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Championship Revenue Cycle:
Passion & Purpose

MEDICARE SHARED VISITS & "INCIDENT TO" BILLING: Optimize Your Revenue While Avoiding Fines and Penalties (or Worse!)

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Split/Shared Visits

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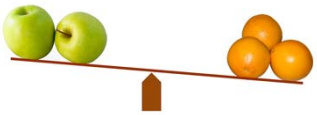
How Does Split/Shared Billing Differ From Incident To?

- The place of service
- Applicable visit types
- Applies to both new and established patients
- Level of physician involvement
- Documentation from both physician and NPP



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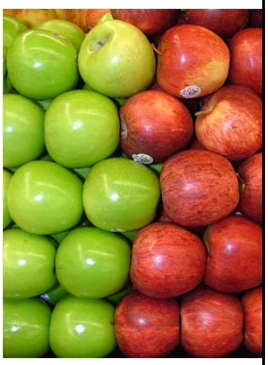
How is Split/Shared Billing Similar?

- The transparency factor-claim looks just as if physician provided the service
- Documentation must support that split/shared billing rules were followed



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Split/Shared E/M Services

- Applicable visit types and settings-Medicare
  - Initial hospital care (99221-99223)
  - Subsequent hospital care (99231-99233)
  - Discharge management (99238-99239)
  - Observation care (99217-99220, 99234-99236)
  - Emergency department visits (99281-99285)
  - Hospital provider based office visits-(99201-99215)
    - On campus or off campus

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Exclusions

- Consults
- Procedures
- Critical care services
- Skilled Nursing or Nursing Facility
- Resident services (teaching physician rules)

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Requirements: Who

- Physician and NPP
  - PA, NP, CNS, CNM
- NPP must:
  - Have sufficient training to provide the service
  - If required, licensed under state law to perform the service and within their scope of practice
    - Physician can not share services NPP isn't otherwise entitled to bill
  - Be enrolled in Medicare; not excluded
  - Employee, independent contractor, or leased employee of same practice/group as physician

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Requirements: When

- Both providers perform at least one required element of E/M service
  - Contribution to visit does not need to be split equally
- Face-to-face encounters
- Encounters occur on same date of service
- Both providers document their portion of the service

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EXAMPLES - Hospital Setting

- NPP sees hospital inpatient in the morning and the physician provides face-to-face visit later in the day.

- NPP evaluates patient in ED and physician sees patient in ED and provides face-to-face visit on same calendar day.
- NPP evaluates patient in ED, discusses case with physician resulting in decision to admit, and physician sees patient later in the day.

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Requirements: Documentation

- Identify clearly both providers involved in the encounter
- Confirm that physician and NPP both saw the patient face-to-face
- Link the physician and NPP notes
- Include valid and legible/electronic signature- both providers.
  - Date, time, credentials of provider

Requirements: Documentation

- E/M level billed is based on combined work.
  - Note must clearly identify the portions of the visit performed by both physician and NPP

- Independent patient evaluation by NPP with review of NPP note by physician and co-signature does not support split/shared visit requirements

Documentation Examples

- "I personally examined and evaluated the patient. Agree with NPP's note and my exam reveals progression of upper extremity numbness and weakness; muscle strength now 2/5. Plan MRI C-Spine," signed by physician.

- "I have personally performed a face-to-face evaluation of the patient. My findings are: 2 cm left gluteal abscess which began 48 hours ago, not responding to warm compresses. Abscess is warm, tender to touch, minimally fluctuant. Start po Antibiotics and patient will follow up in clinic in 2 days. May discharge home," signed by physician.

Support For Split/Shared Visit?

- "I have personally seen and examined the patient independently, reviewed the NPP's Hx, PE, and MDM and agree with the assessment and plan as written", signed by physician.
- "Patient seen and examined. Above noted. Proceed with cardiac catheterization as planned," signed by physician.
- NPP documentation stating "The patient was seen and examined by myself and Dr. ABC who agrees with the plan" and co-signature by Dr. ABC.

Unacceptable Physician Documentation for Split/Shared Visit

Per National Government Services (NGS):

- The following physician documentation is not acceptable to qualify for a shared visit:
  - "Agree with above"
  - "Discussed with NPP. Agree"
  - "Seen and agree"
  - "Patient seen and evaluated"

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Whose NPI?

Who bills?

