

## Services Incident-to a Supervising Health Care Provider and Split or Shared Visits Policy, Professional

### **IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY**

*You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®\*), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

*This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

*This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations. UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.*

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### **Application**

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500), its' electronic equivalent or its' successor form. This policy applies to all products, all network and non-network physicians and other qualified health care professionals (QHP), including, but not limited to, non-network authorized and percent of charge contract physicians and other QHP.

#### **United Healthcare Commercial**

This Reimbursement Policy applies to all UnitedHealthcare Commercial benefit plans.

#### **UnitedHealthcare Individual Exchange**

This Reimbursement Policy applies to all Individual Exchange benefit plans.

### **Policy**

#### **Overview**

This policy sets forth the requirements for (i) reporting the services provided as "incident-to" a Supervising Health Care Provider in the office or clinic setting and (ii) reporting Split and/or shared evaluation and management services in a Facility Setting.

#### **Reporting "Incident-to" Services**

UnitedHealthcare will consider “incident-to” services reimbursable under this policy if the services are rendered by an Advanced Practice Health Care or Nonphysician Provider, pursuant to applicable laws, regulations and scope of practice, under the direct personal supervision of a Supervising Health Care Provider and the following “incident-to” criteria are met:

- o An integral, although incidental, part of the Supervising Health Care Provider’s services.
- o Commonly rendered without charge or included in the Supervising Health Care Provider’s bill.
- o Of a type commonly furnished in the Supervising Health Care Provider’s office or clinic; and
- o Provided by the Advanced Practice Health Care Provider or Nonphysician Provider under the Supervising Health Care Provider’s direct personal supervision.

Direct personal supervision means the Supervising Health Care Provider is present in the location of service and immediately available to provide assistance and direction, throughout the time the Advanced Practice Health Care or Nonphysician Provider is performing services.

Services rendered by a Nonphysician Provider that meet the “incident-to” criteria should be appropriately reported under the Supervising Health Care Provider’s NPI number. Services rendered by an Advanced Practice Health Care Provider that meet the “Incident-to” criteria should be appropriately reported under the supervising physician’s NPI number and the SA modifier appended.

For information related to reimbursement of services rendered by an Advanced Practice Health Care Provider that do not meet the “incident-to” criteria, please see the Advanced Practice Health Care Provider Policy, Professional.

### **Reporting Split or Shared Visits**

According to CMS, a split (or shared) visit is an evaluation and management (E/M) visit in the Facility Setting that is performed in part by both a physician and a Nonphysician Practitioner (NPP) who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if furnished independently by only one of them. Payment is made to the practitioner who performs the substantive portion of the visit.

#### **Substantive Portion:**

Except for critical care visits, the substantive portion can be one of the three key E/M visit components (history, exam, or medical decision-making (MDM)), or more than half of the total time spent by the physician and NPP performing the split (or shared) visit. In other words, the practitioner who spends more than half of the total time, or performs the history, exam, or MDM can be considered to have performed the substantive portion and can bill for the split (or shared) E/M visit.

When one of the three key components is used as the substantive portion, the practitioner who bills the visit must perform that component in its entirety in order to bill. For example, if history is used as the substantive portion and both practitioners take part of the history, the billing practitioner must perform the level of history required to select the visit level billed. If physical exam is used as the substantive portion and both practitioners examine the patient, the billing practitioner must perform the level of exam required to select the visit level billed. If MDM is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner must perform all portions or aspects of MDM that are required to select the visit level billed.

Split (or shared) visits may be billed for new and established patients, as well as for initial and subsequent visits that otherwise meet the requirements for split (or shared) visit payment.

Modifier -FS (Split or Shared E/M Visit) must be reported on claims for split (or shared) visits to identify that the service was a split (or shared) visit. The modifier identified by CPT for purposes of reporting partial services - modifier -52 (reduced services) cannot be used to report partial E/M visits, including any partial services furnished as split (or shared) visits.

