



ATTN: ALL PROVIDERS

Incident-To Billing Updates

Incident-To billing is a way of billing outpatient services (rendered in a physician's office with Place of Service (POS) 11, or patient home POS: 12) performed by a Non-Physician Practitioner (NPP) such as a Nurse Practitioner (NP), Physician Assistant (PA), or other non-physician providers employed by the billing physician indicating the physician was the **rendering** provider on the claim, see CMS 1500 field (box) # 24G or EMC equivalent.

"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. Under Medicare rules, covered services provided/performed by non-physician practitioners (NPPs) are reimbursed at a reduced rate (85% of the fee schedule amount). The "Incident-To" billing rules provide an exception, allowing 100% physician reimbursement for non-physician performed services that meet the Medicare Incident-To Billing Guideline* requirements (later in this blast). Keep in mind that Incident-To billing guidelines were developed by Medicare, and other insurance carriers do not necessarily follow Medicare's lead.

Physicians often believe that by talking to the NPP and reviewing/signing off on the medical records at a later date, that they are following Incident-To Billing Guidelines. However, simply reviewing/signing off on the medical records without being present in the office suite and available during the time of the encounter, i.e., **direct supervision**, will not pass review should charges come under an audit.

The Office of Inspector General (OIG) recently settled with a Texas provider who was not following the guideline for **direct supervision of the NPP for Incident-To billing** (from *Part B News*, June 10, 2019 issue).

Some quick tips to remember when billing Incident-To:

- Billing physician (or his/her physician same specialty partner) must have had a prior visit with the patient and developed a Plan of Care (POC)
- If the POC changes - Incident-To billing cannot be used
 - To bill Incident-To – the NPPs must see established patients
 - If the plan of care changes the billing MD must see the patient to continue future Incident-To billing
 - Deviation from the MD documented POC (with no MD intervention) will result in the NPP billing for the visit, i.e., not Incident-To billing
- Watch documentation including signatures
 - When auditing medical records the presence of two provider signatures can raise alarm bells regarding the nature of the visit
 - Without documentation, the second signature could be a clear sign to auditors that MD providers are claiming Incident-To billing solely to reap 100% of the fee schedule
 - Within the documentation it must be clear that the NPP is within the scope of an MD's previously documented plan of care and the additional statement about the scope of care has to come from the billing MD
- Pay attention to the billing MD's physical presence – must meet Direct Supervision
 - The providers presence must be within the confines of the office suite during the time of the patient encounter that is being reported



- Example – The provider is rounding at the hospital and the clinic is attached to the hospital... this type of physical separation is a clear breach; if a billing MD reports an inpatient E&M at the same time the NPP (under Incident-To) reports an outpatient E&M this is a clear indication to an auditor that Incident-To billing guidelines are not being followed
- Make a business decision
 - Bill 'Incident-To' and follow the rules/guidelines or take a cut on payments for NPP services

Incident-To Billing Guidelines:

There are six basic requirements to meet the Incident-To guidelines for Medicare payment:

1. The service must take place in a “noninstitutional setting”, i.e., outpatient physician’s office
2. A Medicare-credentialed physician must initiate a patient’s care. If the patient has a new or worsened complaint, a physician must conduct an initial evaluation and management (E&M) for that complaint, and must establish the diagnosis and plan of care. Incident-To services cannot be rendered on the patient’s first visit, or if a change to the plan of care (e.g., medication adjustment) is required.
3. Subsequent to the initial encounter (during which the physician arrives at a diagnosis and plan of care), an NPP may provide follow-up care. This care must occur under the “**direct supervision**” of a qualified physician/provider. (**Direct supervision generally means the supervising (physician) is to be physically present, or within an immediate distance, such as on the same floor, and available to respond to the needs of something or someone.**)
4. A physician must actively participate in and manage the patient’s course of treatment. The exact requirement is usually defined by the state licensure rules for physician supervision of NPPs (e.g., the physician must see the patient as agreed upon in the Collaborative Practice Agreement).
5. Both the credentialed physician and the qualified NPP providing the Incident-To service must be employed by the group billing for the service (if the physician is a sole practitioner, the physician must employ the NPP).
6. The Incident-To service must be the type of service usually performed in the office setting, and must be part of the normal course of treatment of a diagnosis or illness.



