Understanding Medicare Part B Incident to Billing: A Fact Sheet

Purpose:

To understand the issues involved in Medicare Part B “incident to” billing that may be considered for use in billing wound, ostomy, and continence nursing services in the outpatient setting.

Originated By:

Reimbursement Task Force, “Incident to” Work Group, of the WOCN® National Public Policy Committee.

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Background:

“Incident to” refers to a Medicare billing mechanism, allowing services furnished in an outpatient setting to be provided by auxiliary personnel and billed under the provider’s national provider identification (NPI) number. “Incident to” the provider’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the provider’s professional services in the course of diagnosis or treatment of an injury or illness (Medicare Benefit Policy Manual, 2011). The provider can include physicians, nurse practitioners, clinical nurse specialists, certified nurse midwives, physician assistants, clinical psychologists, clinical social workers and physical and occupational therapists. The services provided must be delivered under the provider’s direct supervision; the provider must be in the area where care is delivered and be immediately available to provide assistance and supervision. The provider must initiate a course of treatment and the service provided by the auxiliary staff is follow up care, assisting in providing the plan of care. In some outpatient settings there may be an opportunity for a non-provider (i.e., a non-Advanced Practice Registered Nurse) to provide care and obtain reimbursement as “incident to” the provider’s services. The provider can be a physician or an advanced practice nurse (APRN) so there may be opportunities for an APRN to direct care of patients with wound, ostomy and continence care issues and for non APRNs (such as a BSN WOC nurse) to provide the “incident to” care. For example, the WOC/APRN or physician initially sees the patient as the provider, develops a plan of care and the WOC nurse (not licensed as an APRN) provides the ongoing care as “incident to” and can bill as “incident to” at the APRN’s or physician’s reimbursement rate.
Another consideration under Medicare “incident to” provision is to allow services provided by a non-physician provider to be reimbursed at 100% of the physician fee schedule by billing under the physician’s name and NPI number. There may be some practice settings where the non-physician provider such as an APRN would bill “incident to” to increase their reimbursement from 85% to 100% of the physician’s fee schedule. This paper will provide insight into this type of Medicare outpatient billing, and contains the best interpretation of “incident to” issues as of the date it was written. It is hoped that this fact sheet will provide a starting place to become acquainted with the concept of “incident to” billing and potential opportunities, but is not meant to be an authoritative paper on all issues related to “incident to” billing.

**Content:**

“Incident to” billing, as defined by federal legislation, refers to the provider billing of services and supplies that are performed by auxiliary personnel. Medicare defines a provider to include nurse practitioners, clinical nurse specialists, certified nurse midwives, physician assistants, clinical psychologists, clinical social workers and physical and occupational therapists. The provider must first see the patient and develop a plan of care and initiate the course of treatment. The “incident to” service provided by the auxiliary personnel is then an incidental part of the patient’s treatment. The patient can see the auxiliary personnel for continued treatment of the initial problem that was presented to the provider. If a new problem is identified at a visit by the auxiliary personnel, the patient must be referred back to the provider for evaluation and development of a new plan of care. The provider must demonstrate an active participation in the ongoing care of the patient, such as providing services on a regular basis that reflects participation on an ongoing basis. Reimbursement is based on 100% of the provider’s fee schedule amount.

Certain requirements must be met to bill “incident to”:

1. The services are an integral, although incidental, part of the provider’s professional service.
2. The services are of a type commonly furnished in provider’s offices or clinics.
3. The services are furnished under the provider’s direct personal supervision and are furnished by the provider or by an individual who is an employee or independent contractor of the physician. Direct supervision does not require the provider’s presence in the same room but the provider must be immediately available.
4. The provider must perform “the initial service and subsequent services of a frequency which reflect his or her active participation in the management of the course of treatment.”
5. The provider under whose name and number the bill is submitted must be the individual present in the office suite when the service is provided.
6. The documentation in the patient chart must match the service that was billed.

Settings Where “Incident to” May Be Considered

Physician/providers clinic.

A physician/provider directed clinic is one where:

1. A physician or provider (or a number of physicians/providers) is present to perform medical (rather than administrative) services at all times the clinic is open;
2. Each patient is under the care of a clinic physician or provider; and
3. The nonphysician services are under medical supervision (Medicare Benefit Policy Manual, 2011).

In highly organized clinics, particularly those that are departmentalized [typically more advanced medical facilities with beds], direct physician/provider supervision may be the responsibility of several providers as opposed to an individual provider. In this situation, medical management of all services provided in the clinic is assured. The physician ordering a particular service need not be the physician who is supervising the service. Therefore, services performed by auxiliary personnel and other aides are covered even though they are performed in another department of the clinic (Medicare Benefit Policy Manual, 2011).

Home care “incident to” provision for medically underserved areas.

“Incident to” services may be covered in some medically underserved areas where there are only a few physicians/providers available to provide services over broad geographic areas or to a large patient population. The lack of medical personnel (and, in many instances, a home health agency servicing the area) significantly reduces the availability of certain medical services to homebound patients. Some physicians and physician-directed clinics, therefore, call upon nurses and other paramedical personnel to provide these services under general (rather than direct) supervision. In some areas, such practice has tended to become the accepted method of delivery of these services. The following criteria must be met:

1. The patient must be home bound, this is not necessarily bedridden but with absences from the home are infrequent, usually for the purposes of receiving medical treatment, and that there exists a normal inability to leave home and that to do so would present a daunting or taxing effort.
2. The service is an integral part of the provider’s service to the patient and is performed under general provider supervision by employees of the provider or clinic. General supervision does not require the provider to be physically present when the service is performed. The auxiliary personal contacts the provider if additional care instructions are needed.
3. Coverage will not be considered if there is a participating home health care agency that could provide the needed services on a timely basis.

