NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

AUDITING INCIDENT-TO & SPLIT/SHARED SERVICES

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CEU INFORMATION

POST SUPLEMENTAL CEU POLICY

All NAMAS Member Webinars are approved for 2 CEUs based on the post supplemental CEU policy by the AAPC. Sessions in which the 2 CEUs are available are those that are initiated within 2 (two) weeks of the initial LIVE broadcast session which is 1 (one) CEU for attending the event and 1 (one) additional CEU for passing the supplemental quiz.

In order to receive this additional CEU the policy indicates that the attendee must take a related quiz and pass with a score of 70% or better in order to earn the additional CEU. If the minimal quiz score is not reached, the attendee may retake the quiz.

THE QUIZ IS AVAILABLE IN THE MEMBERS ONLY SECTION OF THE WEBSITE

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2014 NAMAS NATIONAL CONFERENCE

Biltmore Christmas Tour and Dinner Tickets are running out!

Topics Include:

- The Art of Auditing
- 2015 Compliance & Auditing Updates
- Audit Risk Analysis
- Finding Efficiency in Auditing
- Myths, Misconceptions and Mistakes
- Auditing Incident-to
- New Exclusions Rules
- When to Self Disclose
- Random Sampling, Universe, & Extrapolation information

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- Shannon DeConda
- Robert Liles
- David Glaser
- Maggie Mac
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- Dr. James Dunnick
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- Sara San Pedro
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- David Zetter

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Today's Agenda

- Define incident-to services
- Define split/shared services
- Place of service clarifications
- General requirements
- Documentation expectations for auditing purposes
- Scenarios

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INCIDENT-TO SERVICES

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INCIDENT-TO SERVICES

- *Incident to a physician's professional service means that the services are furnished as an integral, although incidental part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness*
- Billing for services performed by staff under the providers billing information
  - Ancillary personnel- to be reimbursed for the work they perform
  - Extenders- to gain the additional reimbursement

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INCIDENT-TO SERVICES

- There are 2 fundamental types of incident-to services
  - Those performed by auxiliary personnel
  - Those performed by non-physician providers
- Ancillary personnel
  - 99211 services
  - Administration of injections
- Non-physician providers
  - Routine treatment of patients
  - Place of service varies on the rules
- Services and supplies having their own benefit category are not subject to incident to guidelines:
  - Vaccinations/immunizations
  - Venipuncture or clinical lab services
  - Radiology services and other services requiring a certain level of supervision as stated in the Medicare Physician Fee Schedule Data Base
  - Diabetes Self-Management Training

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INCIDENT-TO SERVICES

- Who Can Supervise "Incident To"?
  - Physicians
  - Non-physician practitioners (with some limitations)
  - Non-physician practitioners that are enrolled as Medicare providers may:
    - Submit claims under their own NPIs, or
    - Submit claims as "incident to" the physician, as long as all "incident to" criteria are met.
    - NPPs may also supervise "incident to" services, if the NPPs are also employed by the practice.

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INCIDENT-TO SERVICES

- Part B Billing (e.g., office) services must be:
  - An integral, although incidental, part of the physician's professional service
  - Of a type that are commonly furnished in a physician's offices or clinics
  - Furnished by the physician or ancillary personnel under the physician's direct supervision
- Incident to services include not only evaluation and management (E/M) services, but can also include:
  - Minor surgeries
  - Chemotherapy administration
  - Applying and removing casts
  - Professional component of radiology services

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INCIDENT-TO SERVICES

- Services meet the description of incident-to services when they are:
  - MD/DO or NPP (when ancillary personnel are working incident-to the NPP) performed a previous evaluation and management (E/M) service and determined the patient's diagnosis and the plan of care (POC)
  - MD/DO or NPP (when ancillary personnel are working incident-to the NPP) performs subsequent services of a frequency which reflects his/her active participation in and management of the course of treatment
    - Determination of the frequency of subsequent visits should be medically appropriate for the patient's condition
    - Increasing with the degree of instability and uncertainty of the situation
  - Medical record does not have to show that any subsequent services will be with a NPP or ancillary staff
  - Services cannot be billed as incident to for a new patient or a new problem
    - This guideline is not overridden by physician set "protocols" in the office

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INCIDENT-TO SERVICES

- Practitioner's Bill
  - Services and any supplies commonly furnished in the practitioner's office and considered part of the physician's normal charge
  - Services that represent an expense to the practitioner
  - Person providing the services is a/an:
    - Employee
    - Leased employee
    - Independent contractor of the practitioner or the legal entity employing the physician

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INCIDENT-TO SERVICES

- Requirements of Direct Supervision
  - The billing MD/DO or NPP must provide direct supervision
  - In the designated office area and immediately available to provide assistance and direction
  - The supervising practitioner does not need to see the patient each time an incident to service is provided
  - Practitioner has an office within an institution
    - "Office" must be a specific designated space, not the entire institution
  - Availability of the practitioner by telephone or the presence of the practitioner elsewhere in the institution does not meet direct supervision requirement
  - Physician must be "immediately" available to furnish assistance and direction
  - Not just emergency responses, but also to take over the performance of the service

