Compliance Concerns:

Who Rendered the Service?
Who Documented the Service?
Who Bills the Service?

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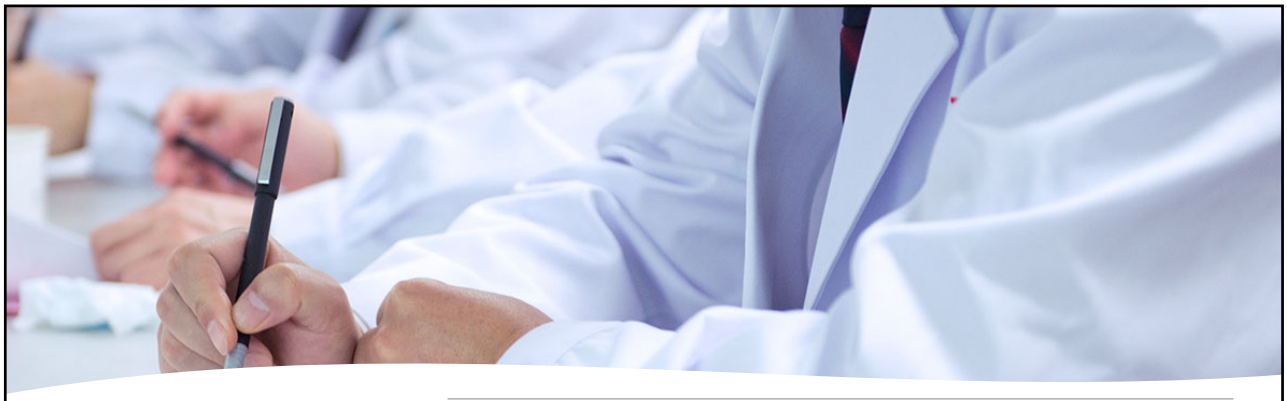

Training Session Agenda

- Incident-to services
- Split-shared services
- Teaching Physician Guidelines

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Definitions for this Training

- Incident-to Services: Services billed by a supervising physician although rendered by a NPP
- Split-Shared Services: Services that are shared between a supervising physician and a NPP
- Direct Bill: The rendering provider is the same as the billing provider
- NPP: Non-physician Provider defined by CMS as Physician Assistants, Nurse Practitioners, Clinical Nurse Specialist, Nurse Midwives, or Clinical Psychologist
- Ancillary Staff: Individuals who work within a practice, but whose services are not reportable to a carrier

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Incident-To Services

Services in which the rendering and billing providers are different

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Incident-To Services Defined

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 and the billing for that services is under the supervising provider's billing information
  - Ancillary personnel- to be reimbursed for the work they perform
  - Extenders- to gain the full fee schedule reimbursement

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Most Common Incident-to Services

ANCILLARY SERVICES

These are serviced performed by staff that are not certified, nurses, lab techs, can essentially be performed by anyone the physician is comfortable with performing the service and may include:

- Nurse visits
- Administration of injection services
- Routine office services as part of the physicians care of the patient

NON-PHYSICIAN PROVIDER SERVICES

Routine services received by patients the same as a physician delivers to a patient.
This includes not only office visits, but additionally may include:

- Minor surgeries
- Chemotherapy administration
- Applying and removing casts
- Professional component of radiology services

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Reasons to bill NPP Services Incident-To

Financial

- If billed under the supervising physician the claim is reimbursed at 100% of the allowed amount
- If direct billed under the NPP the reimbursement is reduced to 85% of the allowed amount (mental health services oftentimes are reduced further)

Credentialing

- Many organizations believe that if they bill under the supervising, then the NPP does not have to go through the credentialing process with the payor
- This is not always true. Medi Cal requires all NPPs be credentialed even though they are billed through the supervising provider

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CMS vs. Commercial Carriers

- CMS has very specific rules regarding Incident-to and Split/Shared, which will be discussed through out today's presentation
- Not all Commercial Carriers recognize Incident-to or Split/Shared
- When a provider or organization elects to become a PAR Provider with any carrier, they are agreeing to abide by their specific rules in order to be reimbursed.
- Therefore, you must know the rules, and be prepared for any changes to their rules.

