TIPS FROM OUR CONSULTANT

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WPS Reverses Decision on Allergy Injections and "Incident To" Billing

On January 18, 2016, WPS GHA published an article in *eNews* indicating

> …if the physician employing the person giving an allergy injection is not the physician treating the allergy, "incident to" requirements are not met and the service should not be billed to Medicare…

The article explained that part of the requirement for "incident to" is that the billing physician (treating physician or a supervising physician/qualified health care professional of the same group practice) is treating the patient for the illness or injury. Under this interpretation of the "incident to" requirements, the only way a PCP (primary care provider) could bill for administering an allergy injection based on the allergist's plan of care is if the physician or practitioner personally administered the injection.

Knowing that for various reasons many patients evaluated by an allergist who prepares the serum specific to the patient, choose to have their PCP administer the injections, we requested WPS review and revise their interpretation.

The following information will be published in a future *eNews*.

> Allergy injections may be provided by a local physician when the plan of care has been determined by another medical doctor (MD) or doctor of osteopathy (DO). The information discussing allergy injection is contained in 42 CFR 410.68.

This section states that Medicare can allow for up to a 12-month supply of antigen when that is prepared by an MD/DO who has examined the patient and developed a plan of treatment including dosage levels; and the antigen is administered in accordance with that plan by an MD/DO or a properly instructed person under the supervision of an MD/DO.

Therefore, when the billing physician is supervising ancillary staff in administering an antigen prepared by another MD/DO, the billing physician may submit a charge for the administration of the antigen. The writer apologizes for the error.

This reversal will allow Medicare beneficiaries to continue to receive allergy injections administered by a physician other than the allergist.

"Incident To" Reminders

Many physicians and group practices continue to be confused by Medicare's "Incident To" requirements. This phrase is more than simply billing the work performed by another person using the patient's physician's name and National Provider Identifier (NPI). We decided the remainder of this article should include some of the basic requirements for billing services "Incident To".

Remember, "Incident To" billing requirements are written for Medicare beneficiaries with original Medicare coverage. Medicare Advantage Plans and commercial insurers are able to choose how services performed by clinical staff and qualified health care professionals (Medicare refers to these latter individuals as "nonphysician practitioners").

CPT includes the following definitions in the *Coding Tip* included in the "Evaluation and Management Services Guidelines"

> A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff".

A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specific professional service, but does not individually report that professional service.

Medicare considers the following individuals as non-physician practitioners (qualified health care professionals):

- ✓ Anesthesiology Assistant
- ✓ Audiologist
- ✓ Certified Nurse Midwife
- ✓ Certified Registered Nurse Anesthetist
- ✓ Clinical Nurse Specialist
- ✓ Clinical Social Worker
- ✓ Nurse Practitioner
- ✓ Occupational Therapist in Private Practice
- ✓ Physical Therapist in Private Practice
- ✓ Physician Assistant
- ✓ Psychologist, Clinical
- ✓ Psychologist billing independently
- ✓ Registered Dietitian
- ✓ Nutrition Professional

Physicians should also remember there are additional requirements applicable to billing shared visits where both the physician and the NPP provide services to the same patient during the same encounter, or in the case of hospital inpatient, on the same date of service.

"Incident To" Services - Supervising Provider Billing Instructions

http://www.wpsmedicare.com/j8macpartb/resources/provider_types/incident-services-supervising-provider-billing-instructions.shtml

In the office, among other criteria, "incident to" services must be rendered by a qualified provider who is directly supervised. To meet supervision requirements for "incident to," the billing provider does not have to be physically present in the treatment room while the service is being provided, but **must be present in the immediate office suite**, for the entire duration of the service, to render assistance if needed.

If the billing physician is a solo practitioner, he/she must directly supervise the care. In a group practice, there may be situations when the provider responsible for the treatment plan is not the provider physically present in the office suite when the patient is seen in follow up. Thus, the supervising provider can be different from the ordering provider.

At this time, the supervising physician ***qualifier*** **for Item 17** of the CMS-1500 (02-12) **is not required** for "incident to" services.

Qualifier	**Role**
DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

In the case of a service provided "incident to", when the person who ordered the service is not supervising, enter the National Provider Identifier (NPI) of the "supervising provider" in the lower unshaded portion of Item 24J.

To find additional instructions for completing the CMS-1500, please refer to CMS Internet-Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 26.

To find complete information on CMS "incident to" requirements, please refer to CMS Internet-Only Manual (IOM) Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15.