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INCIDENT-TO SERVICES

- Supervision requirement is met in physician clinic situations when
  - There is a supervising physician responsible for the services performed by the NPPs and ancillary staff
  - Physician need not be the physician who determined the patient's plan of care
  - Does not have to be the same specialty as the originating physician, but do have to be members of the same group, using same tax ID number
  - Billing is under the supervising physician

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INCIDENT-TO SERVICES

- E/M Services
  - The billing MD/DO determines the POC
  - NPP or ancillary staff continue the treatment determined by the billing provider
  - Changes in the plan including changing a drug or the dosage of the same drug constitute a new POC
  - No longer meet the requirements for incident to
  - Services are billed under the NPP provider number

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INCIDENT-TO SERVICES

- Injections
  - When billing for a diagnostic or therapeutic injection, the requirements for incident to must be met
  - POC must show the correct drug, correct dosage, correct route and correct frequency
  - Same incident to rules apply when billing for chemotherapy
  - Medical record documentation for the specific date of service must show
  - Dosage given
  - Time involved
  - Name and signature of the person giving the drug
  - POC documentation showing the correct drug, correct dose, correct route and correct frequency as ordered
  - Injections as part of a diagnostic test can be submitted as incident to when all requirements are met
  - Document supervising practitioner's physical presence in the office setting

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INCIDENT-TO SERVICES

- Signature Requirements
  - For Medicare purposes, the MD/DO or NPP billing the service is not required to sign documentation prepared by the NPP or ancillary personnel
  - Signature of the person performing the service is required
  - Co-signing a note does not qualify the service as incident to; all requirements must be met
  - Incident to requirements for Medicare billing are separate and distinct from any facility or group rule requiring all services must be signed by the physician

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SPLIT/SHARED SERVICES

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SPLIT/SHARED SERVICES

- *A split/shared visit is a medically necessary encounter with a patient, where the physician and a qualified NPP each personally perform a substantive portion of an E&M visit face-to-face with the same patient on the same date of service*
- This service is NOT performed by ancillary personnel
- Services provided in an office setting
  - Must meet the incident to guidelines in **addition** to the split/shared guidelines
- Services provided in a facility setting
  - Do not have to meet the incident to guidelines, but do have to meet the split/shared guidelines

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SPLIT/SHARED SERVICES

- It is NOT sufficient for MD to note “seen and agree” or simply countersign; he/she must specifically document what he/she has personally done
- The following are NOT valid forms of documentation
  - "I have personally seen and examined the patient independently, reviewed the PA's History, exam and MDM and agree with the assessment and plan as written" signed by the physician
  - "Patient seen" signed by the physician
  - "Seen and examined" signed by the physician
  - "Seen and examined and agree with above (or agree with plan)" signed by the physician
  - "As above" signed by the physician
  - Documentation by the NPP stating "The patient was seen and examined by myself and Dr. X., who agrees with the plan" with a co-sign of the note by Dr. X
  - No comment at all by the physician, or only a physician signature at the end of the note

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SPLIT/SHARED SERVICES

- The medical record should clearly identify the part(s) of the E/M service which were personally provided by the physician, and which were provided by the NPP.
- In the absence of such documentation, the service may only be billed under the NPP's provider number per CMS IOM Publication 100-04, Chapter 12, Section 30.6.1 (B).
- This applies to the initial history and physical examination, the discharge summary, and subsequent hospital visits.

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SPLIT/SHARED SERVICES

- Signature Requirements
  - Office setting:
    - If the “incident to” guidelines met Physician must sign.
    - If “incident to” requirements are not met NPP provider must sign.
  - Hospital-based setting:
    - If the split/shared guidelines are met the billing provider (physician or NPP) must sign.

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DOCUMENTATION SPECIFICS

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DOCUMENTATION

The same E/M documentation guidelines for physicians are also applicable to and expected of NPP's.

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - The reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - Current assessment, clinical impression or diagnosis
  - Medical plan of care
  - Date and legible identity of the person providing the service.
- If not documented, the rationale for the ordering diagnostic and other ancillary services should be easily inferred.

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DOCUMENTATION

- Past and present diagnosis should be accessible to the treating and/consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
- The Current Procedural Terminology (CPT) and International Classification of Diseases, 9th Revision, Clinical
- Modification codes reported on the health insurance claim form or billing statement should be supported in the documentation in the medical record.

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PLACE & TYPE OF SERVICE SPECIFICS

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PLACE & TYPE OF SERVICE SPECIFICS

TYPE OF SERVICE	ALLOWED PLACE/TYPE OF SERVICE	NOT ALLOWED PLACE/TYPE OF SERVICE
INCIDENT-TO SERVICES	Office/clinic	Hospital Inpatient/Outpatient
	Patients home	Emergency Department
	Institution (nursing home)	SNF
	Office in SNF/NF/Hospital	Ambulance/EMT
TYPE OF SERVICE	**ALLOWED PLACE/TYPE OF SERVICE**	**NOT ALLOWED PLACE/TYPE OF SERVICE**
SPLIT/SHARED SERVICES	Office/clinic	SNF/NF Setting
	Hospital Inpatient/Outpatient	Consultation Services
	Emergency Department	Critical Care Services
	Hospital Observation	Procedures
	Hospital Discharge	Patients Home/Domiciliary

