National Alliance of Medical Auditing Specialists (NAMAS)

Teaching Physicians and “Incident To”

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About Your Faculty

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What is “Incident To”?

• Medicare Benefit Policy Manual, Chapter 15, Section 60.1
  - This is a “Medicare only” term
  - “Incident to” a physician’s professional services 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.
What is “Integral”? 

- Per the Medicare definition, “incidental services” must be part of the physician’s personal services in the course of diagnosis or treatment of an injury or illness.
  
  - This means the physician has to perform an initial visit on each new patient to establish the physician-patient relationship.

Supervision 

- The Medicare term: “direct supervision.”
  
  - Not to be confused with “general” or “personal”
  
  - Present in the office suite and immediately available to provide assistance and direction throughout the time the ancillary staff or NPP is performing the “incident to” services.

Background 

- As reimbursement from Medicare and other third-party payers declined, physicians were faced with the task of using their time more productively and maximizing the resources of their practices.
  
  - As such, the use of “physician extenders” such as nurse practitioners and physician assistants became increasingly common in the practices of many physicians.
  
  - The “default” E/M code for billing “incident to” is 99211.
Nine Criteria That Must Be Met to Qualify For “Incident-To” Billing:

1. The patient treated by auxiliary staff must be an established patient of some physician and cannot be a new patient.
2. The physician must have seen the patient first and initiated the plan of care, including subsequent services by auxiliary staff.
3. It is recommended that the physician inform the patient that a qualified practitioner will be caring for the patient under the physician’s direction and monitoring.
4. Services provided and billed incident-to must be for office or home services and ordered by a physician. Incident-to billing does not apply to hospital inpatient, comprehensive outpatient rehabilitation facility or rehabilitation agency services.
5. The physician must be present on site, either in the office suite or in the patient’s home, during the time that the patient is seen and immediately available to provide assistance and direction when the qualified practitioner is performing services.
6. The physician must remain actively involved in the patient’s care and must periodically see the patient for the ongoing disease or illness. It is also recommended that the physician review the qualified practitioner’s chart notes in order to monitor treatment progress.
7. Incident-to rules do not apply if there is a new illness or problem for which the physician has not previously seen the patient and there is not an established plan of care.
8. Billing must be done under the billing number of the physician who is actually on site providing supervisory services rather than the physician who initiated and provides ongoing monitoring of the patient’s care.
9. The qualified practitioner must act under the supervision of a physician and must be an employee, leased employee or independent contractor of the physician or of the legal entity that employs or contracts with the physician (“Incident To Terminology and Billing by Qualified Practitioners—Revised” © 2010 Noridian Administrative Services, LLC, posted on Dec. 15, 2010).

Continued Criteria

- A split/shared visit is defined as a medically necessary patient encounter in which the physician and a qualified NPP each personally perform a substantive portion of an E/M visit (all or some portion of the history, exam or medical decision making key components of an E/M) face to face with the same patient on the same date of service.
  - The physician or qualified NPP who performed the E/M visit must personally document the service in the medical record, and the documentation should support the specific level of E/M visit to each individual patient.

Split/Shared Visits

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**Split/Shared in Hospital**

- When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number.

- If there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

- FYI: Consultations are **not** to be reported under “shared” visit model.

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**Reimbursement**

- Compare “incident to” billing at 100 percent of the fee schedule to the reduced rate for non-physician practitioners (typically 85 percent).

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**Where is “Incident To” Permitted?**

- It is also important to note what is **NOT** on the list of permitted locations for “incident to” billing:
  - Hospital Inpatient/Outpatient
  - Emergency Department
  - Hospital Observation
  - Hospital Discharge

- These are billed under another model: “split/shared” service.
Supervision

• “Present” essentially means nearby.
  − CMS has made clear that the availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct supervision.

• “Office suite” means:
  − A single structure that’s usually under a single lease.
  − It must have identifiable boundaries when part of another facility and services must be furnished within the identifiable boundary.
  − Walkways, pathways and sky bridges between the office building and the hospital do not meet the on-premises supervision requirement.

