AUDITING & COMPLIANCE TIP

Incident-to Billing
Medicare's unique "incident-to" billing rules allow for a non-physician practitioner (NPP) to treat a patient for established problems and for the service to be billed to Medicare under the physician's National Provider Identifier (NPI), which means payment at 100 percent of the fee schedule rate rather than 85 percent, which an NPP would receive for billing the same service directly.

This 15 percent boost in payment is certainly tempting, but incident-to billing comes with strict rules that both the physician and NPP must follow. As an auditor, be prepared to dig deeply into the patient's medical record to determine whether you can support these services.

Remember that incident-to billing can only occur in the physician office setting (place of service 11). All other places of service, including provider-based clinics that bill under place of service 22 (outpatient hospital) are covered by split/shared billing, which we will address in a future audit tip.

Key requirements:
Medicare's incident-to billing policy, established in Pub. 100-04, Ch. 12, Sec. 30.6.12 of the Medicare Claims Processing Manual, establishes two key requirements for billing incident-to services.

First, a service may be billed incident-to only when the physician has already seen the patient face-to-face and established a written plan of care for the condition(s) being addressed by the NPP. The NPP must operate exclusively within the parameters of that plan of care.

Second, the NPP's service must be done under direct supervision, meaning that a physician must be in the office suite and available to immediately assist the NPP as needed. In a group practice, any of the group's physicians may satisfy this supervision requirement, not just the one who created the plan of care.

What you need to look for as an auditor
Unlike many audits, where you can go claim-by-claim to determine if each encounter supported the codes billed, auditing incident-to services requires the auditor to turn to multiple places, starting with the original claim.

Original claim:
When you review the claim billed as incident-to, make sure all the conditions being addressed in the note are established conditions known to the practice, in follow-up.

Any time you see a service billed as a new patient visit, or an acute condition described in the history of the present illness with a recent onset, you will know you have visits that cannot be billed incident-to. Such visits must be billed directly under the NPP's identifier because there is no plan of care in place for the new or acute conditions - unless, of course, the physician came in and created one during the encounter.

In cases where the NPP treats both an established condition under a plan of care as well as a new condition, any claim filed incident-to must exclude all of the history, exam and medical decision making related to the new, acute condition. This is more likely to be a scenario where the physician may be called in to establish a plan of care for the acute problem to enable the entire service to be billed incident-to.

Claims history:
When the original claim addresses only conditions known to the provider, the auditor must go back through the claims history to establish that a practice physician created a plan of care for each condition and that the NPP's treatment decisions are consistent with the parameters of the plan of care.

Many EHR systems allow the plan of care to be brought forward to the current note, though that does not always happen. If your review fails to establish that there is a plan of care created by the physician, or shows that the NPP's care deviates from the plan of care, then the NPP's work cannot be supported as an incident-to service and must be billed directly by the NPP.

The key to the plan of care is that Medicare does not offer a lot of specific guidance on the level of detail required. The physician can write a plan of care with vague instructions about keeping a patient's condition stable, including use of medication or other factors to stabilize the patient, giving the NPP wide latitude to make treatment decisions.

When the plan of care is highly specific, the NPP is bound to operate within those specific statements to support incident-to billing.

Beware the absent doctor
One of the key and often neglected components of Medicare's incident-to policy is that the physician must remain active and engaged in the care of the patient. Unfortunately, CMS provides little guidance on how to define "active engagement."

As an auditor, you want your office to establish specific parameters for defining regular physician engagement. DoctorsManagement recommends that the patient always be scheduled to be seen by the physician at least once every three to five visits.

This ensures the patient's chart and documentation reflects the physician's ongoing review and modification of the plan of care, as warranted by changes to the patient's condition.

A plan of care that is more than two years old is not likely to reflect active engagement and involvement in the patient's condition, when all that has followed in the patient's record is a series of encounters with the NPP.

Today's tip provided by:

Scott Kraft, CPC, CPMA
Scott Kraft is a medical auditor who works as part of our NAMAS Team, as well as our parent company DoctorsManagement, LLC. Scott is based out of Portland, OR and incidentally just qualified for the Boston Marathon. Congratulations Scott!

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