Incident to Causing an Incident?

Presented by: Medical Auditing Solutions, LLC

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Learning Objectives

- Participants attending this program will be able to 1) review the requirements to bill midlevel providers under the physician, 2) review some processes to implement to ensure compliance, 3) review potential problems when incident to is billed incorrectly

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Pre-Test

- The Midlevel must be credentialed with Medicare to bill incident to? True or False
- Incident to is only recognized by Medicare? True or False
- If the physician sees the patient initially for diabetes, but the patient returns for respiratory infection the subsequent service may be billed incident to? True or False
- An effective monitoring process can reduce billing errors? True or False
- An office should only have one process in place to monitor ? True or False

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Introduction

- With the ever-changing health care rules and policies, it is increasingly important someone stay on top of the rules
- We will discuss the vast rules related to “incident to” as it relates to medicare primarily, but notes on Medicaid and commercial payers also.
  - Each state has different rules regarding supervision
  - Remember, the most stringent takes precendence
    - Medicare and payers are more stringent
  - just know that Medicare has a comment period open on defaulting to state rules

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Introduction

- A successful monitoring process will help the practice avoid violating many federal and state laws related to “incident to” billing requirements.
- All payers have different requirements as do the state scope of practice for the providers.

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Introduction

- As health

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Introduction

- All health

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Definition

- "Incident to" for Medicare and most payers
- Is when the physician in the practice sees the patients for noted disease states, creates a Plan of Care (POC), and
- Is seen by a midlevel provider (MLP) on established patient visits (subsequent follow-up) on the same disease states in the POC, and

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Definition

- The MLP must be credentialed with the payer, including Medicare at the time the services are provided.
- The physician is in the suite during follow-up, and
- The service is within their scope of practice

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Definition

- Most payers that recognize “incident to” follow Medicare rules.
  - Texas Medicaid – the physician must see the patient every visit to bill “incident to”
  - Critical to pull all payer policies

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Type of Practice using MLP

- Most practices have some midlevel providers
  - Specialist
  - PCP, Internal Med, Multispecialty
- However, I only recommend billing "incident to" in specialty practices ie Sleep, Cardiology, Neurology, etc. where the patient is seen for the same condition repeatedly for monitoring progression

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Type of Practice using MLP with Greater Risk

- Primary Care, Internal Med, and MultiSpecialty Practices use MLP
- RISK is Dr. A sees patient for COPD, then follow up appointment is for sinus infection sees MLP B
  - The EMR (Electronic Medical Records/Billing) software is not sophisticated enough to track this
  - The risk for false, fraudulent claims or just full recoup outweighs the 8-15% reduce for billing under MLP

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Type of Practice using MLP with Greater Risk

- RISK is Dr. A sees patient for COPD, then follow up appointment is for sinus infection sees MLP B
  - Additionally risk, if the payer recoups after the timely filing period you cannot refile a corrected claim
  - The cost of monitoring could outweigh the benefit of collecting the additional 8-15% as well.

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Who is considered a MidLevel Provider?

- Physician Assistant (PA, PAC)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Certified Nurse Mid-wife (CNM)

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Who is **NOT** a MLP?

- States may allow General Supervision by phone; payers do not allow this to bill incident to the physician.
- Register or License Practical Nurses
  - Shots and minimal visit that doesn't require MLP involvement can be billed as 99211
    - This may apply to Medical Assistants but must check state scope of practice for shots like allergy of vaccines.
    - Neither would apply to cortisone or pain injections and similar.
- SPO Therapist, certificate type providers

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Who is **NOT** a MLP?

- Medical Assistants
- Massage Therapist, not all inclusive

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Other Services Incident To physician/MLP

- Speech and other therapy can be provided in the suite, “incident to” the provider (physician/MLP) for Medicare, but
- The person performing the service must be licensed as that type of therapist
- The provider cannot train a Medical Assistant or Massage Therapist to do the therapy and it be billed, period.
- The person must be qualified by policy.

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Other Services Incident To physician/MLP

- The ordering provider who developed the POC must be in the suite during the therapy visit
  - Check payer and state policies for specific
  - Most stringent applies
- Again, risky but could be done with appropriate monitoring to prevent erroneous billing

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New Patients

- New patients or New Conditions
- Must be seen by the physician
- With follow-up by MLP

- Note: It is risky to bill incident to in a multispecialty or primary type practice.