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OFFICE SERVICES

TYPE OF ENCOUNTER	INCIDENT-TO SERVICE	SPLIT/SHARED SERVICE
New Patient (99201-99205)	NOT ALLOWED	NOT ALLOWED
Established Patient (99211-99215)	Documentation of encounter being reviewed along with the visit that originate the current POC	Documentation by BOTH providers indicating their portion of the encounter AND signed by both *Also since incident-to must be met, the initial POC visit is also required
Consult Services (99241-99245)	NOT ALLOWED	NOT ALLOWED
Prolonged Services (99354-99359)	NOT ALLOWED	Documentation by BOTH providers indicating their portion of the encounter AND signed by both

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HOSPITAL BASED SERVICE SPECIFICS

TYPE OF ENCOUNTER	INCIDENT-TO SERVICE	SPLIT/SHARED SERVICE
IP Services (99217-99236)	NOT ALLOWED	Documentation by BOTH providers indicating their portion of the encounter AND signed by both
Emergency Department (99281-99285)	NOT ALLOWED	Documentation by BOTH providers indicating their portion of the encounter AND signed by both
Critical Care Services (99291-99292)	NOT ALLOWED	NOT ALLOWED

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FACILITY SERVICE

TYPE OF ENCOUNTER	INCIDENT-TO SERVICE	SPLIT/SHARED SERVICE
Initial NF Care (99304-99306) Initial Domiciliary (99324-99328) Initial Home Service (99341-99345)	NOT ALLOWED	NOT ALLOWED
Subsequent NF Care (99307-99310) Domiciliary/Rest Home (99324-99337) Subsequent Home Service (99347-99350)	ONLY services performed in designated "office" area Additionally, visit with original POC and current encounter documentation will be required for review	NOT ALLOWED
Care Plan Oversight Domiciliary/Rest Home (99339-99340)	NOT ALLOWED	NOT ALLOWED

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SCENARIOS

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SCENARIO #1

- Patient presents to the clinic for initial evaluation of low back pain. The physician has been called out to the ER for an emergent case, so the NP is going to see the patient. During the encounter, the NP obtains the history, examines the patient, orders x-rays, creates a plan of care that includes obtaining an MRI. The NP documents the encounter and signs the note. Upon returning to the office the physician reviews the chart and countersigns the note.

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Q & A

Patient presents to the clinic for initial evaluation of low back pain. The physician has been called out to the ER for an emergent case, so the NP is going to see the patient. During the encounter, the NP obtains the history, examines the patient, orders x-rays, creates a plan of care that includes obtaining an MRI. The NP documents the encounter and signs the note. Upon returning to the office the physician reviews the chart and countersigns the note.

In this scenario, is the attempt here to bill incident-to or a split/shared service?

Is the order for the MRI a valid order?

Is this service billable as an incident-to service?

What makes this encounter billable based on how it was performed?

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SCENARIO #2

- You are auditing a group of providers for the ED of the hospital. During the audit, you note that one of the charts, handwritten, appears to have two different styles of writing and is signed by a PA and an MD.

If the auditor can properly identify who performed which portions of the encounter, is this documentation adequate to represent a shared service?

If the documentation does not show the true separation of work, would the encounter be billable?

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MULTIPLE SCENARIOS

NP is called to the ER to consult a patient and the NP decides to admit the patient. Is this billable as incident-to?

Patient is discharged from OBS to home and the service is billed incident-to. Is this correct?

Patient presents to the office for repeat UA after treatment for UTI. Patient meets with lab tech, who performs and documents adequately the medical evaluation of the patient and performs the UA which is normal. Patient advised to return PRN. Is this visit billable under incident-to?

In a SNF a NP follows up on a patient that had a UTI. The encounter was billed incident-to, how would this be possible in a SNF?

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Need more resources on incident-to and split/shared services?

NAMAS and our parent company DoctorsManagement will release a new product by September 15, 2014

Resource Guide Will Include:

More information and clarity on incident-to and split/shared services

Specific examples and scenarios

Payer specific information

Contact Us at: namas@namas.co

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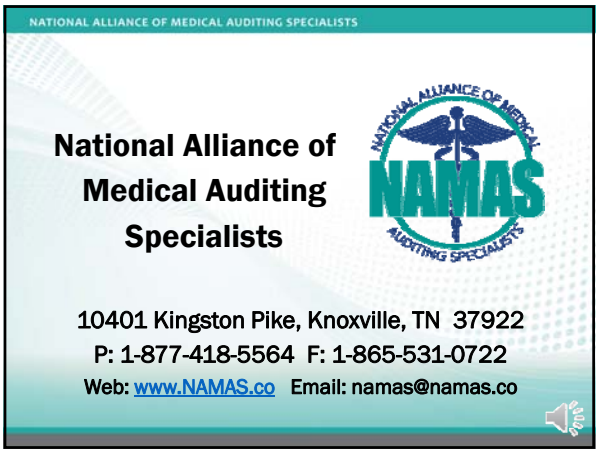
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