Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Refresh Your NPP Incident-To Know-How With This 5-Step Checklist

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

Correctly billing your non-physician practitioner's (NPP's) 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, clarifies **Barbara J. Cobuzzi, CPC, CPC-H, CHBME**, president of **CRN Healthcare Solutions**, a coding and reimbursement consulting firm in Tinton Falls, NJ.

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 explains.

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 get caught using the term direct too loosely. Having the physician available by phone, or having the physician 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 payor's incident-to regulations with Medicare's, cautions **Mary Falbo, MBA**, **CPC**, president of **Millennium Healthcare Consulting Inc**. in Lansdale, PA. Some third party payor's 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 payors whether they credential the NPPs. If they don't credential them, you should get in writing exactly how the payor wants them to be billed, recommends Cobuzzi.

Good idea: Keep physician's 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.

Example: A physician assistant (PA) at a urology practice sees an established patient who is being treated for a urinary tract infection. The urologist has seen this patient in the recent past and has established the diagnosis and initiated a care plan. The PA performs a follow-up history and examination and continues the prescribed treatment. You can bill an established office visit--most likely a 99212 (Office or other outpatient visit for the evaluation and management of an established patient ...) or 99213--under the urologist's name and provider number. Then, reimbursement allowance will be at 100 percent of the physician's global fee.

As long as the patient is not new or undergoing status change, and the urologist is in the office suite, the PA can provide the service, and the office can use the urologist's provider number when filing the claim with Medicare.

Remember: As of Nov. 2004, the supervising physician can be different from the one who actually wrote the plan of care. Important: The reimbursement must go to the physician 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 warns.

Another option: An NPP--an NP, PA, Clinical Nurse Specialist (CNS) or a Certified Nurse Midwife (CNM)--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 physician's, Cobuzzi says.

3. Was the service performed in a non-hospital facility by an employee of the physician?

A major key to incident-to billing is that it doesn't apply to a hospital setting, Falbo reminds. CMS says incident-to services are commonly furnished in physician's offices or clinics."

The only time a hospital setting warrants incident-to billing is when the physician's office is confined to a separately identifiable part of the facility and cannot be construed to extend throughout the entire facility. For instance, a privately practicing podiatrist rents a small wing of a large hospital to practice.

In addition, any NPP providing incident-to services must represent a direct financial expense to the physician, CMS says. This means that the NPP must be an employee or independent contractor of the physician's practice.

4. Have you distinguished auxiliary personnel from NPP services?

NPPs can supervise auxiliary personnel (RNs, LPNs and technicians) for incident-to services just as a physician 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. For example, the physician is out of the suite doing rounds in a hospital while a PA sees patients in the suite under her provider number. A patient comes in for a blood draw, which a nurse on staff performs. The nurse should bill 36415 (Collection of venous blood by venipuncture) under the supervising PA's provider number.

Watch out: State license laws determine the scope of practice under which NPPs can operate, Cobuzzi points out. 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 Carrier's Manual (MCM) online for specific guidelines on different NPP's 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).

5. Does the documentation demonstrate the above points?

Unless your NPP mentions all these key factors in the documentation, you can only expect 85 percent reimbursement.

Tip: The physician should document in his or her plan of care that the patient will follow up with the NPP for monitoring of that particular episode of care, Falbo recommends. That care could be the management of diabetes mellitus,

hypertension, coronary artery disease or other conditions. However, when there is a new problem, the physician must see the patient and modify the plan of care for the NPP to follow accordingly.