

Policies and Procedures: WVU Physicians of Charleston
Medicare “Incident To” Rule

Section: Compliance
Chapter: Billing
Policy: Medicare “Incident To” Rule

I. Purpose

This policy is intended to ensure that Medicare is billed for services/supplies furnished “incident to” the services of a physician only as provided for under applicable Medicare law and regulations.

II. Policy for Billing Medicare “Incident To” Services

A. Ancillary Staff Services

Services/supplies furnished by ancillary staff will only be billed to Medicare “incident to” when they meet the federal “incident to” requirements. Note: Any service provided by ancillary staff (i.e. nurses) to a Medicare beneficiary must meet the “incident to” criteria in order to bill a CPT code 99211.

B. Non-Physician Practitioners (NPPs) Services

Services/supplies furnished by non-physician practitioners (NPPs) may be billed “incident to” a physician’s services, provided all incident to billing requirements are met.

Within the scope of their licensure, some services provided by certain NPPs, (i.e. nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, therapists, clinical psychologists, and certified registered nurse anesthetists) may be billed directly to Medicare under the NPP’s provider number, as long as no other facility or provider bills, or is reimbursed for, furnishing the same services.

II. Scope

This policy applies only to services/supplies provided to Medicare beneficiaries.

For non-Medicare payors, any department of WVUPC wishing to bill such payors pursuant to the “incident to” rules must verify whether or not the specific payor will pay for services provided by ancillary staff or non-physician providers (“NPPs”) “incident

to,” and the payor’s specific rules relating to documentation of incident to services, prior to claim submission.

III. Procedure

A. Medicare pays for services and supplies (including drugs and biologicals which are not usually self-administered) that are furnished incident to a physician’s services, are commonly included in the physician’s bill, and for which payment is not made under a separate benefit category listed in §1861(s) of the Social Security Act.

B. The “incident to” requirements do not apply to services having their own benefit category. For example, diagnostic tests are covered under §1861(s)(3) of the Social Security Act, are subject to the coverage requirements in the Medicare Carriers’ Manual (MCM) Section 2070, and need not also meet the incident to requirements set forth herein. Likewise, pneumococcal, influenza and hepatitis B vaccines are covered under 1861(s)(10) of the Social Security Act and need not also meet incident to requirements.

C. 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. Alternatively, when their services are provided as auxiliary personnel under direct physician supervision, they may be covered as incident to services, in which case the incident to requirements described herein would apply and must be satisfied.

D. In order to be covered as “incident to,” services and supplies must be:

1. *An integral, although incidental, part of the physician’s professional service.*

a. The physician must personally perform an initial service for each new patient and each new condition, make an initial diagnosis and establish a treatment plan;

b. The physician must personally perform subsequent services (i.e., face-to-face service with the patient at a frequency which reflects his/her active participation in and management of the course of the treatment for each medical condition).

2. Commonly furnished without charge or included in the physician's bill.

a. Supplies usually furnished by the physician in the course of performing his/her services, i.e. gauze, ointments, bandages, are also covered. To be covered, supplies, including drugs and biologicals, must represent an expense to the physician.

3. Of a type that are commonly furnished in office or clinic of a physician.

a. Services and supplies commonly furnished in physicians' offices are covered under the incident to provisions. Where supplies are clearly of a type which 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 provisions.

4. Furnished by the physician or by auxiliary personnel under a physician's direct personal supervision.

a. A physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the ancillary staff or NPP is performing the "incident to" service.

i. If WVUPC ancillary personnel provide services outside the physician's office setting (i.e. home visit) their services are billable as "incident to" only if there is direct personal supervision by the physician or other practitioner (i.e. the physician is present and immediately available).

ii. The supervising physician may be an employee, leased employee or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.

5. Furnished by an individual who is acting under the supervision of a physician.

a. The individual furnishing the incident to service may be an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.

