Nonphysician Practitioner Reference Guide

A comprehensive resource for maximizing your NPP revenue with expert coding, billing, documentation, and compliance essentials

SECOND EDITION
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Utilizing nonphysician practitioners (NPPs) offers your practice the opportunity to see more patients and increase your revenue. It also frees up your physicians to apply their time and skills where they are most needed. By skillfully coordinating the talents of your physicians and your ancillary staff, you can create opportunities to maximize reimbursement for your practice.

But the benefits of an ancillary staff can only be realized if you establish best practices for billing NPP services. Without observing the specific coding and billing rules that apply, you are setting your practice up for denials, lost revenue, or worse — fraud charges.

Let us show you all the NPP coding and billing details! The Nonphysician Practitioner Reference Guide includes real-world advice from experienced professionals, plus expert answers to readers’ questions that will ensure you master the ins and outs of coding and billing for NPP services, and much more.

An essential companion for nurse practitioners, physician assistants, clinical nurse specialists, advance practice professionals, and other mid-level clinicians, this guide contains advice on hiring an NPP and some handy clip-and-save tools.

You’ll be sure to gain the competitive edge in your field with the Nonphysician Practitioner Reference Guide!
Concurrent Care
When your physician and another physician perform separate evaluation and management services for the same patient on the same day, it’s considered concurrent care. And if you want reimbursement for both services, know the rules of filing concurrent care claims.

**Benefit:** Provided the encounter meets concurrent care guidelines, both physicians will be able to code individually for the visits when accurately supported by the encounter notes.

**But:** Coding these encounters incorrectly can make things confusing fast. There are several factors to consider before submitting a concurrent care claim.

Check out these tips to avert concurrent care coding confusion.

Ensure the Care Is ‘Concurrent,’ Not ‘Duplicative’
Before diving into the deep end of this compliance issue, you should understand what is and what isn’t concurrent care.

**CMS definition:** “Reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient’s treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services.”

Be careful because Medicare’s *Benefit Policy Manual*, Chapter 15, Section 30.E Medicare contractors to “assure that the services of one physician do not duplicate those provided by another.”

Once you understand the difference between concurrent and duplicative, you can decide between them by asking these two questions:

1. Does the patient’s condition warrant the services of more than one physician on an attending (rather than consultative) basis?
2. Are the services performed by each provider “reasonable and necessary?”

If you can answer affirmatively to the above question pair, you’ve likely got a concurrent care claim. If you answer “no” to either question, the service likely falls under the scope of duplicative care.

On concurrent care claims, ensure you getting the reporting order correct for the diagnoses on each claim as well.

**Explanation:** Let’s say one physician is treating condition A, and the other is treating condition B, but condition C is underlying. When coding for concurrent care, condition C should not be the primary diagnosis for either service. The documentation should clearly illustrate the physician’s involvement with the patient, thus allowing for a clear illustration as to who is treating what injury or illness.

When a Patient Has Multiple Issues, Focus on Diagnosis Codes
Concurrent care can occur when a patient reports to one physician for an E/M, then that physician directs the patient to another physician for a separate issue.

**Example:** An oncologist performs a level-two initial inpatient hospital service for the patient with colon cancer. The oncologist then contacts an acute care pain
Compare the 2020 descriptor for 99203 to the 2021 descriptor below:

<table>
<thead>
<tr>
<th></th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>99203</strong></td>
<td>Office or other outpatient visit for the evaluation and management of a</td>
<td>99203</td>
</tr>
<tr>
<td></td>
<td>new patient, which requires these 3 key components: A detailed history;</td>
<td>Office or other outpatient visit for the evaluation and management of a</td>
</tr>
<tr>
<td></td>
<td>A detailed examination; Medical decision making of low complexity.</td>
<td>new patient, which requires a medically appropriate history and/or</td>
</tr>
<tr>
<td></td>
<td>Counseling and/or coordination of care with other physicians, other</td>
<td>examination and low level of medical decision making. When using</td>
</tr>
<tr>
<td></td>
<td>qualified healthcare professionals, or agencies are provided consistent</td>
<td>time for code selection, 30-44 minutes of total time is spent on the</td>
</tr>
<tr>
<td></td>
<td>with the nature of the problem(s) and the patient’s and/or family's</td>
<td>date of the encounter</td>
</tr>
<tr>
<td></td>
<td>needs. Usually, the presenting problem(s) are of moderate severity.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Typically, 30 minutes are spent face-to-face with the patient and/or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>family</td>
<td></td>
</tr>
</tbody>
</table>

The descriptors for 2021 codes 99202-99205 all follow the same structure as the 99203 example above. Table 1 shows the requirements for the new patient E/M codes in 2021.

