Part B Insider (Multispecialty) Coding Alert

Shared Visits: Save The 'Shared Visits' Rule For The Hospital Ward

Don't try to combine NPP/physician visits in the office setting

Some things are better not shared, like syringes, Justin Timberlake impersonations - and office visits.

Providers are often tempted to use the shared visits rule in the office setting. But while you're allowed to bill for a shared visit under certain limited circumstances, you won't find the rule very useful in the office, according to experts. The **Centers for Medicare & Medicaid Services** introduced shared visits in last year's Transmittal 1776, which allows a physician and a non-physician practitioner (NPP) to perform parts of an evaluation and management service separately in the hospital and bill under the physician's number.

If you bill for shared visits in the office setting, you still have to follow all the rules for incident-to billing, says consultant **Quinten Buechner** with **Proactive Consultants** in Cumberland, WI. That means the NPP can only see existing patients under a plan of care (POC) the physician has established.

But some offices have gone wild. They allow the NPP to see a new patient or a patient with a new problem, perform the history and physical portions of the visit, and then bring in the physician to perform the medical decision-making portion. This is a misunderstanding of the shared-visit rule. The only thing to do with a visit like that is bill unlisted code 99499 and cross your fingers, says Buechner.

"We don't advocate billing for shared visits in the office setting," says **Jan Towers**, director of health policy at the **American Academy of Nurse Practitioners**. In fact, NPPs should bill under their own number in almost all circumstances, she recommends. They should only bill incident-to for routine follow-ups where they're closely following the doctor's plan of care, she continues.

There's only one situation in which you might bill for a shared visit in the office setting, says Buechner. An NPP is seeing an existing patient under the physician's plan of care, and then the NPP discovers a new problem that the POC doesn't cover. The NPP calls in the physician, who treats the new problem. In this case, you would bill both providers' services as one combined E/M visit under the physician's number.

"That gets to be a gray area," notes consultant **Joan Gilhooly**, president of **Medical Business Resources** in Evanston, IL. In that situation, the physician must perform 100 percent of the work-up on the new problem the NPP discovers. "My recommendation to practices that have nurse practitioners and physician assistants is only to use the split/shared rule when the provider has asked for the physician's opinion on the progress of the patient who's being seen on an incident-to basis," she adds.

Providers should remember that medical decision-making isn't something that happens after the history and physical, notes consultant **George Alex** with **Iatro** in Baltimore, MD. Most physicians will be asking questions during the history and physical, and already making some medical decisions by virtue of the amount of history and physical they perform.

Besides the reimbursement issues, many states prohibit NPPs from prescribing care, making diagnoses or forming treatment recommendations, adds Alex. In other words, many state laws prohibit medical decision-making by NPPs.

"The split/shared rules in the office setting truly gain you nothing," concludes Gilhooly.