Billing Incident-to Services

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Objectives

Incident-to background

• To describe Medicare’s Incident-to policy
• To define who can perform Incident-to services
• To review Medicare’s split/shared care definition
• To outline the necessary documentation to support billing 99211 to comply with Incident-to guidelines
Incident-to Background

Medicare Part B pays for services that are billed by physicians but are not performed by physicians – these are ‘incident to’ services.

Incident-to Background

Report published August 2009 by the Office of Inspector General (OIG), “Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services.” Purpose of study was to identify the services physicians bill to Medicare but do not perform personally. To assess the qualifications of the nonphysicians (NPP) who perform those services.
OIG Findings

Claims history for the first quarter of 2007 in which Medicare allowed services for physicians in a single day that exceeded 24 hours of physician work time.

- Medicare allowed $105 million for approximately 934,000 services that the physician personally performed.
- Allowed about $85 million for approximately 990,000 services that NPPs personally performed.

OIG Findings

Unqualified nonphysicians performed 21% of the services that physicians did not perform personally.

- Medicare allowed $12.6 million for approximately 210,000 services performed by unqualified NPPs.
- NPP did not possess the necessary licenses or certifications or lacked training to perform the services.
What is Incident-to??

Medicare Definition

“Incident to a physician’s professional services means that 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.” (Medicare IOM Publication 100-02, Chapter 15, Section 60.1)
Supplies Covered

Supplies are clearly of a type a physician is not expected to have on hand in his/her office.

Supplies must be an expense to the physician.

Supplies NOT Covered

Supplies usually furnished by the physician in the course of performing his/her services, eg. gauze, ointments, bandages, and oxygen.

Drugs that the patient purchases and the physician administers (The drug is not covered, but the administration of the drug is considered an expense).
Each occasion of service by auxiliary staff does not necessarily warrant
the billing of a personal, professional service by the physician.

***Cautionary Note***

Where do you use Incident-to??
Location, Location, Location

Services and supplies that are commonly furnished in the physicians’ office, a patient’s home or an institution.
Payment for most non-physician services to hospital patients, either inpatient or outpatient, are considered bundled, and cannot be billed Incident-to.
Cannot bill Incident-to services for patients in the hospital or a skilled nursing facility.

Location…with One Exception

Homebound patients in medically underserved areas.

Require only general supervision, meaning the service is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the service.

Reasonable and medically necessary service that are required for the patient’s care.
Who can provide Incident-to services??

Auxiliary Personnel

Personnel must be an employee of the physician, or a leased employee of the physician.
Personnel may work part-time or full-time.
Personnel must work under the direct supervision of a physician.
Auxiliary Personnel

Can only bill lowest level of E/M service, code 99211.
Medicare will pay the claim at 100% of the physician fee schedule, even though the services were furnished by the auxiliary personnel.

Non-Physician Personnel (NPP)

Nurse Practitioner
Nurse Midwife
Clinical Nurse Specialist
Physician Assistant
Clinical Psychologist
Clinical Social Workers
Physical/Occupational Therapists
Non-Physician Personnel

NPP can bill E/M levels 99211-99215. Medicare will pay the claim at 100% of the physician fee schedule, even though the services were furnished by the NPP.

CPT® code 99211 and How to Bill Incident-to (Medicare guideline)
CPT® 99211

“Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.” (CPT® 2010)

Criteria for billing 99211 Incident-to

Must be an established patient
There must be an established plan of care
There must be an E/M service provided by an employee of the physician
Must be provided in the office
There must be direct physician supervision
Established Patient

“An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.” (CPT® 2010)

Established Plan of Care

To bill incident-to, “there must have been a direct, personal, professional service furnished by a the physician to initiate the course of treatment of which the service being performed by the non-physician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his/her continuing active participation in and management of the course of treatment.”
Established Plan of Care

The personnel performing the incident-to-service should:

- Document the 'link' between their face-to-face service and the preceding physician service to which their service is incidental.
- Reference by date and location the precedent providers' service that supports the active involvement of the physician.
- Legibly record both their identity and credentials.

Performance of E/M Service

No specific criteria in CPT® for a 99211 (eg. level of history, exam or medical decision making).

