TITLE: Medicare and Tricare Incident to Billing in Physician-Based Settings

POLICY/PURPOSE: Compliance with Medicare and Tricare standards for incident to billing is critical as both of these payers reimburse physician services at a higher rate than services billed directly by Non-Physician Practitioners (NPPs). This policy sets forth a procedure to be used to determine whether or not a service rendered in a physician-based setting (office - place of service code 11) may be billed to Medicare or Tricare incident to a physician. **The Tricare guidance detailed in this policy pertains to specialist services only.**

DEFINITIONS:

PROCEDURE:

A. Incident to Billing Requirements

1. The supervising physician must be present in the office suite and immediately available to provide assistance and direction to the non-physician practitioner (NPP) or ancillary staff (Staff) throughout the time the NPP or Staff is performing the service.
2. The service rendered by the NPP or Staff must represent an expense to the physician group practice.
3. The NPP or Staff must be employed by, leased to, or an independent contractor of the physician group practice.
4. The service provided by the NPP or Staff must be within their respective State scope of practice.
5. The physician must perform the initial service and subsequent services with a frequency that reflects the physician's **active participation** in the ongoing care of the patient. This means that for each new problem being treated, the physician must have seen the patient previously for that problem and established a plan of treatment for that problem. Subsequent services for those same problems could be billed incident to the physician if bullets A1-A4 are supported.

B. Active Physician Participation

Neither Medicare nor Tricare guidelines specify precisely what constitutes the physician's "active participation" in the care of the patient. Accordingly, this policy

establishes the following internal guidelines for incident to billing that should satisfy the intent of the existing Medicare and Tricare guidelines.

1. **Frequency of Physician Involvement.** The medical record must document the physician's direct involvement in the evaluation and management of the patient's established problems once every 12 months. This is the minimum acceptable frequency of direct physician involvement.

2. **Level of Physician Involvement.** The medical record must reflect that the physician has seen the patient, reviewed the evaluation and management of the patient's problem(s) and concurs with care that is being provided. This may be accomplished in one of two ways:

   a. The physician may see the patient for a routine scheduled appointment once a year for review and approval of all problems and treatments provided by the NPP during
   the past year or modification of such treatment if indicated. In essence, the physician would perform and document an independent evaluation and management service.

   b. The physician may see the patient during a routine visit with the NPP. In this case either the physician or the NPP must document in the medical record that the physician saw the patient and either concurred with the care being provided by the NPP or made recommendations for changes in the care provided. In either case, the medical record entry must be signed by the physician.

   c. Changes made to treatment plan must be documented by the NPP or physician. If the NPP documents there should be an attestation from the physician stating that the charge was reviewed and discussed with the physician in order to bill the service incident-to the provider.

C. **Billing Options**

1. NPP Appointments

When a NPP provides the service, the NPP is in the best position to determine how the service should be billed. Before closing an encounter, the NPP will complete all work flows including Orders, Diagnosis, Notes and LOS.

Additionally, the NPP will determine if this visit complies with the "incident to" guidelines and will make the appropriate selection in the LOS screen. There are two options in the LOS screen:
1) Bill as NPP Service;
or
2) Bill as Physician Service.

The "Bill as NPP Service" option must be selected if the incident to guidelines have **not** been met.

The NPP will "Close the Encounter" and send to the supervising physician for cosignature.

2. Appointments without Physician or NPP Patient Contact

If a patient presents and is seen by Staff rather than the physician or NPP (e.g., previously ordered blood draw or BP check), the ordering provider (may be a physician or NPP) is responsible for determining whether the incident to requirements have been met. After Staff completes documentation for service, Staff must route the documentation to the ordering provider for cosignature. The ordering provider will determine whether the incident to requirements have been met and bill accordingly. Provider selection should conform with ***Bullet F*** below.

D. Non-Compliance with Regulations

Adherence to these guidelines may present certain logistical challenges for physicians, NPPs and Staff. If compliance with these standards cannot be obtained, the charge must be billed under the NPP's billing number if the service was performed by a NPP. If the service was performed by Staff, the service is not billable.

E. E&M Limit for Services by Staff performed Incident to a Physician or NPP

The procedure as set forth in Sections A through D may also be applied to services provided by Staff incident to a NPP service. However, unlike a NPP who may bill any level of E&M service incident to the physician that is medically necessary, appropriately documented, and within the NPP's scope of practice, services performed by Staff incident to either a physician or NPP are limited to procedure code 99211 (AKA: nurse visit). This does not preclude other services with distinct procedure codes from being billed incident to either a physician or NPP if the Staff is qualified to perform the service and the incident-to requirements are met.

For example, if a patient presents for a blood draw that was previously ordered by a physician or NPP who fulfilled the requirements in Section A, and the blood draw was performed by Staff, the venipuncture procedure code 36415 would be billed incident to the physician or NPP, not a E&M visit code.

F. NPP in Mid-Level Provider Field

In order to identify charges billed incident to a physician, the NPP's name must be entered in the "Service Provider" field and the Supervising Physician's name is to be entered in the "Billing Provider" field. Likewise, if a service is performed incident to a NPP, the NPP's name shall be entered in both the "Service Provider" and "Billing Provider" fields. Failure to enter the name of the NPP in this fashion may subject the organization to increased compliance risk during government audits.

G. Supervision in Group Practice

The physician who ordered a particular service need not be the physician who is providing direct supervision on the date that the service is performed. In this case, the charge would be billed under the provider number of the physician who was in the clinic and charged with supervising the NPP or Staff on that particular date. NPPs cannot provide supervision for services billed incident to a physician.

REFERENCES:

CMS. *Medicare Benefit Policy Manual* (100-02), Chapter 15, Section 60.
DOD. *Tricare Policy Manual*, Chapter 11, Section 10.1.

APPROVED BY:
Committee or person