E/M Visit Code Family	2022 Definition of Substantive Portion
Other Outpatient *	History, or exam, or MDM, or more than half of total time
Inpatient/Observation/Hospital/SNF	History, or exam, or MDM or more than half of total time.
Emergency Department	History, or exam, or MDM, or more than half of total time
Critical Care	More than half of total time

**\*Office visits are not billable as split (or shared) services:**

Office or other outpatient evaluation and management services are not eligible to be billed as a split (or shared) service in an office setting – place of service 11.

**Distinct Time:**

In accordance with the CPT E/M Guidelines, only distinct time can be counted. When the practitioners jointly meet with or discuss the patient, only the time of one of the practitioners can be counted.

**Qualifying Time:**

The following list of activities can be counted toward total time for purposes of determining the substantive portion, when performed and whether or not the activities involve direct patient contact:

- Preparing to see the patient (for example, review of tests).
- Obtaining and/or reviewing separately obtained history.
- Performing a medically appropriate examination and/or evaluation.
- Counseling and educating the patient/family/caregiver.
- Ordering medications, tests, or procedures.
- Referring and communicating with other health care professionals (when not separately reported).
- Documenting clinical information in the electronic or other health record.
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver.
- Care coordination (not separately reported).

Practitioners cannot count time spent on the following:

- The performance of other services that are reported separately.
- Travel.
- Teaching that is general and not limited to discussion that is required for the management of a specific patient.

For all split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit. The substantive portion can be entirely with or without direct patient contact, and is determined by the proportion of total time, not whether the time involves patient contact.

**Split (or shared) Prolonged Services:**

When practitioners use a key component as the substantive portion, there will need to be different approaches for hospital outpatient E/M visits than other kinds of E/M visits:

- For shared hospital outpatient visits where practitioners use a key component as the substantive portion, prolonged services can be reported by the practitioner who reports the primary service, when the combined time of both practitioners meets the threshold for reporting prolonged hospital outpatient services.
- For all other types of E/M visits (except emergency department and critical care visits), prolonged services can be reported by the practitioner who reports the primary service, when the combined time of both practitioners meets the threshold for reporting prolonged E/M services other than office/outpatient E/M visits (60 or more minutes beyond the typical time in the

CPT code descriptor of the primary service). Emergency department and critical care visits are not reported as prolonged services).

**Split (or shared) Critical Care Services:**

Critical care visits may be furnished as split (or shared) visit. When critical care services are furnished as a split (or shared) visit, the substantive portion is defined as more than half the cumulative total time in qualifying activities that are included in CPT codes 99291 and 99292. Unlike other types of E/M visits, critical care services can include additional activities that are bundled into the critical care visits code(s). For any given period of time spent providing critical care services, the practitioner must devote his or her full attention to the patient and therefore, cannot provide services to any other patient during the same period of time.

In the context of critical care, split (or shared) visits occur when the total critical care service time furnished by a physician and NPP in the same group on a given calendar date to a patient is summed, and the practitioner who furnishes the substantive portion of the cumulative critical care time reports the critical care service(s).

However, in situations where a patient receives another E/M visit on the same calendar date as critical care services, both may be billed (regardless of practitioner specialty or group affiliation) as long as the medical record documentation supports: 1) that the other E/M visit was provided prior to the critical care services at a time when the patient did not require critical care, 2) that the services were medically necessary, and 3) that the services were separate and distinct, with no duplicative elements from the critical care services provided later in the day. Practitioners must use modifier -25 (same-day significant, separately identifiable evaluation and management service) on the claim when reporting these critical care services

**Split (or shared) Skilled Nursing Facility Services:**

Skilled Nursing Facility (SNF) evaluation and management visits may be billed as split (or shared) visits if they meet the rules for split (or shared) visit billing except for SNF evaluation and management visits that are required to be performed in their entirety by a physician. Visits that are required to be performed in their entirety by a physician cannot be billed as a split (or shared) visit.

