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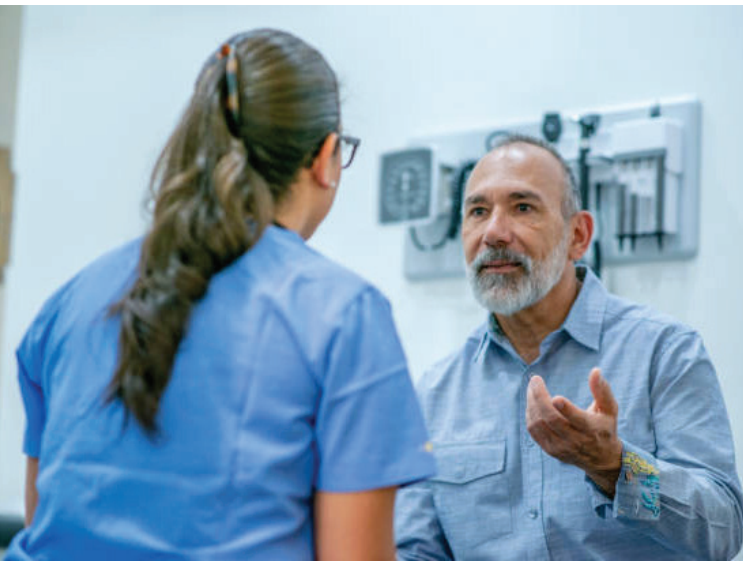

In this issue

Billing

Sharpen your billing after MACs warn practices to clean up incident to

A $900,000 settlement and a Medicare administrative contractor's (MAC) call to perform internal reviews are the latest reminders that incident-to billing remains a challenge. Failure to stay compliant can erase the additional revenue a practice might earn from billing a non-physician's service under a physician's name.

Pennsylvania State University's Penn State Psychological Clinic is the latest provider to discover the high cost of incident-to mistakes. The university voluntarily disclosed several problems with past claims, including the way it handled incident-to claims, according to a March 3 announcement by the Department of Justice (DOJ). The university agreed to pay $899,800 to resolve the matter.

Meanwhile, practices in six states have been instructed to audit their incident-to claims and refund improper payments. WPS GHA, the MAC covering Indiana, Iowa, Kansas, Michigan, Missouri and Nebraska, announced Feb. 24 that it had found a "vulnerability" related to incident-to services. "We ask anyone billing 'incident to' under the [Medicare physician fee schedule] to complete a self-audit verifying services meet the Medicare rules," the MAC said in the announcement. WPS added that after a practice returns any overpayments it should "resubmit the claim correctly."

The DOJ and WPS did not provide details about the problems with the incident-to claims, but alerts from other MACs indicate that incident-to billing for new patients and new problems are top trouble spots. In a notice released Feb. 11, Novitas announced that its medical review department "has observed a continued trend of the utilization of non-physician practitioners

Master 2022 anesthesia coding update

CPT codes 01935 and 01936, billed for percutaneous image-guided procedures of the spine or spinal cord, were created in 2008 and represented millions of dollars a year for anesthesia groups. As of Jan. 1, a series of six new CPT codes replaced them, based on the procedure performed and the section of the spine treated. Ensure your billing is accurate by attending the March 29 webinar **Anesthesia Update 2022: Navigate the New Codes for Percutaneous Image-Guided Procedures on the Spine & Spinal Cord.** Learn more: *https://codingbooks.com/ympda032922*.

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to perform initial office visits as 'incident to' services." And a targeted probe and educate review conducted by CGS in 2019 identified "new complaints inappropriately addressed by [non-physician practitioners (NPPs)] billing incident to [a] supervising physician."

Novitas found that NPPs and physicians were splitting new patient office visits, where the NPP performs part of the visit and the physician creates a plan of care. In these cases, practices were billing the service under the physician's name and national provider identifier (NPI). That's permissible for facility-based visits if the physician performs at least one element of the visit, but in the office setting a split/shared visit for a new patient would have to be billed by the NPP.

The physician must perform the initial service, which includes the history and physical exam and creating the treatment plan. "It is expected that the physician will perform the initial visit on each new patient to establish the physician-patient relationship," Novitas said.

MACs offer audit tips

You'll need to review your practice's schedule for the date of service, the claim and the visit note to check up on your incident-to billing.

The schedule will tell you if a physician provided direct supervision — that is, the physician was in the office suite and immediately available during the encounter. When a physician did not provide direct supervision, skip straight to the claim to determine who billed the encounter and flag for repayment any that were billed under the treating physician's NPI. Remind staff that it does not matter if the NPP is experienced or how minor the patient's problem was. Direct supervision is a must for incident-to service.

When the visit clears the direct supervision hurdle, check the chart to see who performed the visit and the nature of the visit to determine if it was a new patient, an established patient with an established problem or an established patient with a new problem.

Then you'll check the claim to see if the visit was billed by the physician or the NPP. When the patient or problem was new and treated by the NPP, the NPP bills, even when the physician was in the office.

MACs have created charts that you can share with staff to guide them through various established patient scenarios. For example, Noridian and CGS include a decision-making chart in their incident-to fact sheets (*see chart, p. 3*). The chart is based on the assumption that a physician provided direct supervision during the encounter:

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