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Providers for Incident-to Services

- In order to meet guidance for incident-to services, according to CMS, the rendering individual must be employed (contractually is allowed) to the same group/TIN as the billing provider

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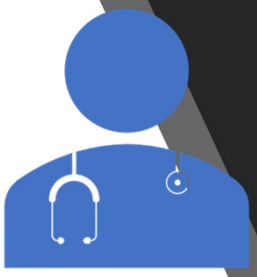

Providers for Incident-to Services

- Ancillary Staff:
  - Location: Office Setting
  - Who: No specific requirements (MA, LPN, RN, Lab Tech, etc…)
  - Example: Patient presents for blood pressure check as follow up to Dr. X's plan of care during the previous encounter
- Non-Physician Providers (NPP):
  - Location: Office Setting
  - Who: Physician Assistants, Nurse Practitioners, Clinical Nurse Specialist, Nurse Midwives, or Clinical Psychologist
  - Example: Patient returns for a 6 month follow up of a stable chronic condition with no new complaints

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Rules for NPP Incident-to

Integral Service:	• Must be a service that would be a normal part of the physician personal professional services in caring for the illness injury of the presenting patient.
Supervising Physician Present:	• The supervising physician MUST be onsite which is defined as: • Same general working area • Same floor of the building • Not in space defined differently from the office suite
No New Patients:	• This is a hard and fast rule. If billing services incident-to the supervising physician, then NO NEW PATIENT'S can be billed in this manner • If a new patient is seen then by a NPP, then the service must be billed under their billing number
No New Problems:	• Established patients with established problems may be billed incident-to, HOWEVER, if the patient has a new complaint, then incident-to is NOT met. • If a new problem arises, then the visit should be billed under the NPPs billing number

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What do you do if you do NOT meet these rules of Incident to?

- The encounter would be reported direct and not incident-to
- Meaning the claim would show the NPP as the rendering AND the billing provider
- Do these rules mean a NPP cannot see new patient's or new problems?
- Absolutely not provided they are direct billed

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Incident-to in a Nutshell

- If the treatment plan must deviate from the one created by the supervising physician, then incident-to is not met
- Modifications to the plan of care can be interpreted to be deviations from the supervising physicians plan of care
- Dangers surrounding the follow up visit to a direct bill encounter
- Create a plan of care that anticipates potential modifications
  - For example- I have prescribed X for the patient and requested follow up in 2 weeks. At that time if no improvement, we will then begin infusion therapy.
  - Best practices are for the NPP to refer back to the original plan of care in their documentation

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Supervising Physician's Involvement

- The supervising physician must remain actively engaged in the treatment of the patient
  - While there is no specific rule, industry standard is every third encounter
- While your organization may require an attestation statement for Incident-to services, CMS does not require one
- Your organization may require you to countersign the documentation created by the NPP, however there is no CMS requirement
- Follow the more stringent rules

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What has changed for 2021?

AMA made a statement about guidelines, but to-date, there has been NO published changes to reimbursement policy

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Locations Reportable as Incident-to

- Office/Clinic Setting
- Patient's Home- however remember that the supervising physician must also be in the home
- Domiciliary/Assisted Living- Only when the service is rendered in an area designated as "office space" for the group organization
- Skilled Nursing/Nursing Facility- Only when the service is rendered in an area designated as "office space" for the group organization

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Hands-On Examples

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Clinical Scenario #1

Sarah is auditing charts for JOP Rheumatology Practice. She notices that the medical record is signed by Dr. Johnson, but there is a note at the end of the encounter that states, *This note was documented by Lyla Ricks, NP on behalf of Dr. Johnson.*

Question #1
Using this statement, were incident-to guidelines met?

The statement alone is not enough to validate if incident-to guidelines were met or not.

Auditors Comment:
When comments such as these are found within documentation, suspicion maybe raised.
Did the NP actually provide the work of the encounter, and this is an effort to collect 100% of the fee schedule amount?