Teaching Physician Guidelines

• Definitions
• General Documentation Instructions
• Auditing Instructions
• Examples

Definitions

• Resident:
  − An individual who participates in an approved graduate medical education (GME) program. Includes interns and fellows.
• Teaching Physician:
  − A physician who involves residents in the care of his or her patients in a teaching hospital
• Critical or Key Portion:
  − The part (or parts) of a service that the teaching physician determines is (are) a critical or key portion.
• Physically Present:
  − Located in the same room as the patient and/or performs a face-to-face service.
E&M services billed by teaching physicians require that they personally document at least the following:

- They performed the service or were physically present during the key or critical portions; and
- The participation of the teaching physician in the management of the patient.

Auditing Reminders

- Reviewers will combine the documentation of both the resident and the teaching physician.
- Combined entries constitute the service and together must support the medical necessity of the service.
- The teaching physician must be specifically identifiable. Simply stating “attending staff” is not sufficient.

Example 1

You are auditing a subsequent inpatient visit. The teaching physician personally performs all the required elements without the resident. The physician performs and documents a detailed history, an expanded problem focused exam, and moderate complexity medical decision making. The physician reported a 99233.
**The Service Is Not Billable Due to Lack of A Resident’s Note.**

- True
- False

**The Service Was Reported Correctly?**

- True
- False

**Example 2**

The resident performs the elements required for an E/M service in the presence of the teaching physician and the resident documents the service in its entirety. The teaching physician documents his/her presence during the critical portions of the service and his/her involvement in the management of the patient.
Example 2 supports the teaching physician requirements

True
Correct

False
Incorrect

Example 3

The resident performs and documents some of the required elements of initial hospital care services in the absence of the teaching physician. The teaching physician independently performs the examination and assessment/plan without the resident present and, as appropriate, discusses the case with the resident. The teaching physician's note makes reference to the resident's note. The combined notes support a detailed history (no family history or complete ROS), comprehensive examination and high complexity medical decision making. The physician reports a 99223.

The Documentation Supports a Billable Service?

True, but wrong level selected
Correct

False
Incorrect
The Correct Level of E&M Was Selected?

- True
- False

Initial Hospital Care (“Admits”)
Resident admits a patient late at night and the teaching physician sees the patient the next calendar day:

- TP must document he/she personally saw the patient & participated in the management
- TP may reference the resident’s note in lieu of re-documenting and agrees with the resident’s note
- TP’s note must reflect any changes in the patient’s condition
- TP’s bill must reflect the date of service he/she saw the patient and his/her personal work

“I performed a history and physical exam of the patient and discussed his management with the resident. I reviewed the resident’s note and agree with the findings and plan of care.” Is this acceptable to support the TP’s participation in the care of the patient?

- This is unacceptable and the service is not billable.
- This would be acceptable if the TP would have documented his/her own assessment and plan
- This is the minimal acceptable note.
TP documented: “Patient seen and I agree. John Slack, MD”. This supports his participation in the patient care.

- True
- False

The physician reported code 99223, is this supported?

- Yes, this is supported with the combination of the resident’s and teaching physician documentation. (Correct)
- No, the resident’s documentation does not support a 99223 due to lack of family history and a complete ROS. (Incorrect)

What level of Hospital admit should be reported?

- 99221, due to lack of review of systems. (Incorrect)
- 99222, due to the severity of the patient. (Incorrect)
- 99221, however not billable due to unacceptable teaching physician note. (Correct)
**Surgical Procedures**

In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

All time based codes require the TP time only!

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**Two Overlapping Surgeries**

- Teaching surgeon must be present for critical or key portions of both surgeries

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**Minor / Endoscopy Procedures**

- To bill Medicare for endoscopic procedures the teaching physician must be present during the entire viewing.

- The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope.

- For procedures that take only a few minutes (five minutes or less) to complete... the TP must be present for the entire procedure to report it
Case 3

Using Case 3, answer the next question.

What documentation would you expect to find from the teaching physician?

- The complete op-note documented from the TP only as required.
- TP must document their presence during the critical or key portions of the procedure.
- TP signature only.

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