Definitions	
<b>Advanced Practice Health Care Provider</b>	A healthcare practitioner, other than a physician, licensed by the state in which they practice to assist or act in the place of a physician, who may bill directly under applicable state law. For the purposes of this policy, an Advanced Practice Health Care Provider includes, without limitation, Physician Assistants (PA), Nurse Practitioners (NP) and Clinical Nurse Specialists.
<b>Supervising Health Care Provider</b>	A physician or Advanced Practice Health Care Provider, who has their own NPI number, when responsible for supervising services rendered by an Advanced Practice Health Care or Nonphysician Provider.
<b>Facility Setting</b>	Facility Setting means an institutional setting in which payment for services and supplies furnished incident-to a physician or practitioner's professional services is prohibited under CMS regulations.
<b>Nonphysician Practitioner</b>	For the purposes of this policy, a Nonphysician Practitioner (NPP) includes, without limitation, Physician Assistants (PA), Nurse Practitioners (NP) and Clinical Nurse Specialists (CNS) to the extent they are legally authorized to practice under State laws, regulations and scope of practice.

<b>Nonphysician Provider</b>	Auxiliary personnel, such as nurses and medical assistants, acting under the supervision of a physician or Advanced Practice Health Care Provider, 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. Nonphysician Providers may include Advanced Practice Health Care Providers, when applicable.
<b>Split or Shared Visit</b>	A split (or shared) visit is an evaluation and management (E/M) visit in the Facility Setting that is performed in part by both a physician and a Nonphysician Practitioner (NPP) who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if furnished independently by only one of them. Payment is made to the practitioner who performs the substantive portion of the visit.

**Questions and Answers**

1.	<p><b>Q:</b> Does the physician have to see the patient or actively participate in each service for “Incident-to” services to apply?</p> <p><b>A:</b> No, if the “incident-to” criteria are met, services provided by Nonphysician Providers, who are associated with the same practice as the physician, may be covered as “Incident-to” the physician’s service if the physician provides direct onsite supervision/direction, when the service is provided, even when the patient does not see the physician.</p>
2.	<p><b>Q:</b> A Nonphysician Practitioner and a physician both spend time with a patient. How do we figure out the substantive portion based on time?</p> <p><b>A:</b> If the Nonphysician Practitioner first spent 10 minutes with the patient and the physician then spent another 15 minutes, their individual time spent would be summed to equal a total of 25 minutes. The physician would bill for this visit, since the physician spent more than half of the total time (15 of 25 total minutes).</p> <p>If, in the same situation, the physician and the Nonphysician Practitioner met together for five additional minutes (beyond the 25 minutes) to discuss the patient’s treatment plan, that overlapping time could only be counted by one (either the physician or nonphysician practitioner) for purposes of establishing total time and who provided the substantive portion of the visit. The total time would be 30 minutes, and the physician would bill for the visit, since they spent more than half of the total time 20 minutes total time (15 individual minutes spent with the patient plus the 5 minute discussion with the nonphysician practitioner).</p>

**Resources**

<p>American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services</p> <p>Health care Common Procedure Coding System (HCPCS)</p> <p>Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services</p>
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**History**

<b>3/1/2026</b>	Anniversary review and version change History Section: Entries prior to 3/1/2024 archived
<b>3/1/2025</b>	Anniversary review and version change History Section: Entries prior to 3/1/2023 archived
<b>4/1/2024</b>	<p><b>Template Update</b></p> <ul style="list-style-type: none"> <li>Transferred content to shared policy template that applies to both UnitedHealthcare Commercial and Individual Exchange benefit plans.</li> </ul>



UnitedHealthcare® Commercial and Individual Exchange  
Reimbursement Policy  
CMS 1500  
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	<ul style="list-style-type: none"><li>• Updated Application section to indicate this Reimbursement Policy applies to:<ul style="list-style-type: none"><li>○ All UnitedHealthcare Commercial benefit plans</li></ul></li></ul> All Individual Exchange benefit plans
8/1/2021	Policy implemented by UnitedHealthcare Employer & Individual