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Clinical Scenario #2

John presents today for a wellness visit. During his wellness visit with NP. Kasey Smith, she notes guarding, tenderness, and lack of use of full use of his right elbow. Ms. Smith evaluates the elbow and makes the decision to injection the elbow today.

Question #1
Can a NP provide a wellness visit as an incident-to service?

A NPP can perform a preventive wellness visit, but it would not be billable under incident-to billing guidelines as it requires the creation of a preventive treatment plan.

Question #2
Can procedure-based services such as a wart removal be billed as incident-to?

First a NP is allowed to perform such procedures.
Second, a NP **could** perform and bill such procedures as incident-to, but they would require that the supervising physician had created the treatment plan already for the procedures

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Split-Shared Services

One encounter performed by a NPP and a Supervising Physician

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Split-Shared Defined

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

Three important components that must be met:

Substantive work by each provider	Documentation of work by each provider	Location of where the work was performed

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Substantive Work

A substantive portion of the work of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service.

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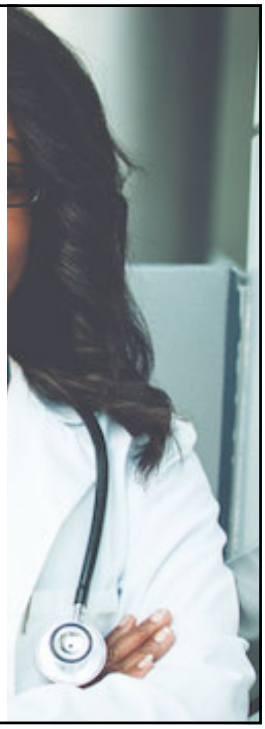
Documentation of the Work

- Documentation is expected to indicate the providers associated with the encounter and their active work
- The documentation should show how each participated to support substantive work
- Best practice require separate documentation by both the NPP and the MD showing the work they each performed
- Documentation may be dictated and typed or hand-written, or computer-generated and typed or handwritten.
- Documentation must be dated and include a legible signature or identity



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Location for Split-Shared

- Hospital inpatient to include observation
  CRITICAL CARE IS NOT ALLOWED TO BE SPLIT-SHARED
- Emergency Department
  CRITICAL CARE IS NOT ALLOWED TO BE SPLIT-SHARED
- Office/Clinic- but this is tricky. The rules state that you must first still meet incident-to which would then preclude new patient/new problems

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Documentation Don'ts

- "Seen and agreed"
- "Reviewed and agree"
- Shannon DeConda, NP dictating on behalf of Dr. Jones
- "This patient was seen by Dr. Jones and myself"

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Documentation Do's

Assuming this statement represents what happened during the encounter

- "I personally saw this patient, reviewed their history, performed key portions of the exam, and created the plan of care."
- Documentation **should** be identified by each rendering provider and should substantiate the work they personally performed.
- Documenting on behalf of each other is not best practices and is not allowed by many health system guidelines
- The supervising physician does not have to document a completely separate note, but should provide more than a mere attestation
- More recently, we have seen CMS placing an emphasis on the supervising provider stating they personally saw the patient

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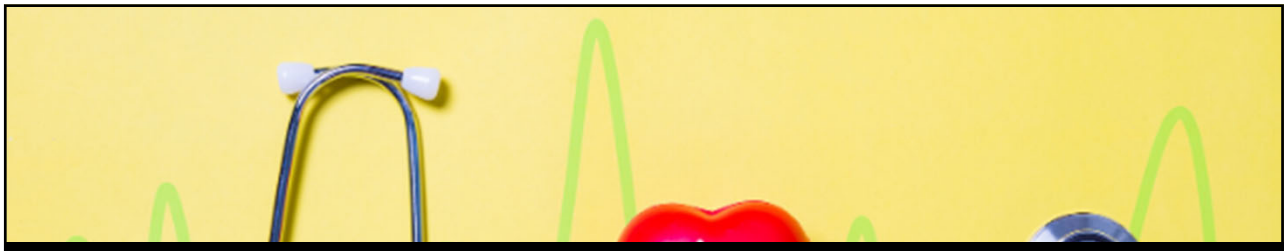

CHARTS TO MAKE IT EASY!