Medicare Claims Processing Manual, Chapter 26, §10.4 - Items 14-33 - Provider of Service or Supplier Information

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. Similarly, if Medicare policy requires you to report a supervising physician, enter this information in item 17.

All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. The following services/situations require the submission of the referring/ordering provider information: *[Not All-Inclusive]*

- ✓ When a service is **"incident to"** the service of a physician or non-physician practitioner, the **name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17.**

- ✓ Effective for claims with dates of service on or after October 1, 2012, all claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished "incident to" a physician or non-physician practitioner, require that the name and NPI of the certifying physician or non-physician practitioner of the therapy plan of care be entered as the referring physician in Items 17 and 17b

Item 17b – Enter the NPI of the referring, ordering, or supervising physician or nonphysician practitioner listed in item 17. All physicians and non-physician practitioners who order services or refer Medicare beneficiaries must report this data.

Item 24J - Enter the rendering provider's NPI number in the lower unshaded portion.

- ✓ In the case of a service provided **"incident to"** the service of a physician or non-physician practitioner, **when the person who ordered the service is not supervising**, **enter the NPI of the supervisor** in the lower unshaded portion.

WPS "Incident To" Services and Diagnosis

http://www.wpsmedicare.com/j8macpartb/resources/provider_types/incident_srvs-dx.shtml

The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-02, Chapter 15, §§60, 60.1, and 60.2 discusses the "incident to" requirements. According to §60, "To be covered "incident to" the services of a physician or other practitioner, services and supplies must be:

- ✓ An integral, although incidental, part of the physician's professional service (see §60.1)
- ✓ Commonly rendered without charge or included in the physician's bill (see §60.1.A)
- ✓ Of a type that are commonly furnished in physician's offices or clinic (see §60.1.A)
- ✓ Furnished by the physician or by auxiliary personnel under the physician's direct supervision (see §60.1.B)".

§60.2 states

…there must have been a direct, personal, professional service furnished by the physician to **initiate the course of treatment** of which the service being performed by the nonphysician practitioner is an incidental part, and there must be **subsequent services by the physician of a frequency that reflects the physician's continuing active participation** in and management of the course of treatment. In addition, the **physician must be physically present in the same office suite and be immediately available** to render assistance if that becomes necessary." *[Emphasis Added]*

For example, Dr. A is currently treating the patient for diabetes. The patient's evaluation and management (E/M) encounter in the office today is with a Physician Assistant (PA) of the same group for an upper respiratory infection. Can the PA bill the service "incident to" Dr. A and bill under Dr. A's provider number?

In the situation described, the upper respiratory infection is not part of the treatment for diabetes and, therefore, is not an "integral, although incidental" part of Dr. A's "professional service." The PA should not bill "incident to" under Dr. A's provider number, but should bill the appropriate level of new or established E/M service provided under his or her own provider number. The physician must have performed the initial service for the diagnosis or condition and must remain actively involved in the course of treatment.

WPS Office Services (Q&As)

http://www.wpsmedicare.com/j8macpartb/resources/provider_types/2009_0622_emfaqoffice.shtml

Q2. Are there any examples of when a physician may bill a 99211 without a face-to-face visit with a physician?

A2. The documentation must support the use of the procedure code 99211 and the "incident to" requirements. 99211 cannot be billed for a telephone call, completing a form to document the results of tests, or if the physician is not in the office suite. Services provided by ancillary staff or a non-physician practitioner (NPP) may be billed by the physician when the "incident to" requirements are met. The Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-02, Chapter 15, §60, discusses these guidelines. The services must be:

- ✓ An integral, although incidental, part of the physician's professional service (see §60.1);
- ✓ Commonly rendered without charge or included in the physician's bill (see §60.1a);
- ✓ Of a type that are commonly furnished in physician's offices or clinics (see §60.1a);
- ✓ Furnished by the physician or auxiliary personnel under the physician's direct supervision (see §60.1B).

Q3. Can we bill a 99211 under the name of the physician in the following situations?

- ✓ Physician is immediately available in the office suite
- ✓ RN checks blood pressure, pulse and weight
- ✓ RN reviews symptoms or complaints
- ✓ RN performs INR test
- ✓ RN follows dosing protocol as directed by the physician

A3. The documentation must meet the history, exam, and medical decision making requirements for the procedure code. In the example given above, history is the review of symptoms and complaints, exam is the blood pressure, pulse, and weight check, and medical decision making is the possible dosage change.

