

The Basics of Incident-to Billing

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Employing non-physician practitioners (physician assistants, nurse practitioners, clinical nurse specialists, etc.) is an effective way to increase productivity in a physician office. However, under Medicare rules, covered services provided by non-physician practitioners (NPPs) are reimbursed at a reduced rate (85 percent of the fee schedule amount).

The “incident-to” billing rules provide an exception, allowing 100 percent reimbursement for non-physician services that meet the requirements detailed in the Medicare Benefit Policy Manual, Chapter 15, Section 60 (Services and Supplies Furnished Incident To a Physician’s/NPP’s Professional Service).

There are six basic requirements to meet the incident-to guidelines for Medicare payment:

1. The service must take place in a “noninstitutional setting,” which the Centers for Medicare & Medicaid Services (CMS) defines as “all settings *other than* a hospital or skilled nursing facility” [emphasis added]. Per the Benefit Policy Manual, “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.”

2. A Medicare-credentialed physician must initiate a patient’s care. If the patient has a new or worsened complaint, a physician must conduct an initial evaluation and management (E&M) for that complaint, and must establish the diagnosis and plan of care. Incident-to services cannot be rendered on the patient’s first visit, or if a change to the plan of care (e.g., medication adjustment) is required.

3. Subsequent to the initial encounter (during which the physician arrives at a diagnosis and plan of care), an NPP may provide follow-up care. This care must occur under the “direct supervision” of a qualified provider. Per the Benefit Policy Manual:

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, e.g., in a patient’s home or in an institution (other than hospital or skilled nursing facility), their services are covered incident to a physician’s service only if there is direct supervision by the physician [e.g., the physician must be physically present to oversee the care].

The supervising physician does not have to be the physician who performed the initial patient evaluation. Any physician member of the group may be present in the office to supervise.

4. A physician must actively participate in and manage the patient’s course of treatment. The exact requirement is usually defined by the state licensure rules for physician supervision of NPPs (e.g., the physician must see the patient every third visit).

5. Both the credentialed physician and the qualified NPP providing the incident to service must be employed by the group entity billing for the service (if the physician is a sole practitioner, the physician must employ the NPP).

6. The incident-to service must be the type of service usually performed in the office setting, and must be part of the normal course of treatment of a diagnosis or illness. The Benefit Policy Manual elaborates:

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.

Services meeting all of the above requirements may be billed under the supervising physician’s NPI, as if the physician personally performed the service. Documentation should detail who performed the service, and that a supervising physician was in the office suite (although not necessarily the same room), at the time of the service.

Remember: Incident to applies only to Medicare. Further, the requirements do not apply to services with their own benefit category. Diagnostic tests, for example, are subject to their own coverage requirements. “Depending on the particular tests,” the Benefit Policy Manual explains, “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.”

Similarly, pneumococcal, influenza, and hepatitis B vaccines do not need to meet incident to requirements. MLN Matters Number: SE0441 elaborates:

Must a supervising physician be physically present when flu shots, EKGs, Laboratory tests, or X-rays are performed in an office setting in order to be billed as “incident to” services?

These services have their own statutory benefit categories and are subject to the rules applicable to their specific category. They are not “incident to” services and the “incident to” rules do not apply.

Additional rules apply for incident to physician’s services in clinic, and services incident to a physician’s service to homebound patients under general physician supervision. These can be found in the [Medicare Benefit Policy Manual, Chapter 15, Section 60](#).

For more information, see also [MLN Matters Number: SE0441](#).