CODING
What to look for when you audit incident-to and split/shared services

Incident-to and split/shared services are a way for a medical practice to earn 100% of Medicare’s allowed charges for services rendered by non-physician practitioners (NPPs), instead of the customary 85% paid when these services are billed directly by the NPP.

The lure of this 15% payment boost is strong, and perfectly legal. But it’s not free. Both incident-to and split/shared billing policies have specific billing and documentation requirements that must be met to earn the extra payments. You also need to be able to audit against vaguely written Medicare policies.

We’ll share some best practices to ensure your billing will stand up to audit scrutiny. First, let’s define the terms.

**Incident-to billing** takes place in the physician office setting (place of service 11). Under incident-to billing, services can be provided by an NPP and billed directly by a physician, provided that all treatment is provided under a plan of care established by the physician and that the services are being provided under direct physician supervision.

**Direct physician supervision** is defined as the physician being in the office suite and available to assist immediately.

**Split/shared service billing rules** apply to facility settings, such as the inpatient or outpatient hospital (places of service 21 and 22, respectively). When a physician group practice operates as a provider-based setting, it bills services as place of service 22 and the split/shared billing rules apply, not incident-to.

Apart from place of service, there are two key distinctions between incident-to and split/shared billing.

(continued on pg. 2)
1. A service may be billed incident-to without any physician participation in the encounter, while a split/shared service requires the participation of the billing physician in the encounter.

2. New diagnoses may not be billed with incident-to visits, but can be billed as split/shared visits.

Let’s take a deeper look at each of these types of services and what to look for when you’re doing an audit.

**Incident-to services**

Auditing incident-to billing can be tricky because the auditor will typically need to review multiple encounters to determine whether incident-to billing was done appropriately. As noted in Pub. 100-02, Chap. 15, Sec. 60.2 of Medicare’s Internet Only Manual (IOM), incident-to billing by an NPP can be done only when the patient has had an initial, direct encounter with a physician to create a treatment plan under which the NPP is rendering care.

In addition, the regulation requires that the physician remain actively involved in the management of the patient’s care, though it doesn’t specify exactly what is required to meet that standard.

When auditing encounters billed directly under a physician but rendered by an NPP, you need to track back through other services the patient has had to find an encounter between the physician and the patient for each condition addressed by the NPP during the incident-to visit.

You must be able to find documentation that supports the establishment of a treatment plan for *every* condition addressed by the NPP. One of the classic traps of incident-to billing is when the patient raises a new condition with the NPP during what is scheduled as a follow-up visit for a known condition with a plan of care in place.

Once this happens, you can no longer bill the service as an incident-to service.

Finally, each physician practice should have a written policy stating the frequency that each patient must have a direct encounter with the physician to reflect the physician’s active management of the patient. We recommend that it be every third to fifth visit, but that no more than a year pass without the patient seeing the physician.

Auditors also need to look for the evidence of this active management when supporting incident-to billing.

**Split/shared services**

The good news about split/shared services is that, as an auditor, you can support or not support a split/shared visit based solely off of the documentation for that visit. You don’t need to track back through other services.

Split/shared billing is addressed in Pub. 100-04, Chap. 12, Sec. 30.6.1 of the IOM. The key things to look for as an auditor are that the physician must have had a face-to-face encounter with the patient and must have performed a portion of the visit.

Again, the regulations are a little bit vague on the expectations of the physician during a split/shared encounter. What is not vague, however, is that the regulation requires the physician to have done more than just review the record of the work done by the NPP.

In addition, CMS has clearly stated that physician documentation in the record such as “seen and agreed with the NPP’s findings” or “reviewed and agreed” are insufficient to support billing a split/shared service under the physician.

When auditing split/shared visits, it doesn’t matter whether the NPP and the physician rounded together or whether each saw the patient separately during the same date. The latter scenario is more likely.

What does matter is that the physician’s documentation clearly reflects that he or she had a face-to-face encounter with the patient and performed *some* element of the service. It doesn’t need to be a specific amount, such as half of the service, to be billed as split/shared.

