UMeNewsletter

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INCIDENT TO BILLING

The 'Incident to' / 2012 audits was addressed in a lecture at the October 2011 PSPA Annual Conference in Erie. The following scenarios are to explain the differences between the various office visits and how they relate to 'Incident to' billing.

SCENARIO 1: 'Incident to' is NOT an issue with this visit.

Patient is seen by MD for Hypertension. The office visit is billed (most likely a 99213, maybe a 99214). The insurance company reimburses at 100% of the allowable charge since the patient was seen by a MD.

SCENARIO 2: ' Incident to' is NOT an issue with this visit.

Patient is seen by PA-C for Hypertension and has NOT previously been seen by MD for Hypertension . The office visit is billed (most likely a 99213, maybe a 99214). The insurance company reimburses at 85% of the allowable charge since the patient was seen by a PA-C.

SCENARIO 3: 'Incident to' IS an issue with this visit.

Patient usually sees a MD for their Hypertension, however at this office visit they are seen by a PA-C. The office visit is billed (most likely a 99213, maybe a 99214) INCLUDING additional coding indicating it is 'Incident to' (meaning the patient has previously been seen by the MD for Hypertension). Now the insurance company will reimburse at 100% of the allowable charge since this office visit was for an issue that is 'Incident to' the patient having been seen by the MD for the same issue in the past.

SCENARIO 4: 'Incident to' IS NOT ALLOWED in this situation

Patient usually sees a MD for their Hypertension, however at this office visit they are seen by a PA-C -- AND -- at this office visit the patient ALSO mentions that they have a sore throat and a sinus headache. The office visit is billed (most likely as a 99214) for Hypertension /Pharyngitis/Sinusitis. Now the 'Incident to' coding is NOT an option because the office visit is no longer for the same reason as when the patient saw the MD (which was just for Hypertension). So the insurance company should only reimburse at 85% of the allowable charge since the patient was seen by a PA-C.

Please also see the attached PDF file for further information for `Incident To` billing

Update on 2012 Medicare Physician Payment Rates

By: AMA

The payroll tax extension legislation that was passed by Congress and signed by the President on Dec. 23, 2011 (Public Law 112-078) delayed the 27.4% Medicare pay cut due to the SGR formula for two months. It also extended the floor on the work geographic practice cost index (GPCI) and certain other policies. The Centers for Medicare & Medicaid Services (CMS) has confirmed to the AMA, however, that all of the other changes that were included in the Medicare physician payment final rule for 2012 will still take effect. Physicians should not expect that payment rates will remain unchanged. As detailed in a memo sent to the Federation on Nov. 4, 2011 following release of the final rule, numerous changes are being made in the relative value units, GPCIs, electronic prescribing and quality reporting programs, and multiple procedure payment rules for 2012. All of these changes will take effect as scheduled for dates of service beginning Jan. 1, 2012.

CMS also has indicated that because Congress acted so late in 2011 to prevent the SGR cut, claims must still be held for a period of time to allow CMS time to develop the new payment rate files and the Medicare claims administration contractors time to install and test the files. CMS expects that most if not all contractors will be ready to process claims under the revised rates on or before Jan. 18, 2012, which is the end of the 10-business-day claims hold period previously announced, but contractors' time frames may differ. Contractors are expected to have the new rates posted to their web sites by Jan. 11th.