“Incident to” and Fee-For-Time Arrangements (Locum Tenens)

A Roadmap for Compliance

Prepared by HBE ADVISORS LLC

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Attendees should be aware that regulatory, coding, and billing information changes frequently, and the information contained in these slides may become outdated quickly.

This information is not intended to replace job specific training and should only be used as a reference after confirming the accuracy and applicability of the information based upon current published laws, statutes, regulations, and guidelines.

We have provided links to several source agencies to assist in locating current information after the date of this presentation.

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Agenda

- Medicare “incident to” billing rules
- Medicare locum tenens billing rules
- Auditing and monitoring strategies
- Internal controls and best practices to promote compliance

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Medicare “Incident to” Billing Rules

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Medicare "Incident to" Billing Rules

- Medicare provision, although private payers may have similar policies.
- Defined as "services or supplies that are furnished "incident to" a physician's professional service when the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness and the services are performed in the physician's office."
- To qualify for payment, the services must be part of a patient's normal course of treatment, during which the physician personally performed an initial service and remains actively involved in the ongoing course of treatment.

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Medicare "Incident to" Billing Rules

- Coverage is available for the services of such nonphysician personnel as nurses, technicians and therapists when furnished "incident to" the professional services of a physician/nonphysician practitioner.
- Medicare also pays for services rendered by employees of a clinical psychologist (CP), nurse practitioner (NP), certified nurse midwife (CNM), physician assistant (PA)or clinical nurse specialist (CNS) only when all "incident to" criteria are met.
  - "Incident to" services supervised by non-physician practitioners are reimbursed at 85%.

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Medicare “Incident to” Billing Rules

- In order to qualify for payment, the following criteria must be met:
  - Services must be rendered under the direct supervision of the physician, CP, NP, CNM, CNS, or in the case of a physician directed clinic, the physician assistant (PA).
  - The services are furnished as an integral, although incidental, part of the physician’s, CP’s, NP’s, CNM’s, or CNS’s professional services in the course of the diagnosis or treatment of an illness or injury.
  - Billing “incident to” a qualified provider, the provider must initiate treatment and see the patient at a frequency that reflects his/her active involvement in the patient’s case. This includes both new patients and established patients being seen for new problems.

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Medicare “Incident to” Billing Rules

- There must be a valid employment arrangement between the physician, CP, NP, CNM, CNS, or physician directed clinic, and the employee.
- The physician/nonphysician practitioner cannot hire and supervise a professional whose scope of practice is outside the provider’s own scope of practice.
- Services must be rendered under direct supervision. The physician/nonphysician practitioner (or a physician/nonphysician member of the group) must be present in the office suite and immediately available to provide assistance and direction throughout the time the employee is performing the services.
  - Immediately available means the supervising physician/nonphysician is readily available and without delay to assist and take over the care as necessary.

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Medicare "Incident to" Billing Rules

Example	Rendering	Proper Billing
Established patient, no new problems	NPP	If "incident to" requirements have been met, the service may be billed under the supervising physician's NPI
Established patient, new problem	NPP	Must be billed under the NPP's NPI
Established patient, new problem	NPP and Physician	If "incident to" requirements have been met, the service may be billed under the physician's NPI. The documentation must support the physician performed a portion of the face-to-face encounter and initiated the course of treatment.
New patient	NPP	Must be billed under the NPP's NPI.

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Medicare "Incident to" Billing Rules

- Common "incident to" billing errors:
  - Billing for new problems or patients
  - Billing for services not included in the physician treatment plan
  - Billing for services rendered in a hospital, SNF, etc.
    - Anything other than POS 11
  - Billing for services that don't meet direct supervision criteria
  - Billing for services rendered by non-employees
  - Billing for services which exceed an employees scope of license
  - Billing "incident to" to payers who do not allow/recognize the provisions

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Medicare “Incident to” Billing Rules

- There is a significant payment differential (15%) between services performed and billed by a NP/PA under their provider number vs. services billed under a physician provider number.
  - This payment differential creates compliance risk.
- In January, a family practice physician settled false claims allegations made by the DOJ related to “incident to” billing.
  - Physician agreed to pay $285,000.
  - Services rendered by nurse practitioners were billed using the physician’s provider number even though the direct supervision requirements were not met.

