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Eli's Rehab Report

Want to Make an Extra 15% Each Time You Report 99213?

5 requirements get you 100 percent nonphysician-practitioner reimbursement

If a nonphysician practitioner (NPP) ever performs E/M services at your practice, you may be able to collect 15 percent more than the NPP's standard fee if you carefully follow Medicare's "incident-to" requirements.

Because the HHS Office of Inspector General is watching incident-to services this year, you should study the following five requirements to ensure that your incident-to claims are airtight.

1. The Employees Belong to the Same Group

To bill an NPP service under your physiatrist's name, the same group must employ both parties. Both the supervising physician and the performing NPP must be employees, leased employees or under contract with the same group, says **Dennis Grindle, CPA**, a partner in healthcare consulting at Seim, Johnson, Sestak & Quist LLP in Omaha, Neb.

2. Your Physiatrist Initiates Treatment

You cannot bill a service incident-to unless your physician previously treated the patient. This rule automatically excludes you from billing incident-to for new patient encounters, so if your NPP treats a new patient, you should bill the service under the NPP's personal identification number (PIN). Medicare will pay the claim at 85 percent of the standard rate.

Real-World Scenario: A nurse practitioner (NP) treats a new patient who has an Achilles bursitis flare-up. The NP recommends that the patient rest, apply ice and use a deep-heating ointment. The NPP reports a code from the **CPT 99201 - 99205** series (Office or other outpatient visit for the evaluation of a new patient ...) linked to 726.71 (Achilles bursitis or tendinitis) under the NP's own PIN number.

Money Tip: If the physiatrist first saw the patient in this example, you'd add almost $10 to a 99202 claim. You could bill 99202, for instance, at 100 percent, or about $65 for Medicare. When billing under the NPP's PIN, Medicare will pay the office visit at $55.25, a difference of $9.75.

3. The NPP Treats an Established Problem

Your physician must see a patient for any new problems, but your NPP can report established patient visits for existing problems as incident-to. The only catch is that the physician must establish the initial diagnosis and prepare the treatment plan.

The Facts: Your physiatrist previously diagnosed a 50-year-old established male patient with lumbar strain and created a treatment plan for his condition. The patient presents today to an NPP to evaluate his condition. The physiatrist is present in the office suite.

In this case, you should report the appropriate established patient office visit code (99211-99215, Office or other outpatient visit for the evaluation and management of an established patient ...) under the physiatrist's PIN. The physiatrist has seen the patient, has provided a diagnosis for the condition, and has been previously involved in the treatment plan. And, he is present in the office to handle any problems that might arise that day.

Possible Snag: Suppose the NPP is in the middle of the lumbar strain E/M visit and discovers a new problem. Must she

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call the physiatrist into the room?

She can ask the physician to come to the room, but if the physician takes over the patient's care, he should bill the entire visit under his PIN.

If the physician doesn't come to the room, however, and the NPP diagnoses the new condition herself, she should bill the entire visit under her own PIN. She can't separate out the lumbar strain portion of the E/M and bill just that part as incident-to.

4. Care Involves the Physician

Make sure that your NPP's documentation reflects your physiatrist's ongoing involvement in incident-to cases. Look for carriers' interpretations of the ongoing-care requirement. Some Medicare carriers require the physician to provide one out of every three encounters, while others are less specific on the topic.

Remember: "It is not a national requirement, per se, that the physician be updated, because he or she was the one who initiated the treatment course," says **Suzan Hvizdash, BSJ, CPC**, physician education specialist at the University of Pittsburgh's department of surgery. "If the treatment course didn't change, he is to assume the course of treatment is going as planned. If it changes, then we don't have an incident-to situation any longer."

Best bet: It's a good idea to document the physician's involvement, even if your carrier doesn't require specific documentation of it, Hvizdash says. "The NPP often will write, for example, 'I reviewed the patient's status with Dr. X, who was in the office this afternoon.' "

5. Your Physiatrist Provides Direct Supervision

To bill a service incident-to, your physiatrist must be present in the office suite. That means the physician is immediately available to help.

Another way: When your physiatrist doesn't provide direct supervision, bill the service under the NPP's number if your state permits NPPs to provide the service in question.

Reminder: Always report the service incident-to the on-duty physiatrist. If an NPP provides a service to Dr. A's patient, but Dr. B is present, bill the service incident-to Dr. B.

Ask "Who is providing the required level of supervision?" Grindle says. Because Physician B is the supervising doctor, you should bill using that identification number, Grindle says.

Protect yourself: "I highly recommend that the NPP document the physician's whereabouts," Hvizdash says. "If this is a PA-C, the physician is required to countersign all documentation. To not complicate matters, I usually suggest that the physician countersign all extender documentation. That way he or she doesn't have to distinguish between staff members."

Don't miss: If an insurer ever questions the documentation and it does not mention the physician's presence, "The payers can request the physician's schedule (personal and professional), and we don't want to get into that territory," Hvizdash says.

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