

Incident To and Shared Visits

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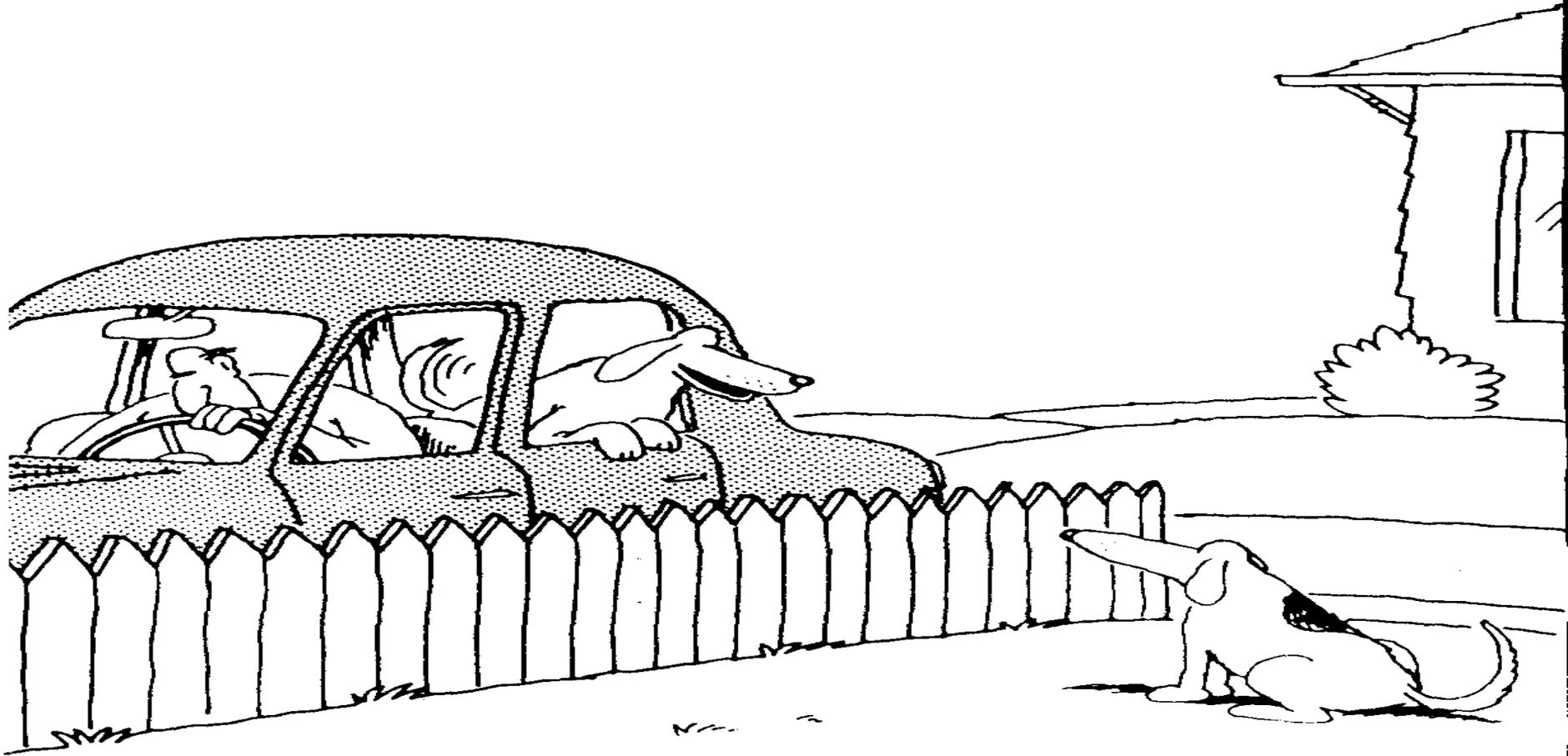
Fredrikson
& BYRON, P.A.

Incident to: Words Matter

- It might be an “incident, too.”
- Or even “Incident 2.”
- The phrase is short for “incident to a physician’s professional services.”
- Designed to cover work that is initiated by the physician and normally included on the physician’s bill.

Incident to: Words Matter

- The term is used a bit differently for clinic services and hospital services.
- The regulatory hierarchy is key. Constitution, statute, reg, Fed. Reg. preamble, Manual, carrier guidance. Know the Brand memo.
- Sloppy word use is endemic.



