Steps to Follow When Auditing for Incident-To Services

The biggest challenge I find when auditing claims to determine if they follow Medicare's incident to billing rules is that, unlike most audits, I need to look in multiple places to determine whether or not the service is allowed as an incident to service or must be billed under the midlevel provider.

These places include the claim being audited, potentially two years of claims history for the patient, and the provider's schedule.

A quick reminder that incident to rules are addressed in Pub. 15. Ch. 60.1 of Medicare's Benefit Policy Manual in the Internet Only Manual, located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf. While these rules apply to supplies and services, I'm focused today on E/M services.

Basically, I know that for any one of the categories addressed below, a certain finding means the service can't be billed as an incident to service and must be directly billed by the midlevel provider. As a result, I start with the current claim and work backwards through previous claims, and ultimately the supervising provider's schedule.

Remember that the supervising physician is the one who was in the office suite and ready to assist that service, not the physician who created the plan of care initially. Here's the o

1. **Acute problem addressed:** Each condition treated during an incident to visit must have a documented plan of care created by a physician. As a result, if I see treatment of an acute problem on the initial claim, I know it's not a proper incident to service and I can stop there.
2. **Changes to any potential plan of care:** When treating a chronic condition, or a condition previously known to the practice, the non-physician practitioner may not do anything that would deviate from a plan of care. This includes such actions as changes to a dose level for a prescription, issuing or stopping a prescription drug, directing the patient to make changes to his or her diet or lifestyle that deviate from the previous plan of care, or the provision of procedures or other services to alleviate any area of the condition that have not been previously addressed within the plan of care for the condition. When any of these factors were found, I don't need to look at old claims because the service is not supported as an incident to claim.
3. **Existence of and adherence to the plan of care:** Here's where the heavy lifting starts.When the documentation made no changes to the patient's established regimen for conditions known to the practice, I look at at least eight previous encounters, or go back a maximum of two years, to find a physician documented plan of care for each condition in the current encounter. When a plan of care could not be located, or there was no evidence of physician participation for more

than eight (8) encounters or two calendar years, I stop there. While these are not CMS parameters, the CMS guidelines require active participation by the physician in the management of the patient, and I don't think more than eight encounters or two years without a documented visit reflects active management.

4. **Schedule verification:** When I've got all of that, my last stop is to review the schedule to ensure the supervising provider was on site that day.

If all four steps are met to my satisfaction, I feel confident supporting an incident-to service. Because of the compliance risks and challenges, I just recommend that mid-level providers bill Medicare services directly for the 15% lower payment.

This Week's Tip Provided By:

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