Making Sense of Incident- to Billing

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Objectives

• Define and identify Incident-to-billing characteristics
• Identify Split services
• Appraise incident-to scenarios
• Recognize other payers position
Defined

**Incident To**

- Incident to refers to services or supplies that are furnished *incident to a physician’s professional services* when the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.

- Services are performed in the physician’s office or in the patient’s home.
Defined

Incident To

• To qualify for payment under the incident-to rules, services must be part of the patient’s normal course of treatment, during which a physician personally performed an initial service and remains involved actively in the ongoing course of treatment.
CMS permits an exception to the Centers for Medicare & Medicaid Services (CMS) requirement that the identity of the person who performed the service be reported on the claim. Specifically,

- CMS allows 100% reimbursement for services provided by non-physician providers (NPPs) instead of the standard 85% for NPP services — if requirements are met.
If a patient mentions a new problem during a follow-up visit for a problem with an established plan of care, the visit cannot be billed incident-to. Documentation of the incident-to service must include the link to the physician’s service to which the service is incidental. Referencing by date and location the initiating provider’s service will support the active involvement of the physician.
A split / shared visit is a medically necessary encounter with a patient, where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the patient on the same date of service.

Sample Shared / Split Visit Note by MD: “Patient seen and examined, findings from my exam are _____. I agree with NPP’s note and care plan as documented. Signed I.M. Attending MD” • Two separate notes required. NPP + MD notes.
New patient visits cannot be billed as incident-to and therefore fall under the split/shared services rule.

The split/shared services rule requires that with a new patient encounter, the supervising physician must document his or her review of the history, perform key portions of the exam, and create a plan of care for the patient. This requires the physician to also see the patient face-to-face, making the visit a split or shared service when the NPP sees the patient during the same encounter.
The NPP’s identity and credentials must be recorded, as well as the name of the supervising physician for the encounter. The supervising physician does not need to be the same provider who ordered the incident-to service. The supervising provider’s number should then be used for billing the service.
Incident-to Billing

Documentation of the incident-to service must include the link to the physician’s service to which the service is incidental. Check with your Medicare carrier for where the physician name(s) (i.e., the supervising physician and the physician who established the patient’s plan of care) should be placed on the claim form.
NP, PA might need to bill their services incident-to (because insurance carriers do not credential them),

NPPs have a choice whether to bill their services incident-to to Medicare.

The incentive to bill incident-to services is reimbursement. Medicare allows 100% of the Medicare fee schedule amount for coverable services submitted by a physician.

Medicare allows a percentage of the physician fee schedule amount when services are submitted under a NPP provider number.

The percentage is 85% for physician assistants, nurse practitioners, and clinical nurse specialists.
Services you perform as a LCSW are eligible for coverage under Part B of Medicare if they are services that would be covered if performed by a physician or if the services are incident to the services of a physician, nurse practitioner or other medical practitioner. Social worker services must be aimed at the diagnosis and treatment of mental illness.
Services to homebound patients in underserved areas, CMS says, are not subject to direct supervision, but rather general supervision requirements.

A patient is considered homebound when his ability to leave his home is restricted and requires considerable effort.
General supervision: The physician or advanced practitioner (AP) must be available by telephone to provide assistance and direction if needed.

Direct supervision: The physician or AP providing supervision must be "immediately available" and "interruptible" to provide assistance and direction throughout the performance of the procedure; however, he or she does not need to be present in the room when the procedure is performed.

Personal supervision: The physician or AP must be in attendance in the room during the procedure.
Incident-To

Do you credential NPPs?
Do you include them in your provider listing?
Whose name and provider number is required on claims, the NPP’s or the physician’s?
Do you require any specific level of supervision or protocol?
If a physician’s name and provider number are required on the claim, do you differentiate between the initiating provider and the supervising provider?
What is your reimbursement rate for NPP services?
Once you have gathered the answers to these questions, you can begin to analyze whether incident-to billing makes sense for your practice.
Colorado Medicaid does not have an incident to policy for physician services and relies on the rule to allow payment for supervised services.

Services performed by non-physician BUT under supervision of a physician may be billed under the physicians name.
Use the checklist

• Do not bill incident to for new patients or established patients with new problems.
• Make sure the services are within the NPP’s scope of practice.
• Make sure the service is performed in an office setting.
• Verify that there is a physician providing direct supervision at the time of the service.
• Verify your payer policies regarding incident-to billing.
2016 Clarification

Physician A: Initiates treatment plan, bills for initial encounter
Auxiliary Personnel (e.g. NP, PA)

Physician B: Supervises "incident to" service

Bills for service

The ordering physician doesn't need to be the same physician that supervises and bills for the "incident to" service.
Can anti-coagulation monitoring be provided “incident to” a physician’s services in an office?

Yes, if the requirements are met, i.e., the services are part of a course of treatment during which the physician personally performs the initial service and is actively involved in the course of treatment, is physically present in the immediate office when services are rendered by the employee, and the service represents an expense to the physician or other legal entity that bills for the service.
If the treating physician (Doctor X) refers a patient to an anti-coagulation monitoring clinic, can Doctor X bill these services as “incident to?”

No, because the services are not being provided by an employee under supervision of Doctor X.
Can the supervising physician (Doctor Y) at the anti-coagulation monitoring clinic (a physician group) bill the services as “incident to” if Doctor Y directly supervises those services at the clinic?

No, because Doctor Y is not treating the patient for the underlying condition. However, if Doctor Y receives a referral from Dr. X, and Dr. Y performs an initial evaluation of the patient and then orders and supervises the services, they may be billed by Doctor Y incident to her initial service.
Must a supervising physician be physically present when flu shots, EKGs, Laboratory tests, or X-rays are performed in an office setting in order to be billed as “incident to” services?

These services have their own statutory benefit categories and are subject to the rules applicable to their specific category. They are not "incident to" services and the "incident to" rules do not apply.
Dr. A is treating a patient for diabetes. The patient’s evaluation and management (E/M) encounter in the office is with a PA of the same group for an upper respiratory infection. Can the PA bill the service incident-to Dr. A and bill under Dr. A’s PIN?

In this situation, the upper-respiratory infection is not part of the treatment for diabetes and, therefore, is not an “integral, although incidental” part of Dr. A’s “professional service.” The PA should not bill incident- to under Dr. A’s provider number, but should bill the appropriate level of new or established E/M service provided under his or her own provider number. The physician must have performed the initial service for the diagnosis or condition, and must remain actively involved in the course of treatment.
Compliance failures can create overpayment liability that will increase with time. Incorrect billing practices may lead to overpayments and False Claims Act violations. In correct use of "incident to" billing encourages inefficient practice patterns that can result in a loss of efficiency and reduced revenue generation.
If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.
Thank You.

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