![moda HEALTH]	Reimbursement Policy Manual	Policy #:	RPM040
Policy Title:	**Incident-To Services**		
Section:	Administrative	**Subsection:**	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:	
Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network
Originally Effective:	7/25/2011	Initially Published:	11/12/2014
Last Updated:	9/11/2024	Last Reviewed:	9/11/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		9/11/2024	

Reimbursement Guidelines

A. For Commercial Plans

We do not recognize or allow incident-to billing for our Commercial plans. Practitioners must bill under their own name and provider identification (NPI, TIN).

B. For Medicare Advantage Plans

We follow CMS Incident-to billing rules for our Medicare Advantage plans. The medical record documentation must clearly indicate the service provider, the supervising provider, and support the service followed all Incident-to guidelines and limitations.

C. For Oregon Medicaid Plans

Incident-to does not apply to the Oregon Medicaid plan, as reimbursement is based on procedure code and is not specific to provider type.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
AMA	American Medical Association
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka "CCI")
NP	Nurse Practitioner
PA	Physician Assistant
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
SNF	Skilled Nursing Facility
UB	Uniform Bill

Modifier Definitions:

There is no procedure code or modifier available to identify services which are billed under incident-to guidelines.

Modifier SA (shown below) does exist, but it specifies services by a nurse practitioner (does not apply to other types of non-physician providers) and specifies the practice and supervisory relationship between the nurse practitioner and the supervising physician. Nurse practice laws and regulations are specific to each state. Some states allow nurse practitioners a full practice without physician supervision, and other states require varying levels of physician supervision to provide patient care.[9] Modifier SA may indicate that those state requirements are being met, even when the services are not billed under the incident-to billing method and rules.

Modifier	Modifier Description & Definition
Modifier SA	Nurse practitioner rendering service in collaboration with a physician

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

The specific service being performed must be coded and documented in accordance with correct coding guidelines for the procedure code(s) billed.

CMS Incident-to requirements and guidelines may be found in the CMS Claims Processing Manual, the CMS Benefit Policy Manual, the CMS website, CMS transmittals, MedLearn Matters, etc.

Cross References

"Supervised Behavioral Health Provider Program Requirements." Moda Health Reimbursement Policy Manual, RPM079.

References & Resources

1. CMS. "Evaluation and Management (E/M) Services Furnished Incident to Physician's Service by Nonphysician Practitioners." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.4.

2. CMS. "Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service." *Medicare Benefit Policy Manual* (Pub. 100-2). Chapter 15, §60.

3. CMS. "Incident to"' Services." *Medicare Learning Network (MLN).* MLN Matters Number: SE0441.

4. Balen, Beth A. "'Incident To' Billing: Is It Worth It for Medical Practices?" *PhysiciansPractice.com.* <http://www.physicianspractice.com/blog/incident-to-billing-it-worth-it-medical-practices> January 21, 2014: October 15, 2014.

5. Gosfield, Alice G., JD. "The Ins and Outs of "'Incident-To"' Reimbursement." *Fam Pract Manag.* 2001 Nov-Dec;8(10):23-27.

6. Dowling, Renee. "Incident-To Billing: Clearing Up The Confusion." *Medical Economics.* <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/incident/incident-billing-clearing-confusion?page=0,2> April 24, 2014: October 15, 2014.

7. Silva, Chris. "Medicare Pay For Services By Nonphysicians Comes Under Scrutiny - OIG Finds The "Incident To" Rule Is Allowing Care To Be Provided By Nonphysicians Who Lack The Necessary Qualifications." *American Medical News.* <http://www.amednews.com/article/20090824/government/308249983/6/> August 24, 2009: October 15, 2014.

8. AAPC. "3 Tips Guide Successful Incident-to Billing." *American Academy of Professional Coders.* <http://news.aapc.com/index.php/2013/03/3-tips-guide-successful-incident-to-billing/> March 1, 2013: October 15, 2014.

9. AANP. "State Practice Environment." *American Association of Nurse Practitioners.* <http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment > October 15, 2014.

10. Stantz, Renee. "Demystifying Medicare's 'Incident To' Billing By Nurse Practitioners, Physician Assistants." *Medical Economics.* <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/billing/demystifying-medicares-incident-billing-nurse-practitioners-p > September 25, 2014: October 15, 2014.