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Medicare “Incident to” Billing Rules

- “Incident to” has been the subject of multiple DOJ settlements and OIG reports.
- There has been substantial pressure on CMS to eliminate the provisions altogether.
- In the June 2019 Medicare Payment Advisory Commission (MedPAC) report to Congress, the commission unanimously recommended that Medicare eliminate the “incident to” provisions.
  - It would not be a surprise to find this recommendation addressed in the 2021 Proposed Physician Fee Schedule.

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Medicare Locum Tenens Billing Rules

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Medicare Locum Tenens Billing Rules

- Medicare provision, although private payers may have similar policies
- Over the last couple of years, Medicare discontinued the term "locum tenens" and now officially references the rules as "Fee-for-Time Compensation Arrangements".
  - For simplicity where this presentation uses the term "locum tenens", the official Medicare rules for "Fee-for-Time Compensation Arrangements" apply.
- Provisions allow a physician to retain a substitute physician to take over his/her professional practice when the physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician's services as though he/she performed them.

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Medicare Locum Tenens Billing Rules

- In order to bill under these provisions, the following criteria must be met:
  - Regular physician is unavailable to provide services
  - Medicare beneficiary seeks services from the regular physician
  - Regular physician pays fee-for-time compensation arrangement physician (locum) for his/her services on a per diem or similar fee-for-time basis
  - Substitute physician (locum) does not provide services to patients over a continuous period of longer than 60 days
  - Regular physician retains records of the substitute physician's (locum) NPI. These records must be available upon request.
  - Claims for the services rendered by the locum must be submitted with the Q6 modifier (services furnished by a fee-for-time compensation arrangement physician).

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Medicare Locum Tenens Billing Rules

- Services rendered by non-physician practitioners (i.e. CRNA, NP, PA, etc.) may not be billed under fee-for-time compensation arrangements (locum).
  - There are limited exceptions for physical therapy.
- There is an exception to the 60-day limitation. If the regular physician is called to active duty military, then the locum may provide continuous services for longer than 60 days.
  - Services rendered during the initial 60-day period are billed under the regular physician's NPI with the Q6 modifier.
  - Services beyond the initial 60-day period, must be billed with the substitute physician's (locum) NPI.
- The regular physician may not personally provide and bill services during the same time period as the locum.

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Medicare Locum Tenens Billing Rules

- For medical group billing under the fee-for-compensation arrangement (locum), it is assumed that the substitute physician is paid by the regular physician.
  - Regular physician includes a physician who has left the group and for whom the group has hired a fee-for-time physician (locum) as a replacement.
  - A physician who has left a group, and for whom the group has engaged a fee-for-time compensation physician (locum) as a temporary replacement, may still be considered a member of the group until a permanent replacement is obtained.
    - May not bill for locum for more than 60 days even if multiple locums are used.
  - Medical group must report the locum's NPI on the claim (field 24).
  - Group must retain records of the substitute physician's (locum) NPI along with a copy of all services provided by the locum. These records must be available upon request.

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Medicare Locum Tenens Billing Rules

- Common locum tenens billing errors:
  - Billing for continuous services beyond 60 days
  - Billing for providers who have not yet obtained their NPI
  - Billing for non-physician practitioners
  - Billing for services without a written agreement
  - Billing services without the Q6 modifier

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Auditing and Monitoring Strategies

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Auditing & Monitoring Strategies

- Auditing & monitoring is critical to any organization and is a fundamental element of compliance.
- There are many methods for conducting effective auditing and monitoring, but in the case of "incident to" and locum tenens services, a combination of data analysis and medical record reviews is preferred.
- All payers and audit agencies utilize data analysis in order to identify aberrant or unusual billing patterns and target providers for audit.