Print and Clip Incident-to and Split/Shared Charts

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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
	Patient's 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 (99202-99205)	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

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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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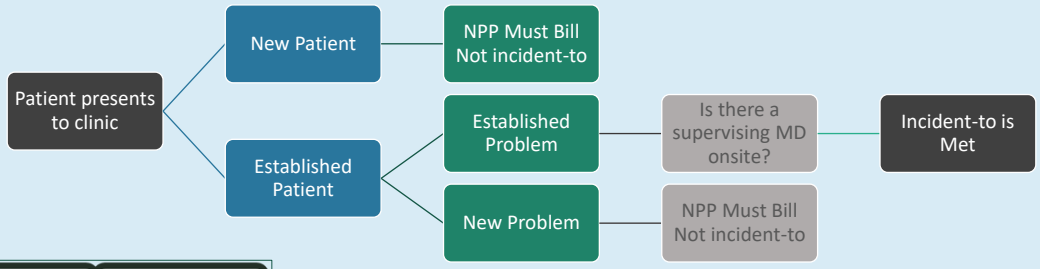
INSTRUCTIONS FOR USE:
Prior to using this decision tree, be sure you have verified the following:
✓ Services are integral part of care
✓ The NPP has an employment relationship with the same practice/TIN



THE RULES GO HERE!

An Incident-to Decision Tree to make it easy!

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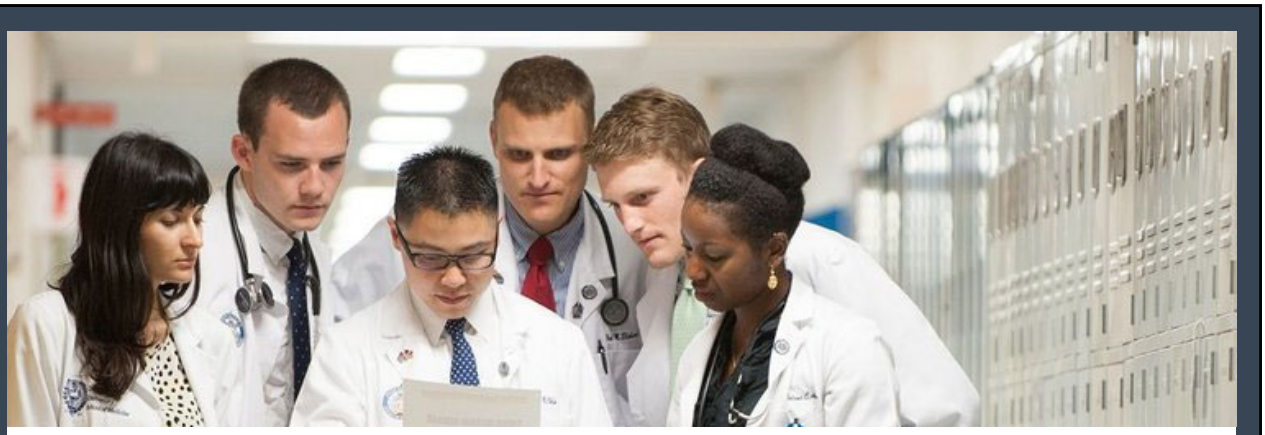

Teaching Physician Guidelines

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Definitions

- Critical or Key Portion- The part or parts of a service the teaching physician determines are a critical or key portion.
- Direct Medical and Surgical Services: Services to individual patients personally furnished by a physician or a resident under the supervision of a teaching physician.
- Indirect Medical Education Adjustment An additional payment a prospective payment hospital receives for a Medicare discharge when it has residents in an approved GME Program.
- Intern or Resident An individual who participates in an approved GME Program or a physician who is not in an approved GME Program, but who is authorized to practice only in a hospital setting (for example, has a temporary or restricted license or is an unlicensed graduate of a foreign medical school). For DGME and IME payment purposes, a resident means an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program including programs in osteopathy, dentistry, and podiatry as required to become certified by the appropriate specialty board.
- Physically Present When the teaching physician is located in the same room as the patient (or a room that is subdivided with partitioned or curtained areas to accommodate multiple patients) and/or performs a face-to-face service.