<table>
<thead>
<tr>
<th>Code</th>
<th>History/Exam</th>
<th>MDM</th>
<th>Total Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>Medically appropriate history and/or examination</td>
<td>Straightforward</td>
<td>15-29</td>
</tr>
<tr>
<td>99203</td>
<td></td>
<td>Low</td>
<td>30-44</td>
</tr>
<tr>
<td>99204</td>
<td></td>
<td>Moderate</td>
<td>45-59</td>
</tr>
<tr>
<td>99205</td>
<td></td>
<td>High</td>
<td>60-74</td>
</tr>
</tbody>
</table>

For services longer than 74 minutes, the AMA created a new prolonged services add-on code: +99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services).

**AMA 2021 Office/Outpatient E/M Codes: Established Patient**

The office and other outpatient E/M codes for established patients changed in line with the revisions to the new patient codes in 2021.

**99211**: Level-one established patient E/M code 99211 is still available, but it changed in 2021 with the removal of the time reference crossed out below:

99211 **Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.**

**99212-99215**: Established patient E/M codes 99212-99215 look a lot like the new patient codes in 2021. For instance, review the revised descriptor for 99213:

99213 **Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.**
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Acute, uncomplicated illness or injury   | • The problem is recent and short-term.  
• There is a low risk of morbidity.  
• There is little to no risk of mortality with treatment.  
• Full recovery without functional impairment is expected.  
• The problem may be self-limited or minor, but it is not resolving in line with a definite and prescribed course.  
• Cystitis  
• Allergic rhinitis  
• Simple sprain                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                              |
| Acute illness with systemic symptoms     | • The illness causes systemic symptoms, which may be general or single system.  
• There is a high risk of morbidity without treatment.  
• For a minor illness with systemic symptoms like fever or fatigue, consider acute, uncomplicated or self-limited/minor instead.                                                                                                                                                                                                                                                                                                                                                   | Pyelonephritis  
• Pneumonitis  
• Colitis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                              |
| Acute, complicated injury                | • Treatment requires evaluation of body systems that aren’t part of the injured organ, the injury is extensive, there are multiple treatment options, or there is a risk of morbidity with treatment.  
• Head injury with brief loss of consciousness                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                              |
| Stable, chronic illness                  | • This type of problem is expected to last at least a year or until the patient’s death.  
• A change in stage or severity does not change whether a condition is chronic.  
• The patient’s treatment goals determine whether the illness is stable. A patient who hasn’t achieved their treatment goal is not stable, even if the condition hasn’t changed and there’s no short-term threat to life or function.  
• The risk of morbidity is significant without treatment.  
• Well-controlled hypertension  
• Non-insulin dependent diabetes  
• Cataract  
• Benign prostatic hyperplasia  
• NOT stable: Asymptomatic but persistently poorly controlled blood pressure (pressures don’t change), with a treatment goal of better control                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                              |
| Chronic illness with exacerbation,       | • The chronic illness is getting worse, is not well controlled, or is progressing "with an intent to control progression."  
• The condition requires additional care or treatment of the side effects.  
• Hospital level of care is not required.                                                                                                                                                                                                                                                                                                                                                                                                   | No examples given by CPT® guidelines                                                              |
| progression, or side effects of treatment|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                              |
| Chronic illness with severe exacerbation,| • There is a significant risk of morbidity.  
• The patient may require hospital care.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | No examples given by CPT® guidelines                                                              |
| progression, or side effects of treatment|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                              |
| Acute or chronic illness or injury that  | • There is a near-term threat to life or bodily function without treatment.  
• An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment may be involved.  
• Acute myocardial infarction  
• Pulmonary embolus  
• Severe respiratory distress  
• Progressive severe rheumatoid arthritis  
• Psychiatric illness with potential threat to self or others  
• Peritonitis  
• Acute renal failure  
• Abrupt change in neurologic status                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                              |
Compliance and Regulatory Guidelines

A proficient auditor must understand the complexities of compliance regulations in the healthcare system. This section will cover federal regulations, the Office of Inspector General (OIG), Corporate Integrity Agreements (CIA), compliance plans, and CMS.