Larson

"Ha ha ha, Biff. Guess what? After we go to the drugstore and the post office, I'm going to the vet's to get tutored."

The Big Picture SSA 1861(s)

- The term “medical and other health services” means any of the following items or services:

(1) physicians’ services;

The Big Picture SSA 1861(s)

(2) (A) **services and supplies** (including **drugs and biologicals** which are **not usually self-administered** by the patient) **furnished as an incident to a physician's professional service**, of kinds which **are commonly furnished in physicians' offices** and are commonly either rendered without charge or included in the physicians' bills (or would have been so included but for the application of section 1847B);

The Big Picture SSA 1861(s)(2)

(B) **hospital services** (including drugs and biologicals which are not usually self-administered by the patient) **incident to*** **physicians' services rendered to outpatients** and partial hospitalization services incident to such services;

*Why, why, why did they have to use “incident to” here? Let’s call them “outpatient therapeutic services.”

Hospital Therapeutic Coverage Under Medicare Part B:

- Under the direct supervision (or other level of supervision as specified by CMS for the particular service) of a physician or a nonphysician practitioner as specified in paragraph (g) of this section, subject to the [additional] requirements; and
- In accordance with applicable State law.

- 42 CFR § 410.27(a)(1)

The Big Picture SSA 1861(s)(2)

(C) **diagnostic services** which are—

(i) furnished to an individual as an **outpatient by a hospital or by others under arrangements with them made by a hospital,** and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study.

(D) outpatient physical therapy services and outpatient occupational therapy services.....;

The Big Picture SSA 1861(s)(3)

(3) **diagnostic X-ray tests** (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act [398]),

Words Matter

- Note how “diagnostic tests” are a different benefit.
- HCFA thought of “diagnostic tests” as “incident to”. That is no longer true.

Not Everything Is Incident To....

“Rather, these services should meet the requirements of their own benefit category. For example, diagnostic tests are covered under § 1861(s) of the Act. A/B MACs (A) and (B) must not apply incident to requirements to services having their own benefit category. For example, diagnostic tests are covered under § 1861(s)(3) of the Act and are subject to their own coverage requirements.

Not Everything Is Incident To....

Depending on the particular tests, the supervision requirement for diagnostic tests or other services may be more or less stringent than supervision requirements for services and supplies furnished incident to physician's or other practitioner's services. Diagnostic tests need not also meet the incident to requirement in this section. Likewise, pneumococcal, influenza, and hepatitis B vaccines are covered under § 1861(s)(10) of the Act and need not also meet incident to requirements.

Not Everything Is Incident To....

Physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists, clinical social workers, physical therapists and occupational therapists all have their own benefit categories and may provide services without direct physician supervision and bill directly for these services.”

–Medicare Benefit Policy Manual, Chapter 15 § 60A

Who Can Do E&M?

“Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a nonphysician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.”

MCPM Chapter 12 § 30.6.1

Why Do Incident To?

- For many services it pays more. (NPP services reimbursed at 100% of Physician Fee Schedule vs. 85%.)
- Under the in-office ancillary exception, physicians may receive credit for DHS that are incident to.

Why Avoid Incident To?

- Adds a layer of requirements.
 - Supervision.
 - New patients.
 - Billing confusion.
- For some services (PT) no reimbursement benefit.

“Incident To” Billing

- Clinic can bill for “incident to” services only if:
 - Clinic pays for the expenses of the ancillary person.
 - Clinic is the sole provider of medical direction.
 - The first visit for the course of treatment is with a physician (later visits may be with the non-physician provider). Note the “new problem” myth.

“Incident To” Billing

- The service is something typically done in an office.
- The service is not in a hospital or nursing home (may be a “shared visit”).
- A clinic physician must be in the “office suite.”
- The services should be billed under the supervising physician.

42 C.F.R. § 410.26

Services and supplies incident to a physician's professional services:
Conditions.

(a) Definitions. For purposes of this section, the following definitions apply:

(1) Auxiliary personnel means **any individual** who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an **employee, leased employee, or independent contractor** of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner), **has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked,** and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished.