Before submitting a charge for 99211 in addition to the blood draw and INR test, a physician should verify the visit is for more than the INR. The Comprehensive Error Rate Testing (CERT) program recently identified errors when the documentation did not support the use of this code in addition to the test itself.

Newby Note: Remember the clinical staff's work must be medically necessary and tied to the physician's plan of care. Simply obtaining vital signs is not sufficient to support reporting 99211.

Q5. We schedule patients for injections, blood draws and other minor visits before the physician comes into the office. Can we bill for these services under the "incident to" guidelines?

A5. Medicare pays for services and supplies (including drugs and biologicals) furnished "incident to" a physician's or other NPP's services, which are commonly included in the physician's bills, and for which payment is not made under a separate benefit category listed in §1861(s) of the Act. One of the requirements of "incident to" billing is that the physician must provide direct supervision - the physician must be in the office suite. For more information, see the CMS IOM Publication 100-02, Chapter 15, §60.

Laboratory tests have their own benefit category as listed in §1861(s) of the act and as such are **not subject to the "incident to" guidelines**. Medicare considers a blood draw as part of the Clinical Laboratory services and as such is not subject to the "incident to" guidelines. You can find more information in the Medicare Learning Network (MLN) Matters Special Edition SE0441.

Q6. The patient did not show up for the appointment. Can I bill a low-level office visit code to Medicare?

A6. No. There was no service to the patient; therefore, there is no charge to Medicare. You can bill the patient for the services. CMS requires that office policies be administered the same for all patients.

WPS "Incident To"/Shared/Split Billing (Q&As)

http://www.wpsmedicare.com/j8macpartb/resources/provider_types/2009_0803_incident.shtml

Newby Note: Before billing services provided by a nonphysician provider (NPP) "incident to" by reporting the supervising physician's NPI in Item 24j, for Medicare patients and other insurers using Medicare's "incident to" guidelines, be sure the "incident to" requirements are met. These frequently asked questions are helpful when determining whether the NPP's services can be billed by the supervision physician.

Be aware that "incident to" billing is only available in the office setting. "Incident to" guidelines do not apply in any other setting, e.g., patient's home or facility.

"Incident to" billing is when a service is provided in an office setting by someone other than the physician. However, if the situation meets the guidelines, the physician may bill Medicare for the service.

Shared/split billing is for services provided in any location when both the physician and a non-physician practitioner (NPP) provide, document, and sign the work they each performed. There must be a face-to-face encounter with both the physician and NPP. The physician can bill the service to Medicare.

Why does this make a difference? Medicare allows 100% of the Medicare fee schedule amount for coverable services submitted by a physician. Medicare allows a percentage of the physician fee schedule amount when services are submitted under an NPP provider number. (The percentage is 85% for physician assistants, nurse practitioners, and clinical nurse specialists.) **If the situation does not meet the guidelines, the NPP would bill the services**. You can find more information in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-04, Chapter 12, §30.6.1.b, and 100-02, Chapter 15, §60.

Q1. Can a physician and an NPP perform the discharge visit as shared/split? If they can, who bills for the service? If they cannot, who bills for the service?

A1. A physician and NPP may perform the **discharge management services as shared/split**. The CMS IOM Publication 100-04, Chapter 12, §30.6.9.2, discusses hospital discharge services. **Each party must document the work they performed**. The documentation must show a face-to-face encounter with the physician. If there is no face-to-face encounter with the physician, the NPP must bill the service using his/her National Provider Identifier (NPI).

Q3. We are a physician clinic and our physician has left. We currently have two NPPs providing services. A physician in another office sponsors and supervises the NPPs. Can we bill the NPP services as "incident to" the physician in the other office?

A3. No. Services provided in the office must meet the "incident to" requirements, one of which is that the **billing provider must be present in the office suite**. In the situation you describe, bill the services under the NPI of the NPPs. You can find more information on the "incident to" requirements in the CMS IOM Publication 100-04, Chapter 12, Section 30.6.1, and 100-02, Chapter 15, §60.

Q4. Is it necessary to have the physician sign the medical record when the NPP provides a service "incident to" the physician? Can just the NPP sign the note?

A4. Medicare does not require the physician to sign the medical record when the NPP provides a service under the "incident to" guidelines. Physicians would need to look to state regulations and their own comfort level in determining whether they need to sign the note.

Q5. Is it necessary to have the physician sign the medical record when the NPP and the physician provide a shared/split visit? Can the NPP document that the physician agrees?

A5. Under a shared/split visit situation, both parties must document and sign the work they perform. **A notation of "seen and agreed" or "agree with above" would not qualify the situation as a shared/split visit because these statements do not support a face-to-face contact with the physician. Only the NPP could bill for the services**.