11. Lowe, Michael R., PA. "Proper Incident-To Billing: Avoiding Pitfalls That Could Paralyze Your Practice." *Lowehealthlaw.com.* <http://www.lowehealthlaw.com/Articles/Proper-Incident-To-Billing-Avoiding-Pitfalls-That-Could-Paralyze-Your-Practice.shtml> October 17, 2014.

12. Loya, Kelly C., CPC-I, CPhT, CHC, CRMA and Friederich, Cara, CPC-I, CPC-H. "Billing compliance under the Incident To provision: What's the risk?". *Compliance Today.* June 2013.

13. Noridian. "Incident To Services." *Noridian Medicare.* <https://med.noridianmedicare.com/web/jeb/topics/incident-to-services> October 30, 2014.

14. CMS. "CMS Responses to Questions from the July 21st "ABCs of the Initial Preventive Physical Examination & the Annual Wellness Visit" National Provider Call." *Medicare Learning Network.* <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/IPPE_AWVQuestions.pdf> October 30, 2014.

Background Information

Incident-to billing is a specific method of billing developed by the Center for Medicare and Medicaid Services (CMS). Under Incident-to billing, outpatient services by a non-physician practitioner (such as a nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), or other types of auxiliary personnel) may be billed under the physician's name and provider ID as if the physician personally performed the service.

With incident-to billing, services performed by a mid-level provider which would normally be reimbursed by CMS at a lower rate (mid-level = 85% of the physician fee schedule allowable amount) may be instead reimbursed by CMS at a higher rate (100% of the physician fee schedule allowable amount).

Not all services by mid-level and ancillary personnel will qualify for billing under CMS incident-to guidelines. CMS requirements for services billed under incident-to billing include but are not limited to:
- Place of service.
  - Must be performed in the physician's office or in a patient's home.
  - Services provided at the hospital, SNF, in an ambulance, or other facility settings do not qualify for incident-to billing.[5]
  - Non-physician providers may not round on hospitalized patients and enter data in the record (including the history of current illness or vital signs), and then the physician later round on the patients personally and bill for full visits. This would constitute incident-to billing in the hospital, which is strictly prohibited.[5]
  - For offices or clinics in institutions, the office must be confined to a well-defined and separately identifiable part of the facility.[3]
- Must be performed by a non-physician employee (direct or leased/contracted) of the practice submitting the claim.[5]
- Must be performed by someone whom the physician directly supervises.[12]
- Must be performed on established patients only.[4]
- Type of problem.
  - Must be addressing established problems only.[12]
  - If a patient mentions a new problem during a follow-up visit for a problem with an established plan of care, the visit cannot be billed incident-to under the physician's name and ID number.[4, 10]
- The physician must have personally performed an initial service and initiated the plan of care for the condition or problem being treated.[10]
- If changes to the patient's condition come to light during the visit, the non-physician provider must consult with the physician for new treatment plan orders, rather than making an independent decision (as allowed by their licensure) and informing the physician later.
- The physician (or any physician member of the group) must be present in the office suite to provide direct supervision and render assistance, if necessary.[8]
  - Being available by phone does not constitute direct supervision.[10, 12]
  - If the supervising physician leaves the office for any reason (lunch, errands, called to the emergency room), no services during that time may be billed as incident-to.[4, 12]
- The physician must remain actively involved in the patient's care and personally see the patient periodically.[5]
- The essential requirements for incident to service are to be documented in the patient record.[4]

While office visits are perhaps the most commonly billed service under the incident-to guidelines, incident-to services are not confined to a specific group of procedure codes or services. As long as the

non-physician provider is performing services within the scope of their license, the procedure code description requirements are met, and the incident-to requirements are fully met, the services may be billed to CMS under the incident-to billing provisions.

> (Note that some CPT codes require personal and direct physician supervision in the room, which would prevent billing those services as incident-to.) [5]

The incident-to billing method and guidelines were developed by Medicare. Other insurance carriers do not necessarily follow Medicare's lead. Some commercial carriers have specific guidelines that require all practitioners (physicians, nurse practitioners and physician assistants) to bill under their own name and provider identification number.[6]

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
9/11/2024	Formatting updates. No policy changes.
9/20/2023	Cross References updated. Formatting updates. No policy changes.
8/10/2022	Formatting updates. No policy changes.
11/12/2014	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
7/25/2011	Original Effective Date (with or without formal documentation). Policy based on CMS policy for Medicare Advantage plans and administrative decision for Commercial plans.