- Can be billed under either the physician's or the NPP's NPI provided face-to-face and documentation requirements have been met by *both* providers

- If documentation does not allow for clear determination of physician presence and/or involvement, service should be billed under NPP

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Split/Shared E/M Services

- Billing policy applies to Medicare beneficiaries

- Some payers (Medicaid, private) do not credential and/or enroll NPPs and billing occurs under physician, i.e. no policy guidelines to support shared service billing concept
  - Check the individual policy requirements

- Documentation should look the same regardless of payer

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Split/Shared E/M Services

- Do not confuse with teaching physician rules
- The Medicare requirements for documentation of participation and oversight of interns and residents are slightly different.
  - Teaching physician performed the service *or* was physically present during the key or critical portions of the service performed by the resident

    and
  - Participation of the physician in the management of the patient

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Examine Employment Relationships

- Hospital employed NPP and independent physician
  - Can not bill a shared service
- NPP and physician are employed through separate corporations within a health system
  - Can not bill a shared service

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"Incident To" Billing

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Usual Payment Rules

- Payment to provider who actually performed the service
- Physician service:
  - 100% of Medicare Physician Fee Schedule (MPFS)
- Non-Physician Practitioner (NPP) service:
  - 85% of MPFS

Enhanced Payment

- When can Medicare pay 100% of MPFS for service rendered by NPP or less qualified auxiliary personnel?
- When can Medicare pay 85% of PFS for service rendered by auxiliary personnel as if NPP provided service?
- "Incident To" billing!
  - Services are furnished "incident to" the physician/NPP professional services

Benefit of Incident To Billing

- Incident To Billing:
  - Service billed under Part B
  - Billed as if physician personally provided them
    - 100% of MPFS amount.
  - Billed as if NPP personally provided them –
    - 85% of MPFS amount.
- Increased payments = increased risk

Who are NPPs?

- NPPs (midlevels) for whom services services may be rendered incident to:
  - Clinical Psychologist - §410.71(a)(2)
  - Physicians Assistant - §410.74(b)
  - Nurse Practitioner - §410.75(d)
  - Clinical Nurse Specialist - §410.76(d)
  - Certified Nurse Midwife - §410.77(c)

What Services - General

- The service must be:
  - An integral part of the physician's professional service
  - Commonly provided without charge or included in the physician's bill
  - Commonly furnished in the physician's office or clinic
  - Direct physician supervision
  - An expense to physician/group
  - Without their own benefit category

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Services Not Eligible for Incident To

- Services with their own benefit category
  - Flu shots
  - EKGs
  - Lab tests
  - X-rays

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Requirements: Who

- Only qualified individuals who:
  - Have sufficient training to provide the service
  - If required, licensed under state law to perform the service and within their scope of practice
    - NPPs
    - Auxiliary Staff (Med. Asst., RNs, LPNs, therapists, etc.)
  - Are enrolled in Medicare; not excluded
  - Employee (W-2), independent contractor (1099), or leased employee of same practice/group as supervising physician

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Requirements: When

- When may a service be incident to:
  - Physician must personally have performed initial service and initiate course of treatment/plan of care
  - Patient is an established patient with established diagnosis
  - Service is part of continuing plan of care
  - Physician is active participant in ongoing care
  - There is a physician's service to which the rendering provider's service relates
  - Face-to-face encounter

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Requirements: When

- NGS – active involvement:
  - Must be a stable, established patient for whom the NPP is following a plan of care originally developed by physician
  - Physician performs and documents intermittent, subsequent services of a frequency that reflects active participation in the course of treatment for the specific problem

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Requirements: When

- Direct supervision – a physician must be physically present in the same office suite and is immediately available if needed (need not be in the same room)
- Not via phone, not on the way, not rounding in the hospital next door
- Any member of group may supervise
- Most problems result from not following this requirement
- "General supervision" OK for rural health clinics and FQHCs for care management and transitional care management services

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Requirements: Where

- Typically provided in physician's office
- Not in institutional settings:
  - Hospitals, SNF
- Separate, identifiable office in an institution is okay
- Non-institutional patient

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Requirements: Documentation

- Clearly state reason for visit
- Relate service to physician's initial service and ongoing involvement – periodic review? Oversight?

- Patient's progress, response to, and changes to plan of care
- Date of service
- Signature of person rendering service
- Evidence physician was actively involved in case and was present and available during visit
- Co-signature of physician not required, but not a bad idea

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Other Requirements

- All other Medicare payment rules also apply to Incident To services:
  - Medical necessity
  - Covered service
  - Documentation
  - Billing
  - Enrolled/not excluded from Medicare/Medicaid
  - Within scope of license

Documentation Example

- 9/1/2017-Dr. Jones sees a patient for knee pain, obtains an x-ray and diagnoses osteoarthritis of the knee. Dr. Jones performs injection into the knee joint. The physician instructs the patient to return in 1 month for the 2nd in a series of 3 knee injections.