Look for evidence that the physician performed some element of the examination of the patient and participated in the medical decision making of the case, even if it is duplicative of the work done by the NPP. It ought to reflect that the physician engaged with the patient, not just with the chart.

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What’s behind the surge in urgent care?

It’s not just your imagination – walk-in urgent care or quick care clinics are one of the fastest growing segments of American healthcare today. Once-maligned as a “doc in a box,” the urgent care clinic has emerged as a $14.5 billion industry with as many as 9,000 clinics nationwide, according to the Urgent Care Association of America.

Previously, urgent care was an industry dominated by physician-owned practices with one or two locations and extended evening or weekend hours. Now an urgent care clinic must provide X-rays, repair lacerations, stabilize minor orthopedic injuries, perform simple lab work such as urinalysis and throat cultures, administer immunizations, on top of quick service, lower costs and extended service hours.

Recognizing the potential of the urgent care market, The New York Times indicates that private equity investment firms, insurance companies and even hospitals have invested $2.3 billion in this emerging market. The business model for an urgent care is simple: steadily treat a high volume of 30-75 patients per day at a reasonable price, charge extra for labs, X-rays, or durable medical equipment (e.g. crutches, slings, and boots), and have that the patient in and out in 45 minutes or less. Corporations, healthcare institutions and private physicians are recognizing the opportunity to capitalize on this quick-serve, low-cost delivery trend.

Cost and convenience advantage

Today’s 24/7 consumer wants convenience, access, and affordable pricing. They want to shop and bank online at any time, they value the speed and convenience of drive-through meals, and they want healthcare services when they need them – but at a reasonable price. The average visit time for an urgent care patient to be checked in, treated and discharged is 30-45 minutes, according to Practice Velocity, an EHR vendor which specializes in the urgent care segment. For comparison, the same process at a hospital emergency room usually takes more than three hours.

Urgent care clinics delivered care at significantly lower cost than the hospital ER. The national average urgent care visit cost $155, compared to an average hospital ER visit cost of $814, according to the BCBS provider fee schedule. Such differences are significant to consumers with commercial insurances, who pay an average urgent care co-pay of $30-55, versus up to a $250 co-pay at the hospital ER. Self-pay patients, as well as those with high-deductible plans, value the lower visit costs of urgent care.

(continued on pg. 5)
Many plan sponsors are probably unaware that the Small Business Jobs and Credit Act of 2010 (SBJA) allowed plans, after Sept. 27, 2010, to begin allowing in-plan Roth conversions. A Roth conversion (also known as an in-plan Roth rollover in the context of a qualified plan) is when a participant converts a balance in a pre-tax source, such as employee deferrals, to a post-tax Roth source. This involves creating a tax liability in the current year instead of deferring the taxes until the date of withdrawal at some point in the future.

At the time, the “catch” was that in order to allow such a conversion, the monies to be converted to a Roth rollover had to be eligible for distribution. Meaning that only upon termination, attaining age 59 ½ or another distributable event would such a conversion be possible. The American Taxpayer Relief Act of 2012 (ATRA) changed the landscape by permitting amounts that were not otherwise eligible for distribution to be rolled over inside a plan to a Roth source.

On Dec. 11, 2013, the IRS issued notice 2013-74, which provides guidance on in-plan Roth Rollovers. Unlike IRAs, plan participants have faced very different rules pertaining to Roth conversions inside a 401(k) or other qualified plan.

Qualified plans, including the 401(k), 403(b) and 457(b) plans may now elect to allow participants to rollover some or all of their vested monies, including earnings, from elective deferrals (or annual deferrals for 457(b) plans), matching contributions, non-elective contributions (i.e. profit sharing) qualified matching and qualified non-elective contributions.

Once the amount is rolled over, it does not become immediately available for distribution. Instead the monies are still subject to the distribution restrictions prior to the rollover. A significant issue that all plan sponsors and participants must be aware of is that no withholding can apply to the rollover amounts. It will be the participant’s burden to make estimated payments, increase their withholding or have other sources of money available to offset a likely tax liability at year end.