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Established Patients

- These are the only patients that “incident to” applies
- As mentioned, it must be for the same disease/condition the physician developed the POC

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Monitoring

- This is a much more difficult topic to a complicated process…..
- As I have said EMRs don't track POC by disease states and subsequent visits.
- You would have to create a "POC" Template/Note that would be amended periodically to note:
  - POC – COPD 1/20/20 by physician
  - POC-ESRD 2/14/17 by MLP
  - POC-Chronic Asthma 6/21/16 by physician

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Monitoring

- POC Note would need to be reviewed each visit by the provider then by the QA billing staff prior to billing.
- EMR might be able to setup a custom edit, that New patients hold if billed under physician. Ask EMR vendor.

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Monitoring

- Use the system to your advantage and create a POC Note for date and provider that can easily be reviewed.
  - No, the system is not designed to do that
  - If the system requires a template to have a charge attached do it at zero or .01 charge attached to it
    - Use a Code no one will accept X1234, for example
  - Otherwise, the daily schedule will need to be audited by billing prior to releasing claims for patients seen by MLP.

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Monitoring

- If you have paper superbills, those will need to be audited for rendering provider to code billed and POC.
- There is no easy way to do this, which results in high risk for small reward.

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Reduction Rates on Physician Allowable

- Medicare - 15%
- Commercial Plans – 12-15%
- Texas Medicaid - 8%

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Incident to DOES NOT APPLY TO

- E&M services provided in a hospital or nursing home
- Incident to applies to E&M and limited procedure codes, not lab draws, vaccines, etc. Those are billed by rendering provided and reimbursed based on a fee schedule for the practice not the provider
  - As long as provider is credentialed, and
  - The service/action is within scope of practice

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Risk for Billing Incorrectly

- If internally discovered and addressed, Novitas in my experience has accepted the partial refund (the delta between full physician allowable and the 15% reduction) without penalties
- If discovered by the payer:
  - Full Overpayment
  - In ability to submit corrected claims on some or all
  - False or Fraudulent Claims Penalties

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Risk for Billing Incorrectly

- If discovered by the payer:
  - False or Fraudulent Claims Penalties
    - Especially, if someone informed you it was happening, and nothing was done
    - Also, unfortunately, healthcare seems to be guilty until proven innocent….
  - At this point, the risk of OIG, DOJ, and other agencies getting involved is high.
- This is why I stress, weighing the cost of monitoring to the risk

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Conclusion

- Know the state scope of practice
- Keep current on all payer requirements
- Weigh the risk and cost of monitoring to the reduction in payment
- Ensure there are tight auditing protocols to prevent erroneous billing
- Know the EMR software only knows what you put into it, it is not a good tool to track POC and related incident to billing

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Conclusion

- Know the risk for billing incorrectly
- Suggest having an outside auditor monitor at least twice a year. This is more labor intensive than coding because the provider schedules need to be reviewed to the charges plus looking for new patient visits and diagnosis to meet incident to.
  - Again, this adds to the cost to monitor (even if your staff does this)

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Post Test

- The Midlevel must be credentialed with Medicare to bill incident to? True or False
  - This also applies to Most NOT all payers
  - Texas Medicaid the physician must participate every visit to bill incident to
  - Some payers like CIGNA (in Texas) won't credential midlevel providers and thus must bill under the physician
  - Aetna the providers must be submitted on a list to the payer, not exactly credentialing but a prior notification if you will when they are not credentialed. Needs to be done prior to submitting the claims.

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Post Test

- Incident to is only recognized by Medicare? True or False
  - Many payer recognize the process, although it may not be called "Incident to"
  - You must read your contract and contact provider enrollment prior to starting this process in your office
  - Providers or their staff often start without investigating and end up in overpayment situations

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Post Test

- If the physician sees the patient initially for diabetes, but the patient returns for respiratory infection the subsequent service may be billed incident to? True or False
  - The physician must develop the care plan per diagnosis, so this is false
  - I would only recommend incident to for a specialty practice
  - There is no easy way in the software to track the physician saw the patient for the diagnosis presenting today
  - This requires numerous processes to track before billing

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Post Test

- An effective monitoring process can reduce billing errors? True or False
  - A monitoring process that is consistent and used regularly will reduce billing errors for incident to as well as other billing issues
- An office should only have one process in place to monitor ? True or False
  - Multiple monitoring processes are needed for all medical practices
  - The rules are ever changing and need staff to be on list servs and incorporate audit issues and rule changes into the practice auditing and monitoring processes.

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Post Test

- An office should only have one process in place to monitor ? True or False
  - There is no easy fool proof way to monitor incident to that is not labor intensive.
  - It can be done, the systems just aren't built for this complicated process.

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- Split/Shared time IOM
  - Incident To: Pub. 100-02, Chapter 15, § 60.1. B, 60.2
  - Split/Shared E/M Services: Pub. 100-04, Chapter 12, § 30.6.1 B and 30.6.13H