Incident-to services: Legitimate revenue source or compliance pitfall?

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With increasing numbers of nonphysician practitioners* (NPPs) being hired by medical groups, a common question asked of compliance personnel is how to properly apply Medicare’s incident-to guidelines. The rules for incident-to services are often misunderstood and have landed many physician practices in hot water. Keep in mind that other payers might have different requirements and that all services must comply with state scope-of-practice regulations in addition to Medicare’s rules.

There is an important distinction between incident-to services rendered by NPPs and those rendered by other personnel.

Medicare’s requirements for incident-to services are published in the Medicare Benefit Policy Manual (Chapter 15, Section 60), and some Medicare contractors have published articles, frequently asked questions and other resources about these services.

The incident-to rules apply only in the non-institutional setting, such as a physician’s office. In a hospital or skilled nursing facility, payment for services performed by auxiliary staff is made to the hospital, and the physician cannot bill separately for staff services unless the services are shared by the NPP staff and the physician.

For example, a physician practice might choose to send one of its registered nurses to a hospital to visit the practice’s patients, but the group cannot bill Medicare for the services the nurse provides to these patients unless he or she is an NPP with billing credentials. Likewise, physicians might work very closely with NPPs in a busy infusion center, but if the NPP is part of the facility’s payroll expense, the physicians cannot include any of that NPP’s work in their billing.

The second important rule is that the incident-to policy does not apply to services that fall into a separate benefit category. For example, diagnostic tests are subject to their own supervision requirements. If a particular test requires personal physician supervision (doctor present in the room), a physician cannot choose direct supervision instead.

Incident-to services must be performed by auxiliary personnel who act under a physician’s supervision, according to Medicare regulations. This includes employees, leased employees and independent contractors of a physician or an organization that employs or contracts with a physician. The services of the auxiliary personnel must represent an expense to the physician or to the legal entity that is billing for the services. For example, a physician could not bill for services rendered on an incident-to basis by staff members who are provided free of charge to the physician by a vendor, hospital or other entity. In this situation, the services of the auxiliary personnel are not billable because they do not represent an expense incurred by the physician.

Supervision

According to the Benefit Policy Manual, incident-to services must be:

• Furnished as an integral, although incidental, part of the physician’s personal professional service
• Commonly rendered without charge or included in the physician’s bill
• Of a type that is commonly furnished in a physician office or clinic
• Performed under the physician’s direct supervision

For a service to meet these criteria, it must be provided as part of the physician’s plan of care. The physician must personally see and evaluate the patient and determine what services the patient needs. Then in future encounters, the physician’s auxiliary personnel can provide the services the physician has selected. The physician is not required to personally evaluate the patient during every visit. However, the physician must continue to actively participate in and manage the patient’s care. During each incident-to service, the physician — or another physician from
the same group practice — must be present in the office suite and immediately available to provide assistance and direction throughout the encounter.

For example, a physician starts a patient on a new blood-pressure medication and tells him to come back in a week to have his pressure checked. When the patient returns, an NPP performs the blood-pressure check, and the physician does not see the patient. However, the physician (or a colleague) is present in the office during the visit. The visit is billed under the provider number of the physician who supervised the visit (i.e., the physician who was present), and the physician who established the care plan is listed as the ordering/referring physician.

What about NPPs?

Auxiliary personnel, such as nurses, may provide services incident-to the services of NPPs, such as nurse practitioners, physician assistants and clinical nurse specialists. In the example given above, if a hypertensive patient is being cared for by a nurse practitioner, the nurse practitioner would be reported on the claim as the performing provider for the blood-pressure check. In that case, the service would be paid at 85 percent of the Medicare allowable reimbursement rate.

NPPs can also serve as auxiliary personnel, performing services incident-to a physician's service. For example, a physician sees a patient who has mild diverticulitis, prescribes a course of antibiotics and instructs the patient to return in two weeks for follow-up. During the follow-up visit, the patient is seen by an NPP who is employed by the practice. The physician is present in the office during the visit. In this situation, the visit can be billed under the physician's provider number on an incident-to basis and will be paid at 100 percent of the Medicare allowable reimbursement.

Incident-to services performed by NPPs are subject to all of the same supervision requirements as those performed by other auxiliary personnel. In particular, auxiliary personnel — including NPPs — cannot perform a service on an incident-to basis if it involves a new Medicare patient or an established patient with a new problem that has not yet been evaluated by a physician. Only established patients with established problems qualify.

There is an important distinction between incident-to services rendered by NPPs and those rendered by other personnel. E&M services performed by NPPs on an incident-to basis are not limited to any particular E&M level. For example, if the NPP performs and documents a Level 3 established patient visit for the patient with diverticulitis, the practice can bill for a Level 3 visit. But services rendered by auxiliary personnel who are not NPPs are limited to Level 1 (99211), regardless of how extensive the service is. For example, a service provided by a registered nurse who is not an NPP must be reported with code 99211 whether it lasts five minutes or 45 minutes.

Prior to submitting these claims, we advise auditing a sample of records for incident-to services to determine whether they are adequately documented. A number of Medicare contractors have published guidance on documentation. For example, a manual on incident-to services published by Trailblazer Medicare (September 2011) emphasizes the need for documentation to clearly link the services of the NPP to the services of the supervising physician. A Cahaba Medicare medical review article (March 2009) stresses the need for documentation that the physician was present in the office and that he or she was involved in the patient's care. If the incident-to service is consistent with Medicare rules and appropriately documented, it can serve as a legitimate revenue source for the practice rather than a compliance pitfall.

*Centers for Medicare & Medicaid Services definition of NPP

Learn more about how to bill non-physician providers:
Read “Understand payer requirements for billing non-physician providers” at mgma.com/npp-blog; and see our on-demand webinar, “Using Non-Physician Providers in Your Practice,” at mgma.com/npp-store.