The IRS clarified the timing for any amendments for allowing the rollovers. The deadlines are different depending on the type of plan. For 401(k) and 457(b) plans, the deadline for any plan allowing the rollovers in 2013 and 2014 is Dec. 31, 2014. For 403(b) plans, the rules that apply to a retroactive remedial amendment period apply.

Safe Harbor plans present a challenge because there are certain prohibitions on making any mid-year changes to plan designs. In recognizing the unique issue surrounding the timing for any changes in a Safe Harbor plan, the IRS has given temporary relief to allow sponsors to make a mid-year change specific to in-plan Roth rollovers. The same deadline for all 401(k) plans, as described above, will apply.

The guidance also included several other applicable rules. As an example, plan sponsors should be aware that if they elect to add in-plan Roth rollovers, they can still limit the availability by money source (i.e. deferrals, employer match, etc.) or by frequency. Additionally, the change to add in-plan Roth rollovers is not a protected benefit. For plan sponsors, that means it could be added as a feature, but later withdrawn if it proved to be overly burdensome from an administrative standpoint or any other reason.

If you are interested in adding this plan feature, you will have to be patient. What remains to be seen is how quickly a plan can be amended to allow for this newly-available option.

care clinics. The price to treat a middle ear infection at an urgent care, for example, can cost $100, compared to nearly $500 in an ER.

Urgent care clinics have a business advantage over hospital ERs, in that they get to “cherry pick” their patients. Most urgent care centers do not accept Medicaid and have the ability to turn away uninsured patients unless they pre-pay for services. Hospital ERs, on the other hand, must treat everyone in need of care, regardless of their ability to pay. Regulators are debating about whether urgent care facilities should be required to treat Medicaid or uninsured patients, but to date, none have enacted such legislation on these privately-owned clinics.

Urgent care clinics are usually located in popular retail centers of suburban areas, usually less than a five-minute drive from residential areas, shopping, workplaces and schools, where families and working adults frequent. They choose sites that are convenient located with abundant parking, high visibility and accessibility to major thoroughfares. Other urgent care clinics locate in an area in relatively close proximity to the local hospital trauma center, offering consumers a visible, quick service alternative to the busy ER.

Urgent rush to urgent care

Recent stories from The New York Times reveal that insurance giant Humana paid almost $800 million in 2010 to purchase Concentra, the nation’s largest group of urgent care centers (about 300 locations nationwide). Two years later, San Francisco-based Dignity Health System acquired U.S. HealthWorks, a group that runs over 176 centers today. By 2014, Florida Hospital Orlando has opened more than 24 Centra Care urgent care clinics.

Even subspecialists are jumping on the urgent care bandwagon. Doral, Florida-based OrthoNow has franchised nearly 20 orthopedic urgent care clinics, each offering walk-in imaging, diagnostics, casting and care for broken bones, sprains and ligament injuries. The orthopedists opening OrthoNow clinics say that patients are seen and diagnosed by the specialists immediately, without enduring long triage waits in the ER. Patients also pay the lower urgent care co-pay and are scheduled for surgery immediately, rather than waiting for a consultation with the orthopedic specialist. Patients can even arrange for follow-up care and physical therapy at the time of service. This upfront process eliminates the “middle man” and allows patients to access the specialist right away.

Urgent care clinics offer an attractive complement to a primary care or specialty care clinic, but providers must be mindful of competition from other local urgent care facilities or even new, well-funded corporate-owned clinics that may spring up. At DoctorsManagement, we believe a successful urgent care clinic spends more on marketing and branding than a traditional medical practice. An urgent care facility must remain visible and involved with local sports events, health fairs and seasonal care (like back-to-school and sports physicals, flu and cold season, etc.), so that the facility will be the go-to clinic when the consumer needs quick and affordable care.

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HUMAN RESOURCES

Why you should revisit your employee handbook

The National Labor Relations Board has issued a series of decisions that strike down reasonable employer policies that are common in most employee handbooks. This is most likely only the beginning of a new era of NLRB enforcement activities against non-union employers.