MBPM Chapter 15 § 60.1.B

Auxiliary personnel means **any individual** who is acting under the supervision of a physician, **regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.** Likewise, the supervising physician may be an employee, leased employee or **independent contractor** of the legal entity billing and receiving payment for the services or supplies.

Can one physician be incident to another?

- Conventional wisdom seems to be no.
- As is often the case, the conventional wisdom appears mistaken. There is reason to doubt the conventional wisdom.
- Are physicians “any individual”?

Who Are Auxiliary Personnel?

“Comment: Many commenters wanted us to restrict the definition of auxiliary personnel so that only certain individuals may perform a given incident to service. For example, they want us to mandate that only audiologists may perform cochlear implant rehabilitation services as incident to services. Likewise, they want us to permit only physical or occupational therapists to perform physical or occupational therapy as incident to services. In support, they noted that section 4541(b) of the BBA amended section 1862(a)(20) of the Act and required that physical or occupational therapy furnished as an incident to service meet the same requirements outlined in the physical or occupational therapy benefit set forth in sections 1861(g) and (p) of the Act.

Who Are Auxiliary Personnel?

Response: We have not further clarified who may serve as auxiliary personnel for a particular incident to service because the scope of practice of the auxiliary personnel and the supervising physician (or other practitioner) is determined by State law. We deliberately used the term any individual so that the physician (or other practitioner), under his or her discretion and license, may use the service of anyone ranging from another physician to a medical assistant. In addition, it is impossible to exhaustively list all incident to services and those specific auxiliary personnel who may perform each service. (emphasis supplied).

-66 FR 55246, 55268 (Nov. 1, 2001)

No Need To Credential Physicians, Right?

- Interesting question.
- Must meet the requirements. New patient problem, and more.
- Note licensure issues!

MBPM Chapter 15 § 60.1.B

However, the physician personally furnishing the services or supplies or supervising the auxiliary personnel furnishing the services or supplies must have a relationship with the legal entity billing and receiving payment for the services or supplies that satisfies the requirements for valid reassignment. As with the physician's personal professional services, the patient's financial liability for the incident to services or supplies is to the physician or other legal entity billing and receiving payment for the services or supplies. Therefore, the incident to services or supplies must represent an expense incurred by the physician or legal entity billing for the services or supplies.

42 C.F.R. § 410.26(a)

(2) **Direct supervision** means the level of supervision by the physician (or other practitioner) of auxiliary personnel as defined in **§ 410.32(b)(3)(ii)**.

(3) General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service.

What is “Direct Supervision?”

- 410.32(b)(3)(ii): “Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.”
- Defined more by what it is NOT, rather than what it IS. Not “in the room.” But where?

