Part B Insider (Multispecialty) Coding Alert

INCIDENT-TO BILLING: Your Incident-To Services Could Spark An Unpleasant Incident

6 tips for avoiding $150 K payback

Incident-to billing is on the **HHS Office of InspectorGeneral's** work plan for 2004 -- do you bill correctly?

Massachusetts-based **Arbour Elder Services, Inc**. and **Hri Clinics, Inc**. settled allegations May 20 that they lapsed on incident to billing by paying the government $148,823, according to U.S. Attorney **Michael Sullivan.** Arbour was accused ofsubmitting fraudulent claims to Medicare for nursing facility assessments on new and established patients, subsequent nursing facility care and pharmacological management services. The feds claim the services were allegedly provided by clinical nurse specialists, but were coded as if they had been provided by doctors.

When the physician bills on paper or electronically, she is stating that she performed or supervised the services personally, notes attorney **Judy Waltz** with **Foley & Lardner** in San Francisco. She and others offer the following tips on making sure your incident-to bills aren't investigation bait:

Don't assume that just because the doctor is involved in the patient's care, it's enough to count as incident-to, says Waltz. The doctor needs to initiate the treatment and be involved throughout. The doctor must be supervising even if he or she isn't in the room.

Don't bill incident-to for something that you wouldn't bill for if the physician did it himself or herself. Waltz says people often try to bill incident-to for nurse services that wouldn't be covered if the doctor performed them, such as reading lab tests or making follow-up phone calls.

Make sure the doctor can prove he was actually on-site at the time. "I had one False Claims Act investigation where they asked for physician calendars," notes Waltz. The nurses were just across the hall from the docs, but the docs signed off on the visits the next day. So the OIG asked, "How are you going to prove they were present on the premises?" Waltz relates. "You need to have some way of showing they were there."

Don't keep billing incident-to months after the last physician visit. "When you haven't seen [patients] for months and months, it becomes more and more difficult to claim there's a continuing course of treatment that it's incident to," notes Waltz. It looks more and more like the nurse is " practicing and billing as a physician."

"Providers billing under the incident-to physician services benefit are well-advised to make sure the medical record contains sufficient documentation to support that a physician personally saw the patient periodically to assess the course of treatment and the patient's progress," says attorney **Mary-Ellen Allen** with **Foley & Lardner** in Los Angeles.

Don't confuse incident-to billing by the more recent "shared visits" rule for inpatient visits, which allows physicians to perform part of an evaluation and management visit and sign off on the rest of the E/M service as provided by a non-physician, says attorney **Alice Gosfield** with **Gosfield & Associates** in Philadelphia.

Don't start the incident-to treatment until the physician has seen the patient for the first time, Waltz warns.

"The way that medicine is now, you want to press it down to the cheapest level to provide the service," warns Waltz. "You can't do that for Medicare purposes."

If a non-physician provider wrongly bills his services as incident-to, the practice can try refunding the extra 15 percent it received on the grounds that Medicare would have paid the NPP's services under his own number, Waltz notes. But if the NPP doesn't have his own provider number, then the provider will be in a much tighter spot, she adds.