Warning: You shouldn’t be relaxing your handbook policies because of the NLRB controversy that arose this past summer when the Supreme Court found that President Obama improperly made three recess appointments to the NLRB while the Senate was on break. The NLRB rulings that were jeopardized by this ruling have since been restored and affirmed by the NLRB, after the Board resolved the appointments issue.

The prudent response by employers was and still is to continue to recognize these NLRB rulings in their personnel policies.
NLRB wants employee handbooks cleaned up

The NLRB has been busy finding many standard employment policies unlawful. In the process, it is forcing companies to rethink workplace policies and how those policies should be described in employment handbooks.

For starters, the NLRB has developed a two-part test to determine whether a workplace policy unlawfully discourages employees from engaging in what is known as “concerted activities.” First, the NLRB analyzes whether the rule expressly prohibits concerted activity (defined below). If the rule does not contain any explicit prohibition, then the NLRB analyzes whether any of the following conditions are present: (1) employees would reasonably construe the language to prohibit concerted activity; (2) the rule was promulgated in response to union activity; (3) the rule has been applied to restrict the exercise of concerted activity rights.

‘Concerted activity’ is protected

“Protected Concerted Activity” is a legal term used in labor policy to define employee protection against employer retaliation in the United States. It is a legal principle under the subject of the freedom of association. It defines the activities workers may participate in without fear of employer retaliation.

One employee or a group of employees banding together to speak up about the terms and conditions of their workplace can be enough to trigger NLRB’s involvement. Existing labor law protects employee complaints about salary, benefits, unsafe conditions, harassment, discrimination, retaliation, and abusive supervisors. An employer that interferes with the exercise of these rights commits an unfair labor practice and can be ordered to stop interfering, compensate injured employees for any loss of wages or benefits, and post a notice that assures its employees it will respect their rights.

The NLRB has advanced a troubling approach for protecting rights of concerted activity. The agency has taken the position that employer policies that have a “chilling effect” on concerted activity are unlawful. By “chilling effect,” the NLRB means it wants to target vague or overly broad language in employee handbooks that may make workers less likely to participate in concerted activity. This approach started with social media policies but has now been applied to confidentiality policies, media policies, employment at-will statements, and even a non-disclosure requirement during workplace investigations.

Troubling NLRB positions

The NLRB has found examples of unacceptable policies in employer handbooks addressing the following topics:

- **Social media policies.** Of specific concern to the NLRB is any policy that prohibits employees from engaging in concerted activity via social media (i.e., online discussions about wages, hours, or terms and conditions of employment). Any policy prohibiting employees from disparaging supervisors or coworkers online may pose a problem. A policy stating that social media posts must be completely accurate and not misleading and that they do not reveal non-public company information on any public site may be troublesome.

- **Confidential information.** Instructions that employees not “release confidential guest, team member, or company information” (not PHI) when blogging or using online social networking sites
such as Facebook and YouTube could reasonably be interpreted as prohibiting employees from discussing their own and fellow employees’ conditions of employment. Thus the NLRB concluded the policy was unlawful. Another provision instructing employees not to have discussions about confidential information (not PHI) “in the break room, at home, or in open areas or public places” was found unlawful because it could reasonably be construed as prohibiting employees from discussing their terms and conditions of employment virtually anywhere.

- **Worker expression policies.** The NLRB has also targeted a range of policies that it views as limiting worker expression in a way that “chills” concerted activity. Most surprising was its move to strike down an employer’s workplace civility policy. Unbelievably, the use of curse words or expletives alone are not likely to rise to a level where the NLRB would disallow it. It found the policy statement “Offensive, demeaning, abusive, or inappropriate remarks are as out of place online as they are offline” to be unacceptable. The NLRB concluded that disciplinary action for “insubordination or other disrespectful conduct” and “inappropriate conversation” might be too broad. It decided general rules prohibiting the solicitation of co-workers while on company property are overly broad because they restrict employees on paid company breaks.