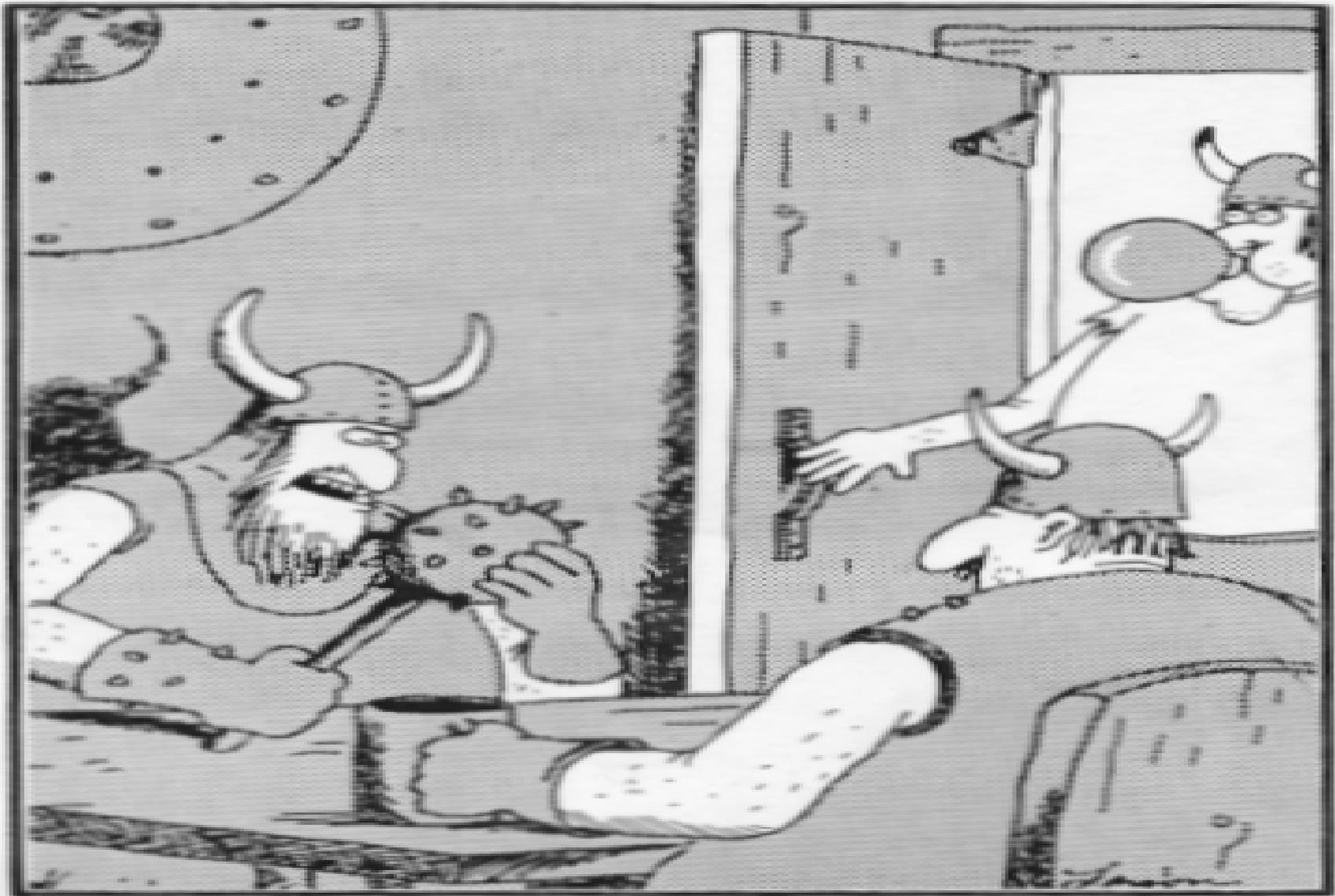
Office Suite?

“We are not proposing that there must be any particular configuration of rooms for an office to qualify as an office “suite.” However, direct supervision means that a physician must be in the office suite and immediately available to provide assistance and direction. **Thus, a group of contiguous rooms should in most cases satisfy this requirement.** We have been asked whether it would be possible for a physician to directly supervise a service furnished on a different floor. We think the answer would depend upon individual...

Office Suite?

circumstances that demonstrate that the physician is close at hand. The question of physician proximity for physician referral purposes, as well as for incident to purposes, is a decision that only the local carrier could make based on the layout of each group of offices. For example, a carrier might decide that **in certain circumstances** it is appropriate for one room of an office suite to be located on a different floor, such as when a physician practices on two floors of a townhouse.”

- 63 Fed Reg. 1685, Jan 9, 1998



“You know, Bjorg, there’s something about holding a good, solid mace in your hand -- you just look for an excuse to smash something.”

MBPM § 60.1.B

Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

MBPM § 60.1.B

If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than hospital or SNF), their services are covered incident to a physician's service only if there is direct supervision by the physician. For example, if a nurse accompanied the physician on house calls and administered an injection, the nurse's services are covered. If the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician) since the physician is not providing direct supervision.

MBPM § 60.1.B

Services provided by auxiliary personnel in an institution (e.g., nursing, or convalescent home) present a special problem in determining whether direct physician supervision exists. The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct supervision. (See § 70.3 of the Medicare National Coverage Determinations Manual for instructions used if a physician maintains an office in an institution.)

How To Mess Things Up 101

- Harmonize that with 410.26(b)(1):
“Services and supplies must be furnished in a noninstitutional setting to noninstitutional patients.”

MBPM § 60.1.B

For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under § 1861(s)(2)(A) of the Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a A/B MAC (A). (See § 80 concerning physician supervision of technicians performing diagnostic xray procedures in a physician's office.)

42 C.F.R. § 410.26(a)

(4) Independent contractor means an individual (or an entity that has hired such an individual) who performs part-time or full-time work for which the individual (or the entity that has hired such an individual) receives an IRS-1099 form.

