

## “Incident To” – Not Incidental to Your Practice

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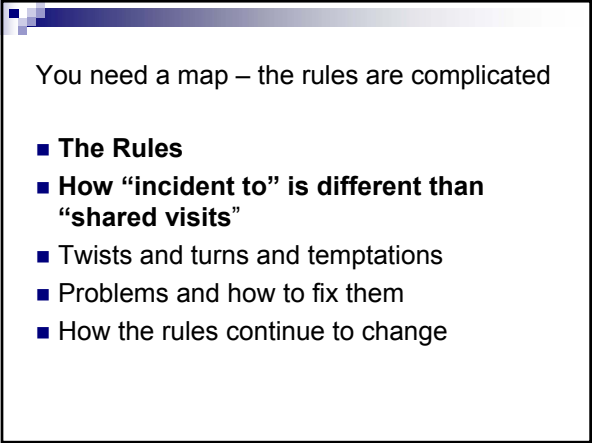
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You need a map – the rules are complicated

- **The Rules**
- **How “incident to” is different than “shared visits”**
- Twists and turns and temptations
- Problems and how to fix them
- How the rules continue to change

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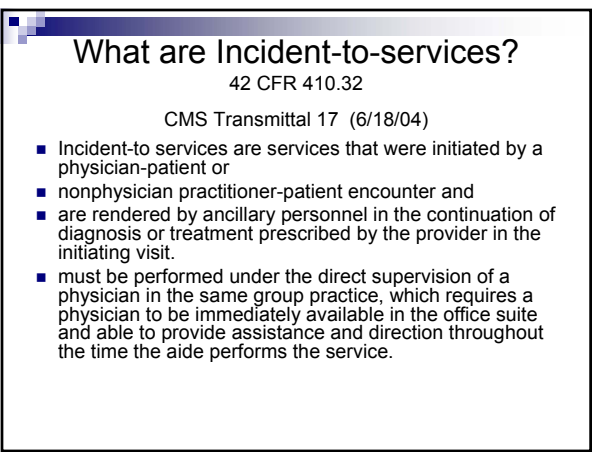
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### What are Incident-to-services?

42 CFR 410.32

CMS Transmittal 17 (6/18/04)

- Incident-to services are services that were initiated by a physician-patient or nonphysician practitioner-patient encounter and
- are rendered by ancillary personnel in the continuation of diagnosis or treatment prescribed by the provider in the initiating visit.
- must be performed under the direct supervision of a physician in the same group practice, which requires a physician to be immediately available in the office suite and able to provide assistance and direction throughout the time the aide performs the service.

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## Application Scenarios

### 60.1 Incident to Physician's Professional Services:

- Commonly Furnished in Physician's Offices
- Direct Personal Supervision

### 60.2 Services of NonMD Pers. Furnished Incident to Physician Services

### 60.3 Incident to Physician's Service in Clinic

### 60.4 Services Incident to Physician's Service to Homebound Patients Under General Physician Supervision

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## The "Incident To" - History

- "Expression of Art" in Medicare
- **THEN:** Origins in the sole practitioner – 1960's
  - with a support person
- Growth of array of non physician providers - to drive down cost and still meet patient needs
- **NOW:** MD's don't necessarily see the patient every visit. Best care to meet patient needs.

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## The Classic Requirements

- Facility must be non hospital based clinic
- Non physician provider must be employee or leased back – must be able to terminate and direct
- Established patient for a problem for which the physician has a documented plan of care
- The physician must be present in clinic (the "office suite") at time of service.
- Physician will continue to follow care and periodically see patient –
  - Key concept in determining frequency is "Active Involvement"

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## The NEW Requirement

- CMS Manual System – Transmittal 17, June 18, 2004 **Effective date October 4, 2004**
- **Must now report on the claim:**
  - The ordering physician information
  - The supervising physician information
- **Must be a physician from same practice and for you need to know who actually rendered the service**

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## “Shared Visits”

Shared Visits are NOT the same as incident to

- “Shared Visit” – **Inpatient and Hospital Based-** the NPP and the Physician can combine services/documentation to support service . Physician must see and evaluate the patient and review NPP note (and clearly reference it.)

