

"Incident To" Services

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IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy. This information is intended to serve only as a general resource regarding UnitedHealthcare’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee’s benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application
This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its

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electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. CPT codes and descriptions are copyright 2010 American Medical Association (or such other date of publication of CPT). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to Government use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Current Dental Terminology (CDT), including procedure codes, nomenclature, descriptors, and other data contained therein, is copyright by the American Dental Association, 2002, 2004. All rights reserved. CDT is a registered trademark of the American Dental Association. Applicable FARS/DFARS apply.

Summary

Overview

Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

Section 1861(s)(2)(B) of the Act establishes the benefit category for hospital "incident to" medical and other health services, which are paid under Medicare Part B. The statute specifies that "incident to" services are "hospital services (including drugs and biological which are not usually self-administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services."

Reimbursement Guidelines

Services and supplies commonly furnished in physicians' offices are covered under the incident to provision. 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.

Commonly Furnished In Physicians' Offices

Supplies usually furnished by the physician in the course of performing his/her services, e.g., gauze, ointments, bandages, and oxygen, are also covered. Charges for such services and supplies must be included in the physicians' bills. To be covered, supplies, including drugs and biologicals, must represent an expense to the physician or legal entity billing for the services or supplies. For example, where a patient purchases a drug and the physician administers it, the cost of the drug is not covered. However, the administration of the drug, regardless of the source, is a service that represents an expense to the physician. Therefore, administration of the drug is payable if the drug would have been covered if the physician purchased it.

Direct Personal Supervision

Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel. Auxiliary personnel means 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. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

However, the physician personally furnishing the services or supplies or supervising the auxiliary personnel furnishing the services or supplies must have a relationship with the legal entity billing and receiving payment for the services or supplies that satisfies the requirements for valid reassignment. As with the physician's personal professional services, the patient's financial liability for the incident to services or supplies is to the physician or other legal entity billing and receiving payment for the services or supplies. Therefore, the incident to services or supplies must represent an expense incurred by the physician or legal entity billing for

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the services or supplies.

Thus, where a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflects his/her active participation in and management of the course of treatment. (However, the direct supervision requirement must still be met with respect to every non-physician service.)

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 SNF), their services are covered incident to a physician's service only if there is direct supervision by the physician. For example, if a nurse accompanied the physician on house calls and administered an injection, the nurse's services are covered. If the same nurse made the calls alone and administered the injection, the services are NOT covered (even when billed by the physician) since the physician is not providing direct supervision. Services provided by auxiliary personnel in an institution (e.g., nursing, or convalescent home) present a special problem in determining whether direct physician supervision exists. The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct supervision.

For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under §1861(s)(2)(A) of the Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a Medicare intermediary.

Non-Physician Practitioner

In addition to coverage being available for the services of such auxiliary personnel as nurses, technicians, and therapists when furnished incident to the professional services of a physician, a physician may also have the services of certain non-physician practitioners covered as services incident to a physician's professional services. These non-physician practitioners, who are being licensed by the States under various programs to assist or act in the place of the physician, include, for example, certified nurse midwives, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists.

Services performed by these non-physician practitioners incident to a physician's professional services include not only services ordinarily rendered by a physician's office staff person (e.g., medical services such as taking blood pressures and temperatures, giving injections, and changing dressings) but also services ordinarily performed by the physician such as minor surgery, setting casts or simple fractures, reading x-rays, and other activities that involve evaluation or treatment of a patient's condition.

Nonetheless, in order for services of a non-physician practitioner to be covered as incident to the services of a physician, the services must meet all of the requirements for coverage specified in §60 through §60.1. For example, the services must be an integral, although incidental, part of the physician's personal professional services, and they must be performed under the physician's direct supervision.

A non-physician practitioner such as a physician assistant or a nurse practitioner may be licensed under State law to perform a specific medical procedure and may be able to perform the procedure without physician supervision and have the service separately covered and paid for by UnitedHealthcare as a physician assistant's or nurse practitioner's service. However, in order to have that same service covered as incident to the services of a physician; it must be performed under the direct supervision of the physician as an integral part of the physician's personal in-office service. This does not mean that each occasion of an incidental service performed by a non-physician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the non-physician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment. In

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addition, the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.

Note that a physician might render a physician's service that can be covered even though another service furnished by a non-physician practitioner as incident to the physician's service might not be covered. For example, an office visit during which the physician diagnoses a medical problem and establishes a course of treatment could be covered even if, during the same visit, a non-physician practitioner performs a non-covered service such as acupuncture.

Services in a Clinic

Services and supplies incident to a physician's service in a physician directed clinic or group association are generally the same as those described above.

A physician directed clinic is one where:

- A physician (or a number of physicians) is present to perform medical (rather than administrative) services at all times the clinic is open;
- Each patient is under the care of a clinic physician; and
- The non-physician services are under medical supervision.

In highly organized clinics, particularly those that are departmentalized, direct physician supervision may be the responsibility of several physicians as opposed to an individual attending physician. 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.

Supplies provided by the clinic during the course of treatment are also covered. When the auxiliary personnel perform services outside the clinic premises, the services are covered only if performed under the direct supervision of a clinic physician. If the clinic refers a patient for auxiliary services performed by personnel who are not supervised by clinic physicians, such services are not incident to a physician's service.

