Internal Medicine Coding Alert

Pay Falls When Coders Can't Recognize Incident-to

If physician does not author care plan, incident-to coding is impossible

Each time a nonphysician practitioner (NPP) provides services or treatment to a Medicare patient, you should be on the lookout for the opportunity to code the service incident-to the physician.

Why? More money for the same service. When you report services incident-to the physician, you can bill under the physician's Medicare unique physician identification number (UPIN) and garner full pay for services.

If you do not bill an NPP visit incident-to the physician, then the NPP must bill under her UPIN, which reimburses at 85 percent the full rate. (The term UPIN will soon be replaced by national provider identifier, NPI.)

Of course, Medicare has strict guidelines regarding what constitutes an incident-to service, and the carrier will deny any claim that does not meet these rules -- so if you're concerned with the bottom line, you should know the ins and outs of incident-to coding.

Find Out if Patient Had Plan of Care

To bill incident-to services, the NPP must be following an established plan of care for the patient and the physician supervision requirements, says **Anna Rosario, CPC,** coding and compliance officer for Affiliated Practice Group in Brockton, Mass. If the NPP is seeing the patient for a new problem, then you cannot bill incident-to.

Consider these two examples:

Example 1: The internist sees a new Medicare patient with type II diabetes with ketoacidosis and benign hypertension, and schedules the patient for a follow-up visit. Two weeks later, the NPP provides a level-two E/M service for the patient to check on his diabetes and hypertension.

In this instance, the NPP followed the doctor's care plan, so you can report an incident-to service, says **Mary Falbo, MBA, CPC,** president of Millennium Healthcare Consulting Inc. in Lansdale, Pa. On the claim, you should report 99212 (Office or other outpatient visit for the evaluation and management of a patient, which requires at least two of these three key components: a problem- focused history; a problem-focused examination; and straightforward medical decision-making) for the E/M under the physician's UPIN.

Don't forget to attach ICD-9 codes 250.10 (Diabetes with ketoacidosis; type II or unspecified type, not stated as uncontrolled) and 401.1 (Benign hypertension) to 99212 to prove medical necessity for the encounter.

Example 2: A new patient comes to the office complaining of stomach pains. The NPP treats the patient and establishes a care plan for treatment of gastroesophageal reflux disease (GERD).

In this example, the patient received treatment for a new problem, meaning the NPP was not following a care plan, Falbo says. In this instance, you should report the NPP's service using the NPP's UPIN number.

In a nutshell: Anytime the NPP sees a patient independently for a new problem, you should code for the service with her UPIN, says **Quinten A. Buechner, MS, MDiv, ACS-FP/GI/PEDS, CPC, CCP, CMSCS,** president of ProActive Consultants LLC in Cumberland, Wis.

Must Meet 'Direct Supervision' Standard, too

Suppose you are examining a claim in which an NPP followed an established plan of care. To bill incident-to the physician, you must also be sure that the NPP provided the service under the "direct supervision" of a physician, Rosario says.

Definition: To meet "direct supervision" requirements, "the doctor must be present in office suite and immediately available to render assistance if necessary. The physician does not have to be physically present in the exam room with the NPP," Rosario says.

Payers are adamant about the physician being in the suite and immediately available, Buechner says. "Generally, audit experience tells us that the requirements mean within the suite -- not outside smoking a cigarette or elsewhere in the building or upstairs -- and within 'hollering distance,' " he says.

Important: The physician supervising the incident-to service does not necessarily have to be the same physician who authored the patient's care plan, Rosario says.

For example, an NPP is treating a patient, and Dr. X is the supervising physician. But the NPP is following Dr. Y's treatment plan, and Dr. Y is not present during the treatment.

"In this scenario, although you are following Dr. Y's treatment plan, you would bill under Dr. X as the supervising physician," Rosario says.

According to Medlearn Matters article SE0441, to bill incident-to you must bill under the supervising physician's UPIN. "CMS also states that any physician members of the same group may be present in the office to supervise incident-to," she says.

Caveat: You must make sure that the physician supervising the incident-to service is an eligible supervisor according to your state's law.

"Any doctor in the group is OK for Medicare incident-to billing, but that doctor may not be an eligible supervisor under state law. If you are billing incident-to, you must always comply with both state law and Medicare," Buechner says.

Best bet: Make sure to check a physician's state eligibility before billing incident-to with him as the supervising physician.

No Direct Supervision = No Incident-to

Remember, even if your NPP is following a physician's care plan for a patient, you cannot bill the service incident-to unless the NPP provides the service under direct supervision, Buechner says.

"Incident-to services go hand in hand with direct supervision; there must be direct supervision by a doctor," Rosario says.