(5) Leased employment means an employment relationship that is recognized by applicable State law and that is established by two employers by a contract such that one employer hires the services of an employee of the other employer.

42 C.F.R. § 410.26(a)

(6) Noninstitutional setting means all settings other than a hospital or skilled nursing facility.

(7) Practitioner means a non-physician practitioner who is authorized by the Act to receive payment for services incident to his or her own services.

(8) Services and supplies means any services or supplies (including drugs or biologicals that are not usually self-administered) that are included in section 1861(s)(2)(A) of the Act and are not specifically listed in the Act as a separate benefit included in the Medicare program.

42 C.F.R. § 410.26(b)

Medicare Part B pays for services and supplies incident to the service of a physician (or other practitioner).

(1) Services and supplies **must be furnished in a noninstitutional setting to noninstitutional patients.**

(2) Services and supplies must be an **integral, though incidental**, part of the service of a physician (or other practitioner) in the **course of diagnosis or treatment** of an injury or illness.

MBPM Chapter 15 § 60.1.B

Thus, where a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

“Course of Treatment*”

MBPM Chapter 15 § 60.1.B

This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment*.

*What happened to diagnosis???

What is a “course of [diagnosis or] treatment?”

- Patient receiving chemo, develops an infection.
- Child has a series of ear infections. What if they now get strep throat?
- Is the course of diagnosis broader?
- NEITHER THE REGS OF THE MANUAL MENTION “NEW PROBLEM.”

42 C.F.R. § 410.26(b)

(3) Services and supplies must be commonly furnished without charge or included in the bill of a physician (or other practitioner).

(4) Services and supplies must be of a type that are commonly furnished in the office or clinic of a physician (or other practitioner).

42 C.F.R. § 410.26(b)

(5) In general, services and supplies must be furnished under the direct supervision of the physician (or other practitioner). Designated care management services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided incident to the services of a physician (or other practitioner). The physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) who is treating the patient more broadly. However, only the supervising physician (or other practitioner) may bill Medicare for incident to services.

We billed under the wrong person, we're SOL, right?

- Wrong!
- Medicare Claims processing Manual Chapter 1, 30.2.2.1: “An otherwise correct Medicare payment made to an ineligible recipient under a reassignment or other authorization by the physician or other supplier does not constitute a program overpayment. “

42 C.F.R. § 410.26(b)

- (6) Services and supplies must be furnished by the physician, practitioner with an incident to benefit, or auxiliary personnel.
- (7) Services and supplies must be furnished in accordance with applicable State law.
- (8) A physician (or other practitioner) may be an employee or an independent contractor.
- (9) Claims for drugs payable administered by a physician as defined in section 1861(r) of the Social Security Act to refill an implanted item of DME may only be paid under Part B to the physician as a drug incident to a physician's service under section 1861(s)(2)(A). These drugs are not payable to a pharmacy/supplier as DME under section 1861(s)(6) of the Act.

42 C.F.R. § 410.26(c)

Limitations.

(1) Drugs and biologicals are also subject to the limitations specified in § 410.29.

(2) Physical therapy, occupational therapy and speech-language pathology services provided incident to a physician's professional services are subject to the provisions established in §§ 410.59(a)(3)(iii), 410.60(a)(3)(iii), and 410.62(a)(3)(ii).

Shared Visits

- Statutory requirement: None.
- Regulatory requirement: None.
- Subregulatory guidance: “any face-to-face portion of an E/M encounter.”
- Where does the Brand memo leave shared visits?



U. S. Department of Justice

Office of the Associate Attorney General

The Associate Attorney General

Washington, D.C. 20530

January 25, 2018

MEMORANDUM FOR: HEADS OF CIVIL LITIGATING COMPONENTS
UNITED STATES ATTORNEYS

CC: REGULATORY REFORM TASK FORCE

FROM: THE ASSOCIATE ATTORNEY GENERAL

A handwritten signature in blue ink, appearing to be "RUB", is written over the text "THE ASSOCIATE ATTORNEY GENERAL".