There are a plethora of services that are included and allowed to be performed under the general supervision of a provider and are as follows: injections, venipuncture, EKG’s,
therapeutic exercises, insertion and sterile irrigation of a catheter, changing of catheters and collection of catheterized specimen for urinalysis, dressing changes, replacement and/or insertion of nasogastric tubes, removal of fecal impaction including enemas, sputum collection for gram stain and culture and possible acid-fast and/or fungal stain and culture, paraffin bath therapy for hands and/or feet in rheumatoid arthritis or osteoarthritis, and teaching and training the patient for the care of colostomy, ileostomy, or urostomy, for the care of permanent tracheostomy, testing urine and care of the feet for diabetic patients, and how to monitor blood pressure. See https://www.cms.gov/manuals/Downloads/bp102c15.pdf, section 60.4 - Services Incident to a Physician’s Service to Homebound Patients under General Physician Supervision for additional information.

“Incident to” Billing – Appropriate Use

Here is an example of appropriate “incident to” billing: A provider evaluates a patient, and diagnoses venous stasis ulcer and initiates treatment. The auxiliary personnel conducts follow-up visits with the patient, monitoring and treating the wound over weeks or months. The provider sees the patient every third visit, under a policy adopted by the practice. The auxiliary personnel’s work may be billed under the provider’s NPI number, and the practice will receive 100% of the provider’s fee schedule rate for the services performed by the auxiliary personnel.

“Incident to” Billing – Illegal Use

Here is an example of inappropriate “incident to” billing: An APRN works with a non-advanced practice nurse in an outpatient office. The APRN develops the plan of care but after this initial visit is never present. “Incident to” billing is inappropriate, as the requirements are not met; the APRN is not immediately available when the patient is seen.

Billing an Auxiliary Personnel’s Service under an APRN’s Provider Number

A practice may bill the services of an auxiliary personnel’s “incident to” an APRN’s services, if the rules for “incident to” billing are followed. For example, if an APRN sees a patient, develops the plan of care and the non-advanced practice nurse sees the patient and continues with the plan for care, for instance, removing the dressing that was ordered by the APRN, evaluating the wound and redressing the wound, this can be billed under the APRN’s NPI. Reimbursement for the APRN is at 85% of the Medicare physician reimbursement schedule.

Where “Incident to” Billing is not Indicated: Hospital Settings and Skill Nursing Facilities

Services and supplies that would normally be covered “incident to” in an office setting are not billable by the provider in hospital settings. Therefore, if the provider uses the services of his/her own employees in a hospital setting and the physician merely supervises his/her services, the provider is not eligible for a payment from Medicare. Although the provider’s employees might meet the supervision and employment requirements generally applicable to “incident to” services in other settings, their services are nevertheless not payable as “incident to” services to the provider when furnished in a hospital setting.
For patients at skilled nursing facilities staying under the coverage of Medicare, there is no Medicare part B coverage of services furnished by auxiliary personnel as service’s “incident to” those of providers.

“Incident to” Coverage with non-Medicare Insurance

Insurance companies develop their own policies and may not follow what Medicare implements. To determine what policy is in affect for “incident to” policies each policy must be examined.

Conclusion:

To consider billing “incident to” the provider must have initiated the course of treatment, and the care provided by the auxiliary personnel must be an incidental part of the patient’s treatment, for instance a follow up visit. The provider (or as noted above a provider in a group practice) must be present in the office and immediately available to provide assistance and direction to the auxiliary personal. Incident-to claims that do not meet Medicare rules are potentially false claims. Such claims are punishable by the Department of Justice and the Office of the Inspector General (OIG) When considering use of “incident to” billing it is strongly suggested that research into this type of billing be done by reviewing the Medicare guidelines and discussing this option with the facilities billing experts.
References:


Additional Reading:


Glossary:

**Auxiliary Personnel:** 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.

**Provider:** A health care provider who meets state licensing obligations to provide specific medical services. Medicare defines a provider to include physicians, nurse practitioners, clinical nurse specialists, certified nurse midwives, physician assistants, clinical psychologists, clinical social workers and physical and occupational therapists.

**NPI number:** A unique eight character ID assigned by the National Provider System to providers/suppliers who bill for services or goods. The NPI is the standard unique health identifier for health care providers. The NPI was mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Non-physician practitioner (NPP):** A health care provider who meets state licensing obligations to provide specific medical services. For Medicare purposes, the term includes: nurse practitioner or clinical nurse specialist, certified nurse-midwife, a physician assistant, audiologist, nurse anesthetist, nurse midwife, clinical social workers, physical and occupational therapist, physician assistant and registered dietician/nutrition professional. The scope of practice, licensure, and credentialing requirements for each NPP are established by the law of the jurisdiction in which the NPP practices. States are responsible for licensing and for setting the scopes of practice.

**Approved by the WOCN® Board of Directors:** November 15, 2011