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Teaching Physician Guidelines

- The patient MUST be seen by the Attending Physician and the Resident
  - If the attending physician does NOT have a face-to-face encounter with the patient- then teaching guidelines have NOT been met
- The resident may document the encounter to include the work of both providers
- GC modifier:
  - "This service has been performed in part by a resident under the direction of a teaching physician,"

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General Documentation Guidelines

- Both you and residents may document physician services in the patient's medical record
- The documentation must be dated and contain a legible signature or identity of both providers of the encounter
- You may use a macro, which is a command in a computer or dictation application in an electronic medical record that automatically generates predetermined text that is not edited by the user, as the required personal documentation if you personally add it in a secured or password-protected system
- In addition to your macro, either you or the resident must provide customized information that is sufficient to support a medical necessity determination
- The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date
- If both you and the resident use only macros, it is not considered sufficient documentation.
- When you bill E/M services, you must personally document at least all of the following:
  - That you performed the service or were physically present during the critical or key portions of the service furnished by the resident and
  - Your participation in the management of the patient
- On medical review, the combined entries in the medical record by you and the resident constitute the documentation for the service and together must support the medical necessity of the service
- Documentation by the resident of your presence and participation is **not** sufficient to establish such presence and participation

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Medical Students

- Any contribution and participation of a student to the performance of a billable service (other than review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or the physical presence of a resident in a service that meets the requirements in this section for teaching physician billing.
- Students may document services in the medical record; however, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam, and/or medical decision making.
- The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed and may verify any student documentation of them in the medical record rather than re-documenting this work.

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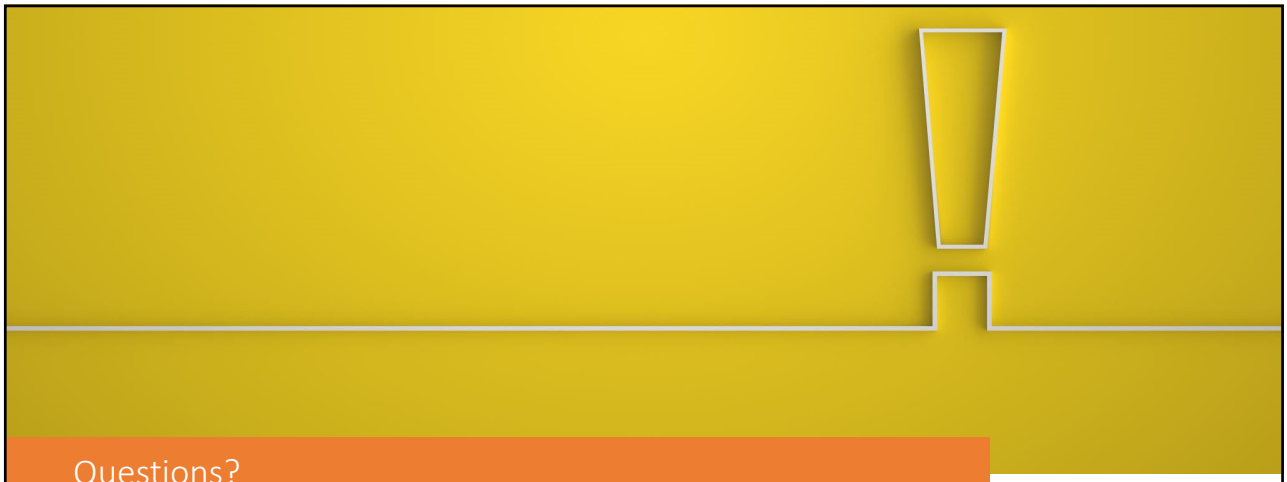

Questions?

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