**THIS IS FOR HOSPITAL AND HOSPITAL BASED SERVICES ONLY!!!**

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## A short history of “shared visits”

- MCM Transmittal 1725, September 27, 2001 split services into two unlisted claims
  - generated a ton of paperwork, didn't work well
  - Replaced by*
- MCM Transmittal 1776, October 25, 2002

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## Shared Visits

### HOSPITAL

- Apply to Evaluation and Management services ONLY
- Physician must SEE and EVALUATE the patient
- Procedures cannot be “shared”

### OUTPATIENT CLINIC

- Incident To
  - Can apply to procedures

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## Headaches for NPP’s

### ■ Provider Status CHANGES with:

- Site of service–
  - ARNP/PA moves from a provider in the inpatient setting to either a ancillary provider OR a provider in the outpatient setting
- Type of service:
  - Incident to Rules not met: If ARNP/PA does more than ROS/PFSH of history for NEW, CONSULTATION, or NEW PROBLEM for Established Pt., then submit service in ARNP/PA billing number at 85%
  - Incident to Rules are met : Bill in Physician information at 100%

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## “Incident to” Headaches

### ■ Established Patient – are you sure it is a problem for which a plan of care has been established?

- Some conditions such as diabetes and other chronic conditions and oncology patients could have a very broad scope.

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### “Incident to” Headaches (cont)

- Billing
  - Can combine physician and NPP times and bill in physician’s name when “incident to” is met and bill at 100% (physician’s number).
  - Cannot combine physician and NPP times for critical care services.
  - Can bill on physician’s time alone for New patient or Consultation in outpatient Setting (or an Established patient with a new problem)

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### “Incident to” Headaches (cont)

- These are all rules specific to Medicare
  - Frequently commercial payors allow the combining of NPP/MD services for new patients and consultations in outpatient arena.
  - Conflicting rules require careful edits and screening on the back end to make sure compliant with payors requirements.

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### Temptations to Resist

- I was using my NPP as a scribe...
- The NPP only did ....  
Since Outpatient new visits, consultations and new problems do not permit shared billing – participation outside PFSH and ROS means billing in NPP provider number (unless only billing on physician’s time or note.)
- Hospital/ Shared visit? Employees on the Cost Report...

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## Auditing and Monitoring

- Periodically review medical records where "incident to" applicable
  - Audit
    - Probe
    - Retrospective
    - concurrent and/or
    - prospective
  - Volume of total claims submitted in time period reviewing will determine method
  - What payors will be included
- Repay any \$\$'s owed from erroneous submissions
  - Go to lowest level of authority first, ie: Carrier, FI, commercial payor (depending on the sample)
- Fix the problem with:
  - Education of physician practice
  - Education of Allied Health Practitioners
  - Peer Reviews on an ongoing basis
  - Develop QA process, ie: self reviews, check lists (real time), etc.

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## How to Fix Problems

- The NPP in an Outpatient Setting sees the patient and "incident to" is not met
  - Must either bill at 85% in NPP name
  - Or Physician must fully document the service and not use any of NPP documentation except ROS and PFSH.

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## Repayment

- Refund the 15%
  - Case by Case
  - Or a lump sum
- Or refund and rebill.

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### It's not in the Carrier Manual - yet

- Consultations and Critical Care cannot be shared services anywhere (inpt or outpt)
- Recommendations: Work actively toward the requirement of the person in whose name the service is submitted be the individual to formulate the opinion to the requesting provider.

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### Why It's Important

- **Federal Enforcement**
- **Money**
  - Non-physician Practitioners (NPP's) bill at 85% of the Physician Fee Schedule
- **Trend** toward use of NPP's

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### CMS Contact Person

Cathleen "Kit" Scally  
Centers for Medicare and Medicaid  
Services Baltimore, Maryland  
Phone 410-786-5714  
Email [cscally@cms.hhs.gov](mailto:cscally@cms.hhs.gov)

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### Additional email references

- <http://www.cms.hhs.gov/manuals/cmsindex.asp>
- [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp)
- [http://www.cms.hhs.gov/manuals/transmittals/comm\\_data\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_data_dsc.asp)
- <http://www.cms.hhs.gov/medlearn/tollnums.asp>
- <http://www.cms.hhs.gov/medicaid/tollfree.pdf>

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### Looking to the Future

How do we encourage the federal government to link the best clinical outcomes to billing practices?

Can it be demonstrated that combined services in the outpatient arena improve care and reduce costs long term?

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