

*Locum tenens physician* (or substitute physician) is a physician who substitutes in exigent circumstances for another physician, in accordance with section 1842(b)(6)(D) of the Act and Pub. 100–04, Medicare Claims Processing Manual, Chapter 1, Section 30.2.11.

\* \* \* \* \*

Parenteral and enteral nutrients, equipment, and supplies \* \* \*

(1) *Parenteral nutrients, equipment, and supplies*, meaning those items and supplies needed to provide nutriment to a patient with permanent, severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain strength commensurate with the patient’s general condition, as described in Pub. 100–03, Medicare National Coverage Determinations Manual, Chapter 1, Section 180.2, as amended or replaced from time to time; and

(2) *Enteral nutrients, equipment, and supplies*, meaning items and supplies needed to provide enteral nutrition to a patient with a functioning gastrointestinal tract who, due to pathology to or nonfunction of the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with his or her general condition, as described in Pub. 100–03, Medicare National Coverage Determinations Manual, Chapter 1, Section 180.2.

\* \* \* \* \*

*Physician in the group practice* means a member of the group practice, as well as an independent contractor physician during the time the independent contractor is furnishing patient care services (as defined in this section) for the group practice under a contractual arrangement directly with the group practice to provide services to the group practice’s patients in the group practice’s facilities. The contract must contain the same restrictions on compensation that apply to members of the group practice under § 411.352(g) (or the contract must satisfy the requirements of the personal service arrangements exception in § 411.357(d)), and the independent contractor’s arrangement with the group practice must comply with the reassignment rules in § 424.80(b)(2) of this chapter (see also Pub. 100–04, Medicare Claims Processing Manual, Chapter 1, Section 30.2.7, as amended or replaced from time to time). Referrals from an

# **Medicare Claims Processing Manual**

## **Chapter 12 - Physicians/Nonphysician Practitioners**

**Table of Contents**  
*(Rev. 2159, 02-15-11)*

Version 02/15/2023  
Check for Updates

(Rev. 178, 05-14-04)

B3-15501-15501.1

### **30.6.1 - Selection of Level of Evaluation and Management Service**

(Rev. 1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

#### **A. Use of CPT Codes**

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

#### **B. Selection of Level Of Evaluation and Management Service**

Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C.

Any physician or non-physician practitioner (NPP) authorized to bill Medicare services 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 (refer to sections 60.1, 60.2, and 60.3, chapter 15 in IOM 100-02).

#### **SPLIT/SHARED E/M SERVICE**

### **Office/Clinic Setting**

In the office/clinic setting when the physician performs the E/M service the service must 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), 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, the service must be billed under the NPP's UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

### **Hospital Inpatient/Outpatient/Emergency Department Setting**

When a hospital inpatient/hospital outpatient or emergency department 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 (e.g., even if the physician participated in the service by only reviewing the patient's medical record) 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, 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 physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's UPIN/PIN.

In the rare circumstance when a physician (or NPP) provides a service that does not reflect a CPT code description, the service must be reported as an unlisted service with CPT code 99499. A description of the service provided must 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 also determines 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.