Compliance History

To understand compliance in the healthcare field today, one must understand the history of compliance. This can be helpful when explaining to providers why the standards are what they are, in today’s industry.

Operation Restore Trust (ORT)

In May of 1995, under President Bill Clinton, Operation Restore Trust (ORT) was announced as a two-year partnership of federal and state agencies, working together to protect the healthcare trust funds through shared intelligence and coordinated enforcement. The program was also intended to enhance the quality of care for the programs' beneficiaries. The project initially targeted five states — California, Florida, New York, Texas, and Illinois — that accounted for 40 percent of Medicare and Medicaid beneficiaries. In its first two years, ORT identified almost $188 million owed to the federal government, according to the Department of Health and Human Services (HHS), with total spending of $7.9 million. The operation was then expanded under HIPAA to Arizona, Colorado, Georgia, Louisiana, Massachusetts, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, Virginia, and Washington.

Three agencies were involved in ORT: the Office of Inspector General (OIG), the Healthcare Financing Administration (HCFA, now CMS), and the Administration on Aging (AoA). Based on the successful returns of the pilot program, the AoA increased the grants awarded and expanded the program to every state and U.S. territory. The program is now called Senior Medicare Patrol (SMP). HHS, CMS, and the OIG work with AoA to combat fraud and abuse.

Federal Regulations

There are many federal departments and regulations regarding fraud, abuse, and compliance that a practice must be aware of to audit, educate, and make recommendations to employers and clients in the healthcare industry. We will discuss the federal False Claims Act (FCA), Civil Monetary Penalties Law (CMPL), Physicians Self-Referral law, and Anti-Kickback Statute (AKS).

CMS defines fraud as knowingly making false statements or misrepresenting facts to obtain an undeserved benefit or payment from a federal healthcare program. CMS defines abuse as an action resulting in unnecessary costs to a federal healthcare program, either directly or indirectly.
The National Hospice & Palliative Care Organization applauded the provision, which is especially helpful in underserved areas and rural communities.

The changes "allow patients to continue on with their physician assistant if they are their primary care provider when they enter into hospice, if they so choose," adds the National Association for Home Care & Hospice. While PAs are not able to certify or recertify hospice orders, they are allowed to manage and bill for hospice care.

**Bad news:** But another provision in the law makes accessing hospice more difficult, experts predict. The Centers for Medicare and Medicaid Services will implement a payment penalty for hospitals that discharge and transfer patients to hospice "early." The hospital DRG payment would be prorated based on how early the discharge would be.

**How it worked:** Previously, when "a patient [was] discharged from a hospital to another hospital, or post-acute care setting before a stay threshold based on Medicare severity diagnosis related group (MS-DRG) [was] met, the reimbursement shift[ed] to a per-diem amount to the hospital," NAHC explained. "The stay threshold [was] not met if the length of stay [was] at least one day less than the geometric mean length of stay for the MS-DRG."

**Problem:** The law put the changes into place October 1, 2018. That left CMS "little time to prepare for implementation without fully understanding the impact on hospice providers," NAHC protested. "When a similar policy was applied to post-acute care providers, CMS initially limited the roll-out to a few MS-DRGs to avoid unintended consequences."

Meanwhile, the bill did soften the blow by also requiring a study on the impact of the change conducted by the Medicare Payment Advisory Commission. The study was intended to evaluate the change's "effects on (A) the numbers of discharges of patients from an inpatient hospital setting to a hospice program; (B) the lengths of stays of patients in an inpatient hospital setting who are discharged to a hospice program;" and "(C) spending under the Medicare program" as well as "other areas determined appropriate by the Commission," the law said.