- **Investigation policies.** Many employers include a confidentiality provision in their investigation policy stating that employees and managers must maintain the confidentiality of any workplace investigation. Generally, that includes an admonition to employee witnesses not to share the nature of their discussions with anyone other than HR. The NLRB does not approve of such policies and has held that an employer’s interest in maintaining the integrity of its investigation is not sufficient to outweigh any limits on concerted activity. Instead, each case must be considered on its own merits. It is unclear whether an employer’s interest in

### New DoctorsManagement Clients

<table>
<thead>
<tr>
<th>Client</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental practice, Franklin TN</td>
<td>OSHA/HIPAA training</td>
</tr>
<tr>
<td>Plastic surgery group, Tyler TX</td>
<td>OSHA/HIPAA training</td>
</tr>
<tr>
<td>Rural health group, Cumming GA</td>
<td>Coding/billing support</td>
</tr>
<tr>
<td>Hospital and research group, Tampa FL</td>
<td>Compliance risk analysis and benchmarking</td>
</tr>
<tr>
<td>Pain management group, Sevierville TN</td>
<td>Credentialing services</td>
</tr>
<tr>
<td>Rehab center, Knoxville TN</td>
<td>Credentialing services</td>
</tr>
<tr>
<td>Plastic surgery practice, Ft. Lauderdale FL</td>
<td>DMU sign-up</td>
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<td>Physiatrist, Knoxville TN</td>
<td>Practice transition services</td>
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<tr>
<td>Plastic surgery group, Woodlands TX</td>
<td>Practice start-up</td>
</tr>
<tr>
<td>Alternative medicine group, St. Croix VI</td>
<td>Practice assessment</td>
</tr>
<tr>
<td>Nurse practitioner group, Sevierville TN</td>
<td>Billing services</td>
</tr>
<tr>
<td>Optometry practice, Cedar Park TX</td>
<td>Credentialing services</td>
</tr>
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<td>Hematology/oncology group, Johnson City TN</td>
<td>Technical consulting</td>
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<td>Weight loss/nutrition group, South Lake TX</td>
<td>Technical consulting</td>
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<tr>
<td>Primary care group, Lecanto FL</td>
<td>HR training videos</td>
</tr>
<tr>
<td>Multispecialty group, Washington DC</td>
<td>Concierge practice feasibility analysis</td>
</tr>
<tr>
<td>Large hospital group, Columbus OH</td>
<td>Comprehensive chart audits</td>
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preventing retaliation is sufficient to justify a request for confidentiality.

- **At-will employment policies.** Most troubling of all is the NLRB’s stance on employment-at-will policies. Employers are often advised to include at-will employment statements in their employee handbooks indicating that employment is “at will” and may be terminated by either party for any lawful reason. Some policies also include a statement that the at-will nature of the employment relationship cannot be altered. That is an issue for the NLRB.

**Complying with the NLRB**

The trouble for employers is that employment policies are often written in general terms. It is doubtful every single instance of what is or is not acceptable could be captured in a policy. Therefore, the policies are written as general guidelines that provide the boundaries for acceptable professional behavior. However, unless employers want to risk an NLRB complaint, they should review their policies and determine whether rules once thought to be rather straightforward can now be viewed as having a “chilling effect on concerted activity.”

**Tip:** If an employee could possibly view a rule as prohibiting the right to speak up about workplace conditions with other employees, with supervisors, with the media, or with government agencies and investigators, the policy needs to be amended and space carved out to clarify that concerted activity rights will not be restricted.

**Tip:** When drafting rules of conduct addressing such things as confidentiality and civility, be careful not to use broad, general prohibitions. Be specific and list examples of unacceptable behavior.

**Tip:** When developing an internal investigation policy, stay away from overly broad (blanket) requests for employees not to discuss them so as to protect the integrity of such investigations. This again can be handled by stating that such a request is expected of employees in circumstances where there is legitimate concern over witness protection, destruction of evidence, fabrication of testimony or cover up.

In light of these recent NLRB decisions and others, employers would be wise to review their personnel policies with a careful eye toward whether policy language might be seen as limiting employees’ discussion of matters affecting their employment.

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