Q6. If the physician is not in the office, but available by phone, can the NPP bill under the "incident to" guidelines?

A6. No. If the physician is not in the office suite, the service does not qualify under the "incident to" guidelines. The NPP would bill for the service under his/her provider number.

Q7. Both the physician and the NPP performed part of the Evaluation and Management (E/M) service for the patient. The doctor left the documentation of the visit to the NPP. Is this a shared/split visit?

A7. No. **To bill a shared/split visit, both the physician and the NPP must document the work they performed and sign their part of the medical record**.

Q8. What are you looking for to prove that the doctor had a face-to-face with the patient for **share/split visits**?

A8. **The doctor must document his/her work and sign the medical record**.

Q9. If a PA in orthopedics has the initial encounter with a patient, then the patient meets with the physician the next day and the physician develops a plan of care, can the PA then bill "incident to" for the encounters after the physician's visit?

A9. The initial encounter is billed under the NPP number. Any subsequent visits after the patient sees the physician may be billed under the physician's provider number only if the situation meets the "incident to" requirements. See CMS IOM 100-02, Chapter 15, §60.

Q10. Can we bill inpatient subsequent visits as a shared/split visit?

A10. Yes. You can bill a shared/split visit only if the visit meets the documentation requirements for facility services. **For a shared/split visit, both the MD/DO and the NPP must document and sign the portion of the visit they performed**.

Q11. Are nurses able to perform services "incident to" an NPP when the NPP is present in the office?

A11. The "incident to" requirements apply to services "incident to" both the physician and the NPP. A nurse is able to provide a service "incident to" the NPP when the situation meets all requirements. If the nurse or auxiliary person performs E/M services, use code 99211.

Q12. In the **office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service**. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's NPI.

In the above scenario, when "incident to" requirements are not met, can the physician bill for the service using only his/her documentation? If not, what is the reasoning. If the physician can bill, can he then use any documented PFSH or ROS if these were documented by the APN/PA? If they in fact perform a shared visit knowing a consult cannot be shared, can the physician then bill a consultation based on his documentation only?

A12. A consultation cannot be performed as a shared/split service. The physician would submit a new or established patient visit as appropriate. **In an office setting where the physician and NPP share/split the service, if the "incident to" requirements are not met, only the NPP can submit the charge**. This is based on the CMS IOM Publication 100-04, Chapter 12, §30.6.1.

Q14. If the service performed in the **office meets the shared/split billing guidelines but does not meet the "incident to" requirements** in the office, can we still bill under the MD/DO?

A14. No. Shared/split visits in the office must meet the "incident to" requirements. **The NPP must bill for the services under his/her own Medicare number.**

Q15. The physician reviews the documentation from the PA, but does not see the patient. Is this a shared/split visit? The PA documents the physician reviews and agrees. Does it make a difference if this is a new or established patient visit charge?

A15. **If the physician is not performing any of the E/M services, it is not a shared/split visit**. If the service is performed in a facility setting, only the NPP may submit a charge for the service. If the service is performed in an office setting, the physician may submit a charge for the service if the "incident to" requirements are met. One requirement is that it is the physician who has established the plan of care. Therefore, if the patient is new, only the NPP may bill the service.

Q16. Is there a restriction on the level of procedure codes allowed under the "incident to" or shared/split guidelines?

A16. There is no restriction on the level of service as long as the situation meets the requirements and the person providing the services can legally perform the services.

Q17. We schedule patients for injections, blood draws and other minor visits before the physician comes into the office. Can we bill for these services under the "incident to" guidelines?

A17. Medicare pays for services and supplies (including drugs and biologicals) furnished "incident to" a physician's or other NPP's services, which are commonly included in the physician's bills, and for which payment is not made under a separate benefit category listed in §1861(s) of the Act. One of the requirements of "incident to" billing is that the physician must provide direct supervision - the physician must be in the office suite. For more information, see the CMS IOM Publication 100-02, Chapter 15, §60.

Laboratory tests have their own benefit category as listed in §1861(s) of the act and as such are not subject to the "incident to" guidelines. Medicare considers a blood draw as part of the Clinical Laboratory services and as such is not subject to the "incident to" guidelines. You can find more information in the Medicare Learning Network (MLN) Matters Special Edition SE0441.