The study will evaluate "whether the timely access to hospice care by patients admitted to a hospital has been affected" by the payment change, the legislation added. MedPAC would have to report its preliminary results to Congress in March 2020, and its final report in March 2021, according to the law.

NHPCO is "discouraged" by this new policy, one industry insider said.

**More bad news:** NHPCO also is disappointed that the budget deal lacked "a provision that would allow Rural Health Clinics and Federally Qualified Health Centers to receive payment for serving as the hospice attending physician - which would be a significant benefit to Medicare beneficiaries in rural and underserved communities who face barriers in accessing hospice," the expert added.

**Services Furnished in Home ‘Susceptible To Fraud,’ the Budget Proposal Says**

Meanwhile, the administration’s budget proposal for 2019 called for increased enforcement for “additional funding to address fraud, waste, and abuse in home health and other noninstitutional-based services.”
Medicare Carriers Manual

60 - Services and Supplies Furnished Incident To a Physician’s/NPP’s Professional Service

(Rev. 1, 10-01-03)

B3-2050

A - Noninstitutional Setting

For purposes of this section a noninstitutional setting means all settings other than a hospital or skilled nursing facility.

Medicare pays for services and supplies (including drug and biologicals which are not usually self-administered) that are furnished incident to a physician’s or other practitioner’s services, are commonly included in the physician’s or practitioner’s bills, and for which payment is not made under a separate benefit category listed in §1861(s) of the Act. A/B MACs (A) and (B) must not apply incident to requirements to services having their own benefit category. Rather, these services should meet the requirements of their own benefit category. For example, diagnostic tests are covered under §1861(s)(3) of the Act and are subject to their own coverage requirements. Depending on the particular tests, the supervision requirement for diagnostic tests or other services may be more or less stringent than supervision requirements for services and supplies furnished incident to physician’s or other practitioner’s services. Diagnostic tests need not also meet the incident to requirement in this section. Likewise, pneumococcal, influenza, and hepatitis B vaccines are covered under §1861(s)(10) of the Act and need not also meet incident to requirements.

(Physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists, clinical social workers, physical therapists and occupational therapists all have their own benefit categories and may provide services without direct physician supervision and bill directly for these services. When their services are provided as auxiliary personnel (see under direct physician supervision, they may be covered as incident to services, in which case the incident to requirements would apply.

For purposes of this section, physician means physician or other practitioner (physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, and clinical psychologist) authorized by the Act to receive payment for services incident to his or her own services.

To be covered incident to the services of a physician or other practitioner, services and supplies must be:

- An integral, although incidental, part of the physician’s professional service (see §60.1);
- Commonly rendered without charge or included in the physician’s bill (see §60.1A);
- Of a type that are commonly furnished in physician’s offices or clinics (see §60.1A);
- Furnished by the physician or by auxiliary personnel under the physician’s direct supervision (see §60.1B).

B - Institutional Setting

Hospital services incident to physician’s or other practitioner’s services rendered to outpatients (including drugs and biologicals which are not usually self-administered by the patient), and partial hospitalization services incident to such services may also be covered.

The hospital’s A/B MAC (A) makes payment for these services under Part B to a hospital.
60.1 - Incident To Physician’s Professional Services

(Rev. 1, 10-01-03)

B3-2050.1

Incident to a physician’s professional services means that 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.

A - Commonly Furnished in Physicians’ Offices

Services and supplies commonly furnished in physicians’ offices are covered under the incident to provision. Where supplies are clearly of a type a physician is not expected to have on hand in his/her office or where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the incident to provision.

Supplies usually furnished by the physician in the course of performing his/her services, eg, gauze, ointments, bandages, and oxygen, are also covered. Charges for such services and supplies must be included in the physicians’ bills. (See §50 regarding coverage of drugs and biologicals under this provision.) To be covered, supplies, including drugs and biologicals, must represent an expense to the physician or legal entity billing for the services or supplies. For example, where a patient purchases a drug and the physician administers it, the cost of the drug is not covered. However, the administration of the drug, regardless of the source, is a service that represents an expense to the physician. Therefore, administration of the drug is payable if the drug would have been covered if the physician purchased it.

