



“Incident-to” Billing Requirements



To Our Healthcare Clients and Friends:

In the 2009 Outpatient Prospective Payment System (OPPS) Final Rule, the Centers for Medicare and Medicaid Services (CMS) issued a restatement and clarification of the requirements for physician supervision for “incident-to” billing. This clarification created additional confusion in the provider community. Therefore, when the CMS issued its proposed 2010 OPPS Rule, it provided further clarification of the supervision requirements related to “incident-to” billing. These 2010 proposed rules have now been finalized in the 2010 OPPS Final Rule which is effective as of January 1, 2010.

The amendment and clarification addresses the confusion and concern in the provider community around the supervision issue and other issues concerning the “incident-to” billing requirements. In this edition of IMA Insights, we will provide some understanding and guidance concerning “incident-to” billing and certain related issues.



BACKGROUND



Therapeutic services performed by non-physician practitioners ("NPPs") may be billed in one of two ways. The first way is to bill for the service under the NPP's name and National Provider Identifier (NPI). The second way is to bill the service as "incident-to" under a physician's name and NPI. If a service is billed directly by the NPP, the reimbursement is at 85% of the allowable fee. However, if billed "incident-to", the payment is at 100% of the allowable fee. Because of the difference in payment, "incident-to" billing is an area of compliance concern for both CMS and the provider community.

CHALLENGES

"Incident-to" requirements are set out in 42 CFR 410.27. In general, this regulation requires that in order to bill a therapeutic service as an "incident-to" service it must meet the following requirements:

1. The service must be provided in "... the hospital or at a department of a provider... that has provider-based status in relation to a hospital..."
2. The service must be "... an integral though incidental part of a physician's services"
3. The service "... must be under the 'direct supervision' of a physician"

The changes that have been finalized by the CMS in the 2010 OPPS Final Rule will change the second criteria to "... an integral though incidental part of a physician's *or non-physician practitioner's services*" (emphasis added) and the third criteria to "Under the direct supervision of a physician *or a non-physician practitioner... Non-physician practitioners may directly supervise services that they may personally furnish in accordance with State law and all additional requirements...*" (emphasis added).

In addition to these requirements, an additional requirement is detailed in the Medicare Benefit Policy Manual, Chapter 6, Section 20.5.1, which states that the service "... must be furnished under the order of a physician or other practitioner practicing within the extant of the Act, the Code of Federal Regulations, and State law..."

The first criteria outlined above, that the service be provided by the hospital or a provider-based department of the hospital, necessitates that the provider-based regulations as detailed in 42 CFR 413.65 also be considered. This regulation lists out a series of requirements that a specific department must meet in order to be considered provider-based. These requirements encompass various areas including, but not limited to, the following:

1. Licensure
2. Clinical Integration
3. Financial Integration
4. Public Awareness
5. Ownership and Control
6. Administration and Supervision
7. Location
8. Management Contracts

Assuming that the service rendered takes place in a hospital or a provider-based department of a hospital, the second criteria that the service must meet is that it is an "integral though incidental" part of a physician's or a NPP's service. The common understanding of this requirement is that, although the physician or a NPP is not required to see the patient each time a service is rendered, the physician or a NPP must see the patient periodically. In addition, the physician or a NPP must see the patient sufficiently enough in order to assess the treatment that is being given. CMS has never specified what is "sufficient enough" to satisfy this requirement. A hospital needs to continually monitor this area in order to ensure that documentation is adequate to support the billing of the "incident-to" service.

The final condition outlined in 42 CFR 410.27 concerns the "direct supervision" of the service and has been the cause of much confusion in the provider community. The confusion has centered on a number of items including:



1. The definition of "direct supervision"
2. Where does direct supervision apply?
3. Who can provide the direct supervision?
4. Where do they need to be located?

The current guidance from CMS, as outlined in the 2009 OPPS Final Rule is that the direct supervision "... means the physician must be present and on the premises of the location 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. This language makes no distinction between on-campus and off-campus provider-based departments."

In general, this clarification has been interpreted to mean that there needs to be a physician (which could be an MD, DO, Dentist, Podiatrist, Optometrist, or Chiropractor) present in the department (as defined by the hospital and consist with the requirements as outlined in 42 CFR 413.65 (2)), in which the service is being rendered in order for that service to be billed as "incident-to" a physician service.

The change in the 2010 OPPS Final Rule allows NPPs to perform direct supervision duties, with certain limitations, and distinguishes between on-campus supervision requirements and off-campus supervision requirements. Specifically, the CMS is allowing that NPPs may directly supervise hospital outpatient therapeutic services that they are allowed to perform under state law. However, this revision would not be applicable to cardiac rehabilitation, intensive cardiac rehabilitation or pulmonary rehabilitation services. For these services, the CMS is still requiring that the direct supervision be performed by a physician.

Concerning the location of the department where the services are being performed, the CMS now considers that the direct supervision requirement would be met for on-campus departments if the supervising physician or NPP is present in the hospital or in the department and is immediately available to assist in the procedure. For off-campus provider-based departments, the CMS is still requiring that the physician or non-physician practitioner be present in the department and immediately available.

INSIGHTS

"Incident-to" billing has been receiving more attention throughout the nation by both fiscal intermediaries and the RAC auditors. It is an area that has traditionally been very unclear and, even with additional recent amendments and clarifications from CMS, remains problematic. Hospitals should attempt to ensure compliance in this area by:

1. Identifying any department within the hospital that is currently billing "incident-to" services.
 - a. It is important to also include off-campus provider-based departments.
 - b. Review should also include instances where services performed by a NPP is being billed under their own NPI but could possibly qualify to be billed as "incident-to".
2. Ensuring that the department involved qualifies as provider-based.
 - a. Specifically that the requirements outlined in 42 CFR 413.65 are met.
 - b. A hospital might also wish to submit an attestation to the CMS to ensure the provider-based status of a specific department.
3. Maintaining documentation that supports the service being billed was integral, although incidental, to a physician or NPP service.
 - a. Ensure that the initial service is well documented in the medical records.
 - b. There should also be evidence that the physician or NPP is monitoring the patients progress on an on-going basis.
4. Ensuring that the service was rendered under the direct supervision of a physician or NPP.
 - a. If a NPP is performing the direct supervision, it is important to document that the service is something that the NPPs permitted to personally perform under state law.
 - b. If the service is being performed in an off-campus provider-based department, the documentation must show that the supervising physician or NPP was physically located in that department.





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SUMMARY

Historically, the billing of "incident-to" therapeutic services has been confusing because of the differing interpretations of guidance being issued by the CMS. In the 2010 OPPS Final Rule, the CMS is attempting again to clarify and amend these requirements. These amendments add flexibility around the direct supervision requirements. A hospital that can successfully implement these changes into their operations could benefit from additional reimbursement for the services being performed.

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We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance with "incident-to" billing, please contact me at 610-340-0618.

Very truly yours,

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