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Dermatology Coding Alert

Refresh Your NPP Incident-To Know-How With This Checklist

Don't confuse other payers' regulations with Medicare's

Correctly billing your nonphysician practitioners' (NPPs') "incident-to" services means the difference between 85 and 100 percent reimbursement. But if you bill incident-to haphazardly, you're just waving a red flag at auditors.

Use the following list of questions to evaluate your incident-to claims for all the must-have components -- and be sure the documentation includes the same.

1. Do the services involve direct supervision?

"Direct" means that the supervising physician must be in the immediate office suite while incident-to services are being provided, says **Barbara J. Cobuzzi, CPC, CPC-H, CHBME,** president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J.

But if you're too conservative with the word "direct," you could be giving up the extra reimbursement that comes with billing incident-to. "Direct doesn't mean that the physician has to be supervising the work face-to-face," Cobuzzi says.

Example: A dermatologist has treated Patient A for psoriasis and reported 96921 (Laser treatment for inflammatory skin disease [psoriasis]; total area 250 sq cm to 500 sq cm). Patient A returns for a follow-up appointment with a nurse practitioner (NP). The supervising dermatologist is in another room evaluating new Patient B while the NP performs history, exam and medical decision-making relative to Patient A's progress. You can bill the NP's service (99212-99215) incident-to the dermatologist for 100 percent reimbursement even though the dermatologist is not present in the room.

Caution: You don't want to use the term "direct" too loosely. Having the dermatologist available by phone or having the dermatologist somewhere on the grounds in a large facility is not acceptable. And you may want to check your state practice act to see if it mandates stricter supervision requirements than Medicare.

Also, don't confuse other third-party payers' incident-to regulations with Medicare's, says **Mary Falbo, MBA, CPC,** president of Millennium Healthcare Consulting Inc. in Lansdale, Pa. "Some third-party payers' definition of incident-to is more lenient: They may follow state supervisory rules, which for some states just requires the physician to be available by phone."

"You should also find out from your private payers whether they credential the NPPs. If they don't credential them, you should get in writing exactly how the payer wants them to be billed," Cobuzzi says.

Good idea: Keep physicians' work schedules on file to prove they were present when incident-to services occurred. In addition, some carriers, particularly HGSA, like to see the name of the supervising physician in the actual progress notes -- especially if it is a different physician than the one who wrote the plan of care.

2. Does the patient have an established plan of care?

Incident-to services "...must be part of [the physician's] normal course of treatment during which a physician personally performed an initial service and remains actively involved in the course of the treatment," states Medlearn Matters Article SE0441. This means that incident-to billing works only with an established patient following a plan of care.

Remember: As of November 2004, the supervising physician can be different from the one who actually wrote the plan

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of care. Important: The reimbursement must go to the dermatologist who supervised the incident-to services that day.

Beware: An established patient with a plan of care who comes in for a new, unrelated condition is not an appropriate case to bill incident-to, Cobuzzi says.

Another option: An NPP -- an NP, PA or a clinical nurse specialist -- can still see an established patient with a new problem for 85 percent reimbursement. But you must bill the services under the mid-level provider's own Medicare number -- not the dermatologist's, Cobuzzi says.

3. Have you distinguished auxiliary personnel from NPP services?

NPPs can supervise auxiliary personnel (RNs, LPNs and technicians) for incident-to services just as a dermatologist would supervise the NPP. The catch: You must bill the auxiliary personnel's services under the NPP's number, and you may only receive 85 percent reimbursement.

Watch out: State license laws determine the scope of practice under which NPPs can operate, Cobuzzi says. So be sure that NPPs check their state licensure policy on incident-to as well as other services (such as their ability to prescribe) because the scope of practice may not align with Medicare. The stricter set of laws takes precedence.

Do this: In addition to checking your state laws, check the Medicare Carriers Manual online for specific guidelines on different NPPs' scopes of practice. Refer to section 2154 for a CNM, 2156 for a PA, 2158 for an NP, and 2160 for a CNS. For general incident-to guidelines, see the "Services and Supplies" section of the online MCM (2050).

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