Internal Medicine Coding Alert

Correct Billing for Non-Physician Providers: Make Sure 'Incident To' Services Meet Medicare Standards

Is your internal medicine practice using physician assistants (PAs) to make hospital rounds and billing the service under the internists provider number? Is the nurse practitioner (NPs) in your hospital-based primary care clinic seeing patients while the supervising physician works on another floor? If so, watch out! You could be in hot water with Medicare.

Many practices are circumventing Medicares new guidelines on billing for PAs, NPs and clinical nurse specialists (CNSs) by simply billing all services by these providers as incident to the physician service and receiving reimbursement at 100 percent of the Medicare fee schedule payment, says **Ron Nelson, PA-C,** president of the Fremont, MI-based HSA Consulting Group, and president of the American Academy of Physician Assistants.

The requirements of incident to are very specific, Nelson cautions.

Medicare requirements state that a medical service qualifies as incident to the overall physician service if the services or supplies furnished are an integral, although incidental, part of the **physicians** personal, professional services in the course of diagnosis or treatment of an injury or illness.

In addition, the incident-rule stipulates that the service must meet the following requirements:

A. it must be commonly rendered without charge or included in the physicians bill,

B. of a type that is commonly furnished in the physicians office or clinic,

C. furnished under the physicians direct, personal supervision and,

D. furnished by the physician or an individual who qualifies as an employee of the physician.

If the service provided to the patient was incident to the physicians services to the patient, then the care delivered by the PA or NP should be billed under the doctors provider number, just as if he or she delivered the care personally.

If the medical care is provided solely by the PA or NP, and separate from any care the patient receives from their primary physician, then the service should be billed using the non-physician providers own personal identification number (PIN). (See sidebar on Medicare PIN numbers for mid-level providers on page 12.)

Note: Most payers have followed Medicares lead and issued provider numbers for PAs, NPs, and CNSs. However, some private payers may still require the use of a modifier. Check with your individual payers if they are not following Medicare.

Under Medicare guidelines, a PA or NP can bill under his or her provider number and be reimbursed at 85 percent of the physician fee schedule.

Basically, explains Nelson, to comply with Medicare incident to rules, the physician must be readily available to the non-

physician provider, the physician must have seen the patient for the first visit (i.e., it must be an established patient if the PA, NP, or the CNS is providing care incident to), and the physician must be the one to establish the diagnosis.

Physician Must Be Readily Available

Although Medicare spells out the requirements of incident to, varying interpretations of the rules abound, says Nelson.

Some practice managers believe that the phrase direct, personal supervision means that the physician must be present at the bedside of the patient and actually see the patient that day.

Most experts and Medicare officials have agreed that this is not the case.

The physician does, however, have to be present in the office or general area where the care is being provided, even if he or she does not actually see the patient, but instead reads and approves the information taken and the treatment plan devised by the non-physician provider.

Sometimes an NP will be seeing patients in a clinic with a hallway that connects it to the hospital next door, and the doctor is at the hospital, but the patients are seen in the clinic. That is not readily available and does not meet the standard, Nelson contends.

Require Physicians to Be On-Site

To be on the safe side, many practices that bill non-physician provider services as incident to, require their physicians to be on the premises, in the office, when a non-physician provider is seeing patients.

We have them go to lunch at the same time as the doctors, says **Donna Rusak,** practice manager for Primary Care Associates in Cape Coral, FL. We didnt even want to take a chance on the PA seeing a patient when the doctor had run out to get a sandwich.

The doctors directly supervise all patient care delivered by the PA in that practice.

[Compliance] really is not an issue for us, because all of the care meets the incident to guidelines, she says. But, I know some practices that have PAs go see patients in nursing homes or see them in the hospital. This care cannot be billed as incident to the physician service.

Incident To Does Not Apply to Inpatient Care

Medicare has ruled that the incident to concept is not valid in an inpatient setting. Therefore, services delivered by non-physician providers to hospital or nursing home patients cannot be billed under the physicians provider number under any circumstance.

This is a common error among IM practices, Nelson says. In some internal medicine practices he has counseled, a PA routinely performs rounds, with the patients physician simply reviewing the notes and signing them. The service would then incorrectly be billed under the physicians PIN number.

Incident to simply does not apply in the hospital, Nelson emphasizes.

If internists have their PAs round on hospital patients, that service must be billed under the PAs provider number.

Physician Must Establish the Diagnosis

And, even if the physician is present in the office while care is provided, that in itself is not enough to justify billing the service as incident to, says Nelson. The physician must be the one to establish the diagnosis for which the patient is

treated.

There are situations in which an established patient, though seen previously by the physician, comes into the practice and is seen by a PA for a completely different complaint, Nelson states. What happens if an elderly patient comes in for an evaluation of hypertension, the PA sees him and does the workup and finds that the patient has diabetes. Is that incident to?

In this case, the physician has only seen this patient for a separate complaint, has not examined the patient on this visit, and did not have input into the medical decision-making required to establish a diagnosis of diabetes, Nelson says. The PA is qualified to perform this examination, and it should be billed using his or her own provider number, not the physicians. In this case, the practice would receive 85 percent of the Medicare fee schedule for the examination.

What Can Happen?

Because Medicare has allowed PAs, NPs, and CNSs to have their own provider numbers, they are going to place non-physician provider services billed under the physicians provider number under increased scrutiny.

Billing services under the physicians PIN wont result in denied claims. However, if a Medicare audit turns up non-physician services with documentation from only a non-physician provider, but which were billed under the physicians PIN, then the practice could be charged with Medicare fraud, forced to pay back the amount overcharged, and fined.

What they do during an audit is take a random sampling of claims, explains Nelson. Based on that sampling they extrapolate that to the entire practice. Lets say they do a random audit of 100 charts, and 20 percent of those are found to be noncompliant. They will go back for a specific period of time and apply that 20 percent, saying that many claims must be wrong. There will be a significant penalty.

Documentation is Important

For internal medicine practices, it is vital for practice managers to understand the rules regarding billing of non-physician provider services as incident to.

It is also vital for physicians and coders to understand that if the PA, NP, or CNS service is billed as a physician service, the chart must indicate the physicians involvement in the patients care. For example, it must contain a reference to the initial examination performed by the doctor, the physicians establishment of the diagnosis, and the development of the treatment plan.

Auditors will also look at the chart for a service provided by a non-physician practitioner, then check the office schedule to see that the physician was in the office at the same time, Nelson states.

They will use the schedule to verify that the patient was originally seen by the physician to establish the diagnosis for which the non-physician provider performed the follow-up visit, he adds.