SUBJECT: Limiting Use of Agency Guidance Documents
In Affirmative Civil Enforcement Cases

On November 16, 2017, the Attorney General issued a memorandum (“Guidance Policy”) prohibiting Department components from issuing guidance documents that effectively bind the public without undergoing the notice-and-comment rulemaking process. Under the Guidance Policy, the Department may not issue guidance documents that purport to create rights or obligations binding on persons or entities outside the Executive Branch (including state, local, and tribal governments), or to create binding standards by which the Department will determine compliance with existing statutory or regulatory requirements.

The Guidance Policy also prohibits the Department from using its guidance documents to coerce regulated parties into taking any action or refraining from taking any action beyond what is required by the terms of the applicable statute or lawful regulation. And when the Department issues a guidance document setting out voluntary standards, the Guidance Policy requires a clear statement that noncompliance will not in itself result in any enforcement action.

Medicare Claims Processing Manual, Chapter 12, § 30.6.1.

SPLIT/SHARED E/M SERVICE

Office/Clinic Setting

In the [office/clinic setting](#) when the physician performs the E/M service the service must be reported using the physician's UPIN/PIN. **When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient. If “incident to” requirements are not met for the shared/split E/M service, the service must be billed under the NPP’s UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.**

Medicare Claims Processing Manual, Chapter 12, § 30.6.1.

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. However, 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.

Medicare Claims Processing Manual, Chapter 12, § 30.6.1.

1. If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.
2. In an 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 UPIN/PIN.

The Florida Project

- Client says they've heard from the MAC the physician must perform a “substantive” portion of the visit, defined as one of the CPT’s “key components,” i.e. history, exam or medical decision making.
- Manual says “physician provides any face-to-face portion of the E/M encounter with the patient.”
- Are those the same? “How are you?” Is MDM face-to-face?

First Coast Website

Split and shared visits FAQ

Q: What is a split/shared visit? Can you provide an example?

A: A split/shared evaluation and management (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 non-physician practitioner (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.

• The physician and NPP both must be in the same group practice or employed by the same employer.

The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non-facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to critical care services or procedures.

Common split/shared visit scenarios

• Hospital inpatient/outpatient/emergency room setting:

• 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 National Provider Identifier(NPI).

• 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 NPI.

• Payment will be made at the appropriate physician fee schedule rate based on the Provider Transaction Access Number (PTAN) entered on the claim.

EXAMPLE: If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.

EXAMPLE: In an 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.

Documentation for split/shared visits should follow the documentation guidelines for any E/M service: each physician/NPP should personally document in the medical record his/her portion of the E/M split/shared visit and legibly sign and date the record. The documentation must support the combined service level reported on the claim

Comprehensive Error Rate Testing (CERT) Finding: Split/Shared Evaluation & Management Services

Provider Types Affected: Physicians and Non Physician Practitioners (NPP)

Background: A Split/Shared service is an encounter in which a physician and an NPP, such as a Nurse Practitioner (NP), Physician Assistant (PA), Clinical Nurse Specialist (CNS), or Certified Nurse Midwife (CNM), each personally perform **a substantive portion** of an Evaluation/Management (E/M) visit face-to-face with the same patient on the same date of service.

OTHER CONSIDERATIONS

SPLIT/SHARED SERVICES

A split/shared service is an encounter where a physician and an NPP each personally **perform a portion of an E/M visit**. Below are the rules for reporting split/shared E/M services between physicians and NPPs:

- ❖ In the office or clinic setting:
 - For encounters with established patients who meet incident to requirements, use either practitioner's National Provider Identifier (NPI); and
 - For encounters that do not meet incident to requirements, use the NPP's NPI.
- ❖ Hospital inpatient, outpatient, and ED setting encounters shared between a physician and a NPP from the same group practice:
 - When the physician provides any face-to-face portion of the encounter, use either provider's NPI; and
 - When the physician does not provide a face-to-face encounter, use the NPP's NPI.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Evaluation and Management Services

Medicare Claims Processing Manual, Chapter 12, § 30.6.13 - Nursing Facility Services

H. Split/Shared E/M **Visit** **A split/shared E/M visit cannot be reported in the SNF/NF setting.** 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.** The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to critical care services or procedures.

Florida Project Lessons

- Don't assume you know the answer.
- Make them show you the rule.
- The Medicare program is too darn complicated for the people running it to get everything right.
- Just because it's written, doesn't mean it's a rule. Brand awareness.

Questions?



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