Note: The physician performing the services or furnishing the supplies, or supervising the auxiliary personnel furnishing such services or supplies, must have a legal relationship with the legal entity billing and receiving payment for the services or supplies that satisfies the requirements for valid reassignment in the Medicare Carriers Manual, §3060. *The incident to services or supplies must represent an expense incurred by the physician or the legal entity billing for the services or supplies.*

E. Billing for “Incident to” Services

1. In selecting the level of service to bill “incident to” a physician’s service, the service must be:
 - a. Provided within the non-physician’s scope of licensure;
 - b. Documented by the ancillary staff or NPP providing the service and countersigned by the physician (or other practitioner) under whose number the service will be billed, and;
 - c. Provided while the physician is in the office suite and immediately available to provide assistance and direction throughout the time the service is being performed.
2. Services provided by ancillary staff (i.e. nurses and pharmacists) may be considered “incident to” services, but their “incident to” services cannot be billed higher than a 99211 (established patient visit), the lowest possible level. Services of a certified diabetic educator providing nutritional counseling cannot be billed “incident to.”
3. Evaluation and management (E/M) services furnished “incident to” a physician’s service by a nurse practitioner (NP), certified midwife (CMN), or physician’s assistant (PA) may be billed using the CPT code (established patient visit) that best describes the E/M service furnished.
4. Billing for time in counseling or coordination of care may not be billed “incident to.”

IV. Services “Incident To” a Physician’s Service to Homebound Patients Under General Supervision (See Sec. 2051.1 of Medicare Carrier’s Manual for definition of “homebound patient”)

A. Medicare coverage: In very limited circumstances, WVUPC may bill for individual or intermittent services provided by qualified WVUPC NPPs to homebound patients “incident to” a physician’s services under general physician supervision. “General physician supervision” means that the physician need not be physically present, but the service must be performed under the physician’s overall supervision and control. All other “incident to” criteria, as outlined above, must also be met. “Incident to” services to homebound patients shall not be billed where there is an available participating home health agency (HHA) in the area which could provide the needed service on a timely basis.

B. Availability of home health agency services: When services can be performed by an HHA in the local area, “incident to” services to a homebound patient shall not be billed, except where the following conditions exist:

1. Where the patient has exhausted home health benefits, or
2. Where the HHA could not respond on a timely basis; or
3. Where the physician could not have foreseen that intermittent services would be needed, and more services are necessary.

C. Covered Services: Section 14-3-2051.B of the Medicare Carriers Manual identifies the “incident to” services that may be covered when provided to homebound patients when the above criteria are met. Medicare will not pay for E/M services provided to homebound patients by ancillary staff or NPPs.

V. Supervision

A. Supervision of “incident to” Services: Once the initial physician plan of care has been established, incident-to services can be billed even when there is not a physician in the room. The physician must, however, be on the premises and immediately available to assist the non-physician provider rendering the services.

B. The supervising physician does not need to be the physician who performed the initial patient visit. Any physician in the group who is in the clinic or office seeing other patients qualifies to provide the requisite supervision, even if he/she is not the patient's primary physician or even of the same specialty as the primary physician. Independently contracting physicians who reassign their right to payment to the group practice can also supervise nonphysician services as the on-premises supervisor.

C. Supervision of Diagnostic Tests: Supervision requirements for diagnostic tests are different than for office visits. The Centers for Medicare and Medicaid Services (CMS) has developed three levels of supervision: general; direct; and personal. The CPT code determines which level of supervision is required.

1. General supervision: Services are under the general quality control of physicians; a physician does not need to be in the office (e.g. electrocardiogram (CPT 93000)).
2. Direct supervision: Services require the physician to be on the premises in the office suite (e.g. incident to services)
3. Personal supervision: The physician must be in the room while the non-physician provider/technician is performing the service (e.g. transesophageal echocardiogram (CPT 93312))

VI. Implementation

Each practice administrator shall assure that services provided by ancillary staff and NPPs to Medicare beneficiaries which are billed "incident to" a physician's services meet the criteria set forth above.

VII. Administration and Interpretations

Questions regarding this policy must be addressed with your billing supervisor, practice administrator, the WVUPC Coding Committee, or the WVUPC compliance officer.

XII. Amendments or Termination

This policy may be amended or terminated at any time.

XIII. References

- 42 U.S.C. §1395x(s)(2)(A)
- Medicare Carriers Manual, Chapter 14-3 - §§2049.3, 2050, 2050.1, 2050.2, 2050.3, 2051, 2051.1. 4147.1; 15501.G; Palmetto GBA “Incident To Provision,” 2003.
- Medicare Carriers Manual, Program Memo AB-98-15 and Transmittal #1734, 12/13/2001 (Revisions to Sections 2156, 2160, 4112, 4112.1 and 4112.2)
- 42 C.F.R. 410.26 (“Services and supplies incident-to a physician’s professional service: conditions”), 11/1/01, pp. 55328-29.

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