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Outpatient Facility Coding Alert

Documentation: Tread Carefully When Billing ' Incident to' Services

Meet the criteria or be ready for the OIG's scrutiny.

Do you know you might be compromising about 15 percent difference in reimbursement rates if you are not aware of correctly billing for services non-physician practitioners (NPPs) perform in your office?

Here's why: In the 2012 Work Plan, the HHS Office of Inspector General (OIG) indicated it would begin scrutinizing incident to services. Your best bet is not to bill "incident to" unless you're sure you've met the requirements.

Here's what you need to know to keep your practice off the OIG's watch.

Get a Grip on the Service Itself

To qualify as "incident to," services must be part of your patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment.

As defined by CMS: "Incident to" services are defined as those services that are furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home. These services are billed as Part B services to your carrier as if you personally provided them, and are paid under the physician fee schedule.

Note: Incident-to services are also relevant to services supervised by certain non-physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists. These services are subject to the same requirements as physician-supervised services.

The physician does not have to be physically present in the patient's treatment room while these services are provided, but must provide direct supervision. That is, the physician must be present in the office suite to render assistance, if necessary. The patient record should document the essential requirements for incident to service.

Understand How the Billing Happens

When an NPP provides a service to a Medicare patient incident-to the physician, you can report the service under the physician's NPI as long as all of the rules for incident-to services are followed. You will charge the payer 100 percent of the service's fee. Remember if you find the service does not meet incident-to billing requirements, you don't have to forego payment altogether in many cases. If a Medicare credentialed NPP provides the service, you can bill under his own NPI. In that case, you'll usually receive 85 percent of the normal global fee found in the Medicare Physician Fee Schedule, for an NP or PA, says **Jill Young, CPC, CEDC, CIMC,** owner of Young Medical Consulting in East Lansing, Mich.

Caveat: If a member of your auxiliary staff, such as a medical assistant (MA), provides a service when there is no direct supervision, you cannot bill for the service.

Get to Know OIG's Plans

The OIG intends to determine whether payment for incident-to services showed a higher error rate than non-incident-to services.

"Incident-to services represent a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record," the Work Plan notes. "They may also be vulnerable to overutilization and expose Medicare beneficiaries to care that do not meet professional standards of quality."

"Incident-to billing is always something being scrutinized by the Office of the Inspector General (OIG) simply by nature," says **Suzan Berman, CPC, CEMC, CEDC,** senior manager of coding education and documentation compliance for UPMC-Physician Services Division in Pittsburgh. "The claims are sent in under the physician's name. The mid-level provider is 'transparent' to this process. If the carriers see more claims than normal coming in for the physician, that type of specialty, etc., they will want to investigate to see if the patients are being seen appropriately and thus being billed appropriately.

"Incident-to services were actually listed in the OIG Work Plan back in 2001, 2003, 2004, 2007 through 2009, and [again in] 2012," says **Elin Baklid-Kunz, MBA, CPC, CCS,** a director of physician services in Daytona, Fla. "Many of the recent overpayment, audit, civil false claims act, and even criminal cases instituted by the federal and state agencies overseeing the Medicare and Medicaid programs involve allegations of improper billing for incident-to services," Baklid-Kunz says.

Know When You Can -- And Can't -- Bill Incident-To

To qualify for incident to, you must first ensure the visit meets a few criteria. CMS' Benefit Policy Manual defines "incident to" as "services furnished as an integral although incidental part of a physician's personal professional service." CMS pays NPP office service reported under a physician's NPI at 100 percent, provided you meet these requirements:

- The NPP performs the service in a physician's office (place of service 11).
- The NPP performs the service within the scope of her practice and in accordance with state law.
- The physician establishes the care plan for the new patient to the practice or any established patient with a new medical condition. NPPs may implement the established plan of care during a follow-up visit.
- The physician is onsite when the NPP is rendering the service.

As noted in the first criterion, you should not report services rendered in a hospital setting -- either outpatient, inpatient, or in the emergency department -- as incident-to. Medicare doesn't allow it.

No new problems: The physician must have seen the Medicare patient during a prior visit and established a clear plan of care. If the non-physician practitioner is treating a new problem for the patient, or if the physician has not established a care plan for the patient, then you cannot report the visit as incident-to.

Check supervision: In addition, when meeting the requirements for a follow-up to an established plan of care, if the physician does not directly supervise the NPP, the incident-to rules do not apply. Direct supervision means a supervising physician must be immediately available in the office suite during the service. The supervising physician, however, does not need to be the physician who initiated the treatment plan, Berman says. You should bill in the name of the physician present in the office suite and providing the supervision at the time of the NPP visit, whether or not he initially saw the patient and developed the plan of care.

"The billing must reflect this difference," Young says. "Physician supervising in the office goes in box 33. The physician who wrote the plan of care for the visit goes in 17."

The NPP can document the name of the physician available for supervision. This is not mandatory, but will assist in eliminating any confusion if the claim is questioned.

Watch out: You need to know your state's laws governing the scope of practice for your different NPPs as well, Young warns. Medicare guidelines specify that "coverage is limited to the services a PA or NP is legally authorized to perform in accordance with state law," she adds.

Bottom line: "Following the incident-to rules to the letter will help combat any audit that might take place," Berman says.