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Auditing & Monitoring Strategies

- As an example, E/M services are often the most frequently billed.
  - Although the times associated with E/M services are "averages," the analysis of time is often a payer's first indication that a provider may be improperly coding.
  - By analyzing the E/M services submitted on the same date of service, payers can determine the number of hours per day the provider is billing.
  - If a provider routinely bills for "excessive time" and/or an abnormal volume of high level services it will likely trigger an audit where provider schedules and medical records are reviewed to support the aberrant billing patterns.

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Auditing & Monitoring Strategies

- If you bill for a high volume of "incident to" services, it can quickly create the appearance of improper billing by the provider.
- In the table, let's assume ½ the visits were rendered by a NP and the other ½ by the supervising physician but all the NP visits were billed "incident to".
- A physician who appears to be billing for over 20 hours of services per day, not counting procedures, is going to be targeted for audit.

DOS 2/1/20	Total Number of Visits	Average Time	Total Time (Minutes)	Hours Per Day
99213	30	15	450	
99214	20	25	500	
99215	4	40	160	
99204	3	45	135	
Total	57		1,245	20.75

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Auditing & Monitoring Strategies

- Conduct regular data analysis to identify your high volume providers.
- Review a sample of medical records for the identified providers.
  - Does the documentation support each of the “incident to” criteria were met?
  - Does the documentation support the E/M level was correctly?
  - Do you have a problem that requires further investigation?
  - Document your actions and results and retain them.

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Auditing & Monitoring Strategies

- Analyzing your data to review locum billing trends is also valuable.
- Identify your claims with a Q6 modifier.
  - Do you have claims with dates of service exceeding the 60-day period?
  - Do you have overlapping claims (personally performed and locum) for the same physician for the same time period?
  - Compare your claims data to the locum schedules. Was the Q6 modifier appropriately reported?
  - Do you have a locum contract for each date/period the Q6 was reported?
  - Do you have a problem that requires further investigation?
  - Document your actions and results and retain them.

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Internal Controls and Best Practices

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Internal Controls & Best Practices

- "Incident to"
  - Know your payer guidelines! Not all payers allow "incident to".
  - Develop system edits to prevent "incident to" billing where prohibited by the payer, or in the following scenarios:
    - New patients
    - Non-office place of service
  - Revise documentation templates to include direct supervision attestation statements for "incident to"
    - These should accurately reflect the supervision for the encounter rather than a template statement.
  - Develop policies and procedures to address direct supervision requirements.
  - Develop policies and procedures which outline how often, at a minimum, a supervising physician must evaluate the patient and update the treatment plan.

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Internal Controls & Best Practices

- Locum tenens
  - Know your payer guidelines! Not all payers recognize locums.
  - Develop policies and procedures for tracking locums to ensure the 60-day limitations are not exceeded.
  - Develop policies and procedures to prevent billing under the locum provisions for non-physicians.
  - Develop policies and procedures to prevent services rendered by non-credentialed providers from being billed under the locum provisions.
  - Develop system edits to identify and prevent overlapping billing of a regular physician and their locum for the same time period.
  - Develop policies and procedures to ensure all services rendered by a locum are readily identifiable and reproducible.
  - Develop policies and procedures to ensure current, written agreements with locums are maintained and easily produced.

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Internal Controls & Best Practices

- In all cases, educate your providers, coding and billing staff on the documentation and coverage requirements.
- Conduct routine auditing and monitoring of your medical records and claims to ensure compliance with the rules.
- Encourage open communication with between providers and staff.
- Keep your eyes open for changes in the "incident to" rules.

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Questions?

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Thank You

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Resources

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Resources

- Medicare Benefit Policy Manual, Chapter 15
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
- Medicare Claims Processing Manual, Chapter 1
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

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