Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: 3 Facts You May Not Know About Incident to

And one that you probably do know□but aren't following properly.

As most practices are aware, you can maximize your income if you report your mid-level providers' services as incident to the physician□but to do this ethically, you must follow the rules.

Background: If your services meet all of the requirements for incident to as specified in the Medicare Benefit Policy Manual, Chapter 15, Sections 60□60.1, you can collect 100 percent of the visit's charges instead of the 85 percent that mid-level providers can usually capture.

CMS says that your incident to services must be an integral, although incidental, part of the physician's personal professional services, and they must be performed under the physician's direct supervision. In addition, the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.

Although you're probably aware of these hard and fast incident to requirements, there are some rules that you might have missed. Read on to find out the scoop on incident to billing.

1. Supervision Isn't Optional

When CMS says the physician has to be in the office suite, the agency means the doctor should be there the entire time.

Example: The physician is running late at the hospital, so the nurse practitioner starts the established patient's visit before the doctor arrives. The NP performs the history, exam and medical decision-making. Just before the patient leaves the examination room, the physician comes into the room, but because the NP already finished the visit, the doctor leaves and reviews the notes later that day to check on the patient's progress.

Reality: You must report this visit under the NP's identification number, because it doesn't qualify as a split/shared visit or meet the incident to guidelines under the CMS rules since the physician was not in the suite during the actual visit.

Here's why: "When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed 'incident to' if the requirements for 'incident to' are met and the patient is an established patient," CMS says in section 30.6.1 of the Medicare Claims Processing Manual. "If 'incident to' requirements are not met for the shared/split E/M service, the visit must be billed under the NPP's UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment."

In the example above, the incident to requirements are not met since the physician was not in the suite for the service. The doctor reviewing the NP's notes later are not enough to satisfy the rules.

2. Some Medicaid Payers Have Their Own Rules

Although we might think of incident to rules as being enforced universally among government payers, the reality is that not every state Medicaid program handles incident to the same way.

Example: Texas Medicaid recently spelled out its incident to guidelines, which appear to be more stringent than the Medicare rules.

"Previously, Texas Medicaid was silent about physician supervision and involvement in care for services billed incident to, which presented practices with both flexibility and uncertainty," says **Kris Kwolek, JD**, partner with Husch Blackwell

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LLP in Texas.

This changed significantly effective Jan. 1, when the state specified how the physician must be involved in the patient's care to qualify for incident to billing. "The physician must make a decision regarding the patient's care on the same date as the service rendered by an APRN or PA and the physician's involvement and decision must be documented in the record," Kwolek tells the Insider.

If your state Medicaid program has a regulation similar to this, making it stricter than the Medicare guidelines, be sure that your documentation stands up to the requirements.

Best bet: "I think to best mitigate risk under the new requirements, a billing physician should at least counter-sign the record of service provided by the PA or APRN on each date of such service," Kwolek advises. "A counter-signature arguably establishes that the counter-signing physician decided care and treatment documented in the record was appropriate. Any additional specific details a physician adds such as care instruction or changes advised by the physician would further support compliance. It is important that the record of physician decision-making be dated to mitigate against recoupment based on an inability to show when the decision-making took place."

3. CMS May Allow Rule Tweaking for Some Homebound Patients.

Although one of the cardinal rules of incident to billing is that the physician must provide direct supervision, there is an exception to the rule if your mid-level provider is seeing a homebound patient in a medically underserved area where no available home health services are available. "In this instance, you need not be physically present in the home when the service is performed, although general supervision of the service is required," CMS says in MLN Matters article SE0441.

The doctor still must order the service, stay in contact with the mid-level provider and remain professionally responsible for the service, the agency says.

Pay Sharper Attention to This Rule

Although you probably already know that incident to only applies to specific mid-level providers, you may not be adhering to the rule. According to the OIG's 2009 report, "Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services," unqualified non-physician practitioners (NPPs) performed 21 percent of incident to services that the agency audited. This finding has led to intense scrutiny over incident to claims, and even caused the OIG to add incident to as a focus of the agency's Work Plan several times since the report was published.

"Some nonphysicians in our sample were not licensed or certified but instead had received other formal medical training, on-the-job training, or no formal medical training at all," the report noted.

Reality: Your mid-level providers must only perform services that are within their scope of practice and in accordance with state laws. Even if the practitioner is licensed and trained in another state, if he doesn't meet your state's licensing requirements, you may not be able to report his services incident to your physician.

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