B - Direct Personal Supervision

Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel.

Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

However, the physician personally furnishing the services or supplies or supervising the auxiliary personnel furnishing the services or supplies must have a relationship with the legal entity billing and receiving payment for the services or supplies that satisfies the requirements for valid reassignment. As with the physician’s personal professional services, the patient’s financial liability for the incident to services or supplies is to the physician or other legal entity billing and receiving payment for the services or supplies. Therefore, the incident to services or supplies must represent an expense incurred by the physician or legal entity billing for the services or supplies.

Thus, where a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician’s service if there is a physician’s service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment. (However, the direct supervision requirement must still be met with respect to every nonphysician service.)

Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

If auxiliary personnel perform services outside the office setting, eg, in a patient’s home or in an institution (other than hospital or SNF), their services are covered incident to a physician’s service only if there is direct supervision by the physician. For example,
## Incident-to Audit Checklist

**AUDIT CHECKLIST:** | INCIDENT TO
---|---
Month: | Physician: | Met criteria:
Patient: | Reviewer: | Payer:

If the answer is “no” to any of the questions, it is not appropriate to bill the service incident to the physician.

<table>
<thead>
<tr>
<th>DOCUMENTATION TASK</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Does the place of service (POS) fall within the definition of an office or a physician directed clinic?</td>
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<td>The service is not performed in the institutional setting (i.e., hospital or skilled nursing facility)? Incident-to service cannot be performed in the emergency room, hospital outpatient department or provider-based physician office (POS 22).</td>
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<td><strong>Employment relationship</strong></td>
<td>Does the physician or group incur an expense and meet the employment requirements for the auxiliary staff? <strong>OR</strong> Does the auxiliary staff include employees, leased employees, or independent contractors of the physician or the entity that employs or contracts with the physician?</td>
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<td><strong>Supervision</strong></td>
<td>Did the physician perform direct supervision? (Present in the office suite to assist, if necessary. The physician does not need to be physically present in the patient’s treatment room for these services.)</td>
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<td>Is there a documentation link between auxiliary staff and the physician when the incident-to service was performed? (Archived records of when the supervising physician was in the office suite, i.e., physician schedules, etc. or documentation in the medical record by the physician.)</td>
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<tr>
<td><strong>Services performed</strong></td>
<td>Did the physician personally perform the initial service and develop the plan of care? (Nonphysician practitioners (NPPs) cannot see new patients or established patients with new problems incident to.)</td>
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<td>Is the service a part of the patient’s normal course of treatment?</td>
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<td>Is the physician actively involved in the course of treatment?</td>
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<td>Is the physician’s involvement documented in order to prove physician involvement on an “active” level?</td>
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<td><strong>Auxiliary staff services</strong></td>
<td>If service is performed by auxiliary staff, who are not NPPs, is only a level 1 visit (CPT® 99211) billed?</td>
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<td>If the review of systems (ROS) and past family and social history (PFSH) were performed by auxiliary staff is there documentation to support that the physician and/or NPP personally reviewed this documentation by confirming and/or supplementing to it in the medical record?</td>
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<tr>
<td><strong>NPPs Qualified Staff</strong></td>
<td>Are auxiliary personal performing physician services qualified NPPs? This includes physician assistants, nurse practitioners, and clinical nurse specialists.</td>
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<td>Is the NPP licensed and certified to practice in the state in which they are practicing?</td>
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<td>Are the NPP’s salary and benefits excluded from the facility’s cost report?</td>
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<tr>
<td><strong>Scribing</strong></td>
<td>If a scribe was used, did they only document what was dictated to them by the physician and is the scribe identified as such? (Scribes do not act on their own.)</td>
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<tr>
<td><strong>Incident to?</strong></td>
<td>Yes or No? If incident-to requirements are met, the services may be billed under the physician’s NPI number. If incident-to requirements are not met, the services may be billed under the NPP’s own provider number and paid at 85% of the Medicare physician fee schedule.</td>
<td></td>
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</tbody>
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