Face-to-face encounter with the auxiliary personnel and the patient consisting of both ‘evaluation and management’.
Performance of E/M Service

According to Wisconsin Physicians Service (WPS), the “evaluation portion of CPT 99211 is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information (historical information and/or physical data) between the provider and the patient.” (Evaluation & Management presentation 2004)

Performance of E/M Service

According to WPS, the “management portion of CPT 99211 is substantiated when the record demonstrates an influence on patient care (medical decision-making, provision of patient education, etc.).”
Direct Supervision

“Direct supervision in the office setting does not mean that the physician must be present in the same room with his/her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing the services.”

Direct Supervision – What it is.

Physician readily available in the office suite seeing patients in an adjacent exam room.

There must be a specific physician responsible for the supervision of the billed service.
Direct Supervision – What it isn’t

Physician doing rounds at the hospital and the auxiliary staff performing the service in the office.

Physician having lunch downtown and is available by phone.

Supervising Physician

The physician who performed the initial assessment and initiated the course of treatment does not need to be the physician supervising the incident-to service.
Documentation

The medical record must be adequately documented to reflect the reason for the patient’s visit and any treatment rendered.

The medical record must include elements of history obtained, examination performed and/or clinical decision making.

The medical record must support physician supervision.

What isn’t Incident-to?

Code 99211 should not be used if the sole purpose is:

- Giving patient an injection
- Drawing blood, venipuncture (*INR clinic*)
- Writing a prescription renewal
- Making telephone calls
Example:

Subjective: Patient Prevea is here today for follow up after starting on OCPs. Patient Prevea was seen on 1-26-2006 by Kerin Draak, NP, and given samples of Ovcon 35 to regulate her cycles and control dysmenorrhea. She had been instructed to return in 3 months for evaluation of BP and any possible side effects. Pt seen under the direct supervision of Dr. Prevea. Pt denies any problems with the pill and her cycles have been every 28 days with moderate flow and her cramps have much improved.

Example:

Objective: BP 124/78, Pulse 66
Assessment: Irregular cycle and dysmenorrhea well controlled with OCPS.
Plan: Per Kerin Draak’s POC, pt may continue with Ovcon 35 and a Rx was faxed to Osco for 9 months. Pt advised to schedule a yearly exam in 9 months.

Signed by ancillary staff and supervising MD
A split/shared E/M visit is defined by Medicare Part B payment policy as 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 same patient on the same date of service.

Inappropriate Documentation

- “I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM and agree with the assessment and plan as written” signed by the physician.
- "Patient seen" signed by the physician.
- "Seen and examined" signed by the physician.
- "Seen and examined and agree with above" (or "agree with plan") signed by the physician.
- "As above" signed by the physician.
- Documentation by the NPP stating "The patient was seen and examined by myself and Dr. X., who agrees with the plan" with a co-sign of the note by Dr. X.
- No comment at all by the physician, or only a physician signature at the end of the note.
Split/Shared Care

The physician and the qualified NPP must be in the same group practice or be employed by the same employer.

Split/Share Care: Location

The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes).

The split/shared E/M policy does not apply to consultation services, critical care services or procedures.
Split/Shared Care: Office

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. If “incident-to” requirements are not met for the shared/split E/M service, the service must be billed under the NPP’s UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

Split/Shared Care: Hospital/Outpatient/Emergency Dept

When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s UPIN/PIN.
Examples of Split/Shared Care

If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.

Examples of Split/Shared Care

In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the “incident to” requirements are not met, the service must be reported using the NPP’s UPIN/PIN.
Split/Shared Care: Critical Care

Critical Care CANNOT be performed as a split/shared care service.

The critical care service reported should reflect the evaluation, treatment and management of the patient by the individual physician or qualified non-physician practitioner and not representative of a combined service between a physician and a qualified NPP.

Split/Shared Care: Consultation

A consultation CANNOT be performed as a split/shared care service.
Split/Shared Care: SNF

An E/M visit in the SNF/NF setting CANNOT be performed as a split/shared care service.

Summary

Incident-to are split/shared care are NOT the same thing.
Watch the location.
Heed the supervision rules.
References

http://oig.hhs.gov/oei/reports/oei-09-06-00430.pdf