- 10/1/2017 -NPP sees patient at subsequent visit "I am seeing this patient for Dr. Jones, who diagnosed osteoarthritis of the knee 1 month ago. She noted significant improvement in her knee pain since her last visit and initial injection on 9/1/2017. She returns for her scheduled 2nd knee injection. Dr. Jones was in the office suite while I saw this patient"

Auxiliary Personnel

- E&M services rendered incident to by auxiliary personnel (RNs, medical assistants, technicians, therapists, etc.)
  - Only bill as Level 1 visit
  - CPT 99211
  - e.g. RN sees patient for blood pressure check, giving injections, change dressings

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Whose NPI?

- Some confusion over the years as to whose NPI should be used for incident to billing – the supervising physician or the treating physician?

- 11/15/2016 Final rule – supervising physician's NPI to be used

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Higher Payment But Fraught With Traps

- Incident to payment is transparent to payer – audit or whistleblower could result in huge payback
- Whistleblower often is a patient who did not see the doctor that day

- 2009 OIG report –
  - ½ of services not performed by physicians
  - Non-physicians performed 2/3 of invasive services
  - Unqualified non-physician performed 21% of services
- Law firms advertise for whistleblowers!

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Examples of Providers Who Paid the Price for Not Following Rules

1. 4/20/2017 – primary care physicians, FL $379,085
   - Services rendered by unenrolled providers and other IT requirements not met
2. 12/7/2016 – orthopedists, Jacksonville, FL $4,488,000
   - Part of claim was that physician not present in office or no documentation of that
3. 7/27/2016 – dermatologist, Smithtown, NY $302,000
   - Billing when phys. not present or even out of the country, and some days over 26 hours

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Examples of Providers Who Paid the Price for Not Following Rules

4. 6/20/2016 – internal medicine/geriatricians, N.C. $109,975
5. 12/23/2015 – family practice, Lebanon, TN $24,638
6. 12/16/2015 – sports and orthopedists, CO $19,095
   - physician didn't supervise
7. 6/2/2015 – urology, N.J. $266,882
8. 4/9/2015 – fertility clinic, Jacksonville, FL $98,839
   - Physician involvement was minimal

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Examples of Providers Who Paid the Price for Not Following Rules

9. 1/12/2015 – urgent care centers, S.C.
   - PAs saw new patients
   - PAs saw established pts. with new condition
   - PAs lacked state licenses and were not enrolled in Medicare
   - Occasionally, PA was not employed by physician
10. 2007 – Mass. $150,000 (reportedly first case exclusively on incident to)
   - Dr. Perry Hearn - $100,000
   - Affiliated Prof. Services - $50,000
     - Billing company can be held liable for its actions!!

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How Well Do You Understand Medicare's Split/Shared Service Billing Rules

- Can subsequent critical care services be reported by NPP when physician performed initial service?
- Can the physician share a visit with a medical student?
- Can the physician share a visit with a resident/intern?
- Can NPP perform initial visit in the evening and physician perform their portion the following AM and bill under the physician NPI?
- Can split/shared visit be leveled based on time when counseling and care dominate the visit by both providers?

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How Well Do You Understand Medicare's Incident to Billing Rules

- Can incident to billing be used for:
  - A new patient?
  - An established patient with an established diagnosis who complains of a new problem?
  - An established patient with an exacerbated condition for an existing problem?
  - Services by a resident/intern? Uncredentialed physician?
  - Services in a physician's office to an established patient who is a resident of a SNF?

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How Well Do You Understand Medicare's Incident to Billing Rules

- Services in a physician's office to an established patient who is a resident of a SNF but a non-Medicare covered stay?
- A physician's service incident to the treating physician?
- Services by an NPP supplied by a hospital in a hospital outpatient clinic?
- Services by an NPP supplied by a hospital in the physician's office?
- Services when supervising physician is in suite but doing a procedure and available only by phone?

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How Well Do You Understand Medicare's Incident to Billing Rules

- Whose NPI should be used for billing – treating or supervising physician?
- Must the supervising physician review a minimum of 15% of the NPP's charts?
- May incident to billing be used if the service requires personal, not direct, supervision?

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Resources

- Social Security Act §1861(s)(2)(A)
- 42 CFR §410.26
- CMS Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §60.1
- MLN Matters Number: SE0441
- CMS Pub. 100-04, *Medicare Benefit Policy Manual*, Chapter 12, §30.6.1
- NGS Part B Policy Education Topics Split/Shared and Incident To Services

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