Inpatient Split/Shared Evaluation And Management (E/M) Services

http://www.wpsmedicare.com/j8macpartb/resources/provider_types/inpatientsplitem.shtml

Current review of medical records indicates an increasing number of Initial and Subsequent Hospital, as well as Emergency Department services, being billed as split/shared visits between the billing physician and a Non-Physician Practitioner (NPP) from the same group practice. The purpose of this article is to provide guidance on the appropriate documentation of split/shared services.

For a split/shared service to be reimbursed by Medicare Part B, the supporting medical records must satisfy the documentation requirements found in the Internet-Only Manual (IOM) references. An inpatient Split/Shared Evaluation and Management (E/M) service is defined by the Centers for Medicare & Medicaid Services (CMS) IOM Publication 100-04, Chapter 12, §30.6.1(B), as an E/M service,

> ...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.

Additionally, IOM Publication 100-04, Chapter 12, §30.6.13 (H) states that,

> A **split/shared E/M visit** is defined by Medicare Part B payment policy as 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. A substantive portion 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**."

Both the physician and the NPP must each personally perform part of the visit, and both the physician and the NPP must document the part(s) that he or she personally performed. When the supporting documentation does not demonstrate that the physician "performed a substantive portion of the E/M visit face-to-face with the same patient on the same date of service" as the portion of service performed by the NPP, a service billed under the physician's Provider Transaction Access Number (PTAN) will be denied.

It is of particular importance to remember that **notes documented by the NPP for E/M services performed independently within a facility, and later reviewed and co-signed by the physician, depict neither a scribe situation nor an appropriate split/shared visit. Additionally, ""incident to"" guidelines do not apply to services in an inpatient setting**. In this situation, the service should be **billed under the NPP's provider number**, and would be reimbursed at the established rate for that provider.

With the IOM requirements in mind, the following are examples of medical record documentation by the physician which would not be considered adequate to support a split/shared visit:

- ✓ "I have personally seen and examined the patient independently, reviewed the PA's Hx, 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

In conclusion, please remember that **for a split-shared visit, there must be documentation of the face-to-face portion of the E/M encounter between the patient and the physician**. The medical record should also **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, §30.6.1 (B). This applies to the initial history and physical examination, the discharge summary, and subsequent hospital visits.

Mid-Level Providers, Nursing Facilities, and Evaluation and Management (E/M) Services

http://wpsmedicare.com/j8macpartb/resources/provider_types/mid-level-providers-nursing-facilities-em-services.shtml

WPS Medicare receives multiple questions on the E/M services mid-level providers can perform in nursing facilities. The determination of what E/M services a Mid-Level provider can perform depends on the type of facility. Mid-Level providers include physician assistants (PA), nurse practitioners (NP), and clinical nurse specialists (CNS).

In a **Skilled Nursing Facility (SNF), the mid-level provider cannot perform the initial assessment**. An NP or CNS not employed by the facility, working in collaboration with the physician, and meeting state license requirements may sign the required initial certification and re-certification verifying the patient requires daily skilled nursing care or rehabilitation services. A PA cannot complete this function.

A mid-level can alternate the federally mandated visits with the physician when the collaboration, physician supervision, and state license requirements are met. A mid-level provider can perform medically necessary services prior to and after the physician's initial assessment. Medically necessary services are those E/M necessary to diagnosis or treat an illness or injury or to improve the functioning of a malformed body member.

In a **Nursing Facility (NF), the mid-level,** not employed by the facility**, can perform the initial assessment** when the collaboration, physician supervision, and state license requirements are met. A **mid-level provider may perform any other federally mandated visits**. A mid-level provider may perform medically necessary services prior to and after the initial assessment. A mid-level provider may complete the certification/recertification as necessary.

Medicare does not reimburse shared/split services in a SNF or NF. A shared/split service is where both the MD/DO and the mid-level provide a portion of the service. The services are only billable under the mid-level provider number and coding is based on the services provided by the mid-level. Medicare would not reimburse shared/split services under the physician provider number in this situation.

Medicare does not reimburse services provided as "incident to" the physician when provided in a SNF or NF. Services provided by the mid-level provider are billed only under the mid-level provider number and coding is based on the services provided by the mid-level. A physician may have a discrete part of the facility designated as his/her office. If the discrete part of the facility qualifies as an office setting, services provided in only that area by mid-level and ancillary staff meeting the entire "incident to" requirements may be billed under the MD/DO provider number.

For more information, see the CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 12, §30.6.13 and The Center for Medicaid and State Operations/Survey and Certification Group The Center for Medicaid and State Operations/Survey and Certification Group S&C-04-08.