Documentation should detail who performed the service, and that a supervising physician was in the office suite (although not necessarily the same room), at the time of the service.

Things to Remember when billing Incident-To:

The **initial** problem-focused patient visit (CPT codes 99201-99205) cannot be a “split or shared” (visit) between the NPP and physician. In order to bill follow-up visits under Incident-To, the physician must independently see the patient initially and establish a plan of care for the condition.

When an NPP sees a patient for a **new problem or a deviation from the physician established place of care**, the NPP will need to bill under his/her own NPI. Incident-To billing guidelines do not allow an NPP to bill Incident-To a physician’s services (i.e., under the physician’s NPI) when a new problem is addressed. This could happen in a situation when the patient was scheduled to be seen for an established problem but brings up a new problem during the course of the visit.

For Incident-To services to continue to be billed, Medicare has stipulated that the physician must perform subsequent services that reflect his/her continued active participation in the management of the patient’s care. A specific time frame of physician involvement and management is not stipulated but is left to the physician’s medical judgment based on the patient’s condition and needs.

When billing Incident-To services, the claim should be submitted as though the physician personally performed the service, i.e., MD is the billing/rendering provider (physician NPI in CMS 1500 field (box) 24G). Therefore, the NPP is not listed on the claim form.

***** IMPORTANT NOTICE *****



When an NPP sees a **new** patient, the NPP NPI will display in CMS 1500 field (box) 24G or EMC equivalent.

CAUTION: In a multi-specialty group if the NPP bills a new patient under the NPP's NPI, the 'New Patient' visit is used up, i.e., no other specialty can bill as a New Patient visit for 3 years.

***** REMINDERS *****

LA Medicaid and MCO/BHP plans have never allowed Incident-To billing for NPPs, i.e., NPs or PAs.

Effective **June 1, 2019**, Blue Cross Blue Shield (BCBS) will no longer allow providers to bill under the Incident-To billing guidelines if Blue Cross offers network participation for the performing provider type.

For BCBS, providers must meet the following requirements in order to bill a **split/shared visit** under the physician's provider number (see *BCBS Provider Network News*, 2nd Quarter 2019 issue):

- The physician must provide a face-to-face visit with the patient (*for all places of service*).
- The physician **must document in a separate note at least one element of each of the following components of the evaluation & management service: history, exam and medical decision making.**
 - It is not sufficient for the physician to countersign the medical record or document "seen and agree." The physician must document which aspect of the visit they personally performed for each of the components in a separate note.
- The physician must justify their involvement in the patient care by legibly signing the medical record.

Resources:

MDS Evaluation and Management (E&M) General Information Guide

https://www.medtronsoftware.com/User Guides/E&M_Resources/E&M_Information_Packet_General.pdf

Medicare Claims Processing Manual, Chapter 12, Section 30.6.1 (Selection of Level of Evaluation and Management Service) and Section 30.6.4 (Evaluation and Management (E/M) Services Furnished Incident-To Physician's Service by Nonphysician Practitioners)

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html>

Medicare Benefit Policy Manual, Chapter 15, Section 60 (Services and Supplies Furnished Incident-To a Physician's/NPP's Professional Service); and Chapter 6, Section 20.5.2 (Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After January 1, 2010)

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html>

Louisiana Administrative Code, Professional and Occupational Standards

<https://www.doa.la.gov/Pages/osr/LAC-46.aspx>

MLN SE0441 – Incident-To Services

<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se0441.pdf>

Incident-To billing: Clearing up the confusion

<https://www.medicaleconomics.com/personal-finance/incident-billing-clearing-confusion>

News Blast – 053119 Incident-To Billing – BCBS Updates

https://www.medtronsoftware.com/pdf/2019/053119_Incident_To_Billing_Updates.pdf

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-OR-

Phone: (985) 234-0599 (local), (800) 978-0599 (toll free)

-OR-

Fax: (985) 234-0609