Home Bound Patients

In some medically underserved areas there are only a few physicians 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 Senate Finance Committee Report accompanying the 1972 Amendments to the Act recommended that the direct supervision requirement of the "incident to" provision be modified to provide coverage for services provided in this manner.

Accordingly, to permit coverage of certain of these services, the direct supervision criterion listed above is not applicable to individual or intermittent services outlined in this section when they are performed by personnel meeting any pertinent State requirements (e.g., a nurse, technician, or physician extender) and where the criteria listed below also are met:

- The patient is homebound; i.e., confined to his or her home (see § 60.4.1 for the definition of a "homebound" patient and § 110.1 (D) for the definition of patient's "place of residence.")
- The service is an integral part of the physician's service to the patient (the patient must be one the physician is treating), and is performed under general physician supervision by employees of the physician or clinic. General supervision means that the physician need not be physically present at the patient's place of residence when the service is performed; however, the service must be performed under his or her overall supervision and control. The physician orders the service(s) to be performed, and contact is maintained between the nurse or other employee and the physician, e.g., the employee contacts the physician directly if additional instructions are needed, and the physician must retain professional responsibility for the service. All other "incident to" requirements must be met.
- The services are included in the physician's /clinic's bill and the physician or clinic has incurred an expense for them.
- The services of the paramedical are required for the patient's care; that is, they are reasonable and necessary as defined in the Medicare Benefit Policy Manual, Chapter 16, "General Exclusions from

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Coverage," § 20.

- When the service can be furnished by an HHA in the local area, it cannot be covered when furnished by a physician/clinic to a homebound patient under this provision, except as described in § 60.4.C.

Where the requirements in § 60.4.A are met, the direct supervision requirement in § 60.2 is not applicable to the following services:

- Injections;
- Venipuncture;
- EKGs;
- Therapeutic exercises;
- Insertion and sterile irrigation of a catheter;
- Changing of catheters and collection of catheterized specimen for urinalysis and culture;
- Dressing changes, e.g., the most common chronic conditions that may need dressing changes are decubitus care and gangrene;
- 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;
 - Teaching and training the patient for:
 - The care of colostomy and ileostomy;
 - The care of permanent tracheostomy;
 - Testing urine and care of the feet (diabetic patients only); and
 - Blood pressure monitoring.

Teaching and training services (also referred to as educational services) can be covered only where they provide knowledge essential for the chronically ill patient's participation in his or her own treatment and only where they can be reasonably related to such treatment or diagnosis. Educational services that provide more elaborate instruction than is necessary to achieve the required level of patient education are not covered. After essential information has been provided, the patient should be relied upon to obtain additional information on his or her own.

Physicians may have an office within a nursing home or other institution. Where a physician establishes an office within a nursing home or other institution, coverage of services and supplies furnished in the office must be determined in accordance with the "incident to a physician's professional service" provision, as in any physician's office. A physician's office within an institution must be confined to a separately identified part of the facility which is used solely as the physician's office and cannot be construed to extend throughout the entire institution. Thus, services performed outside the "office" area would be subject to the coverage rules applicable to services furnished outside the office setting.

In order to accurately apply the criteria in the Medicare Benefit Policy Manual, Chapter 6, §20.4.1 or Chapter 15, §60.1, the contractor gives consideration to the physical proximity of the institution and physician's office. When his office is located within a facility, a physician may not be reimbursed for services, supplies, and use of equipment which fall outside the scope of services "commonly furnished" in physician's offices generally, even though such services may be furnished in his institutional office. Additionally, make a distinction between the physician's office practice and the institution, especially when the physician is administrator or owner of the facility. Thus, for their services to be covered under the criteria, the auxiliary medical personnel must be members of the office staff rather than of the institution's staff, and the cost of supplies must represent an expense to the physician's office practice. Finally, services performed by the employees of the physician outside the "office" area must be directly supervised by the physician; his presence in the facility as a whole would not suffice to meet this requirement. (In any setting, of course, supervision of auxiliary personnel in and of itself is not considered a "physician's professional service" to which the services of the auxiliary personnel could be an incidental part, i.e., in addition to supervision, the physician must perform or have performed a personal professional service to the patient to which the services of the auxiliary personnel could be considered an incidental part). Denials for failure to meet any of these requirements would be based on §1861(s) (2) (A) of the Act.

Establishment of an office within an institution would not modify rules otherwise applicable for determining

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coverage of the physician's personal professional services within the institution. However, in view of the opportunity afforded to a physician who maintains such an office for rendering services to a sizable number of patients in a short period of time or for performing frequent services for the same patient, claims for physicians' services rendered under such circumstances would require careful evaluation by the carrier to assure that payment is made only for services that are reasonable and necessary.

Pharmacies Billing Drugs

Pharmacies may bill Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through any piece of durable medical equipment.

- Claims for these drugs are generally submitted to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.
- In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician's service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

The DME MAC, A/B MAC, or carrier will make payment to the pharmacy for these drugs, when deemed to be covered and reasonable and necessary. All bills submitted to the DME MAC, A/B MAC, or carrier must be submitted on an assigned basis by the pharmacy.

When drugs may not be billed by pharmacies to Medicare Part B

Pharmacies, suppliers and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration "incident to" a physician service, such as refilling an implanted drug pump. These claims will be denied.

Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary. When these drugs are administered in the physician's office to a beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. In this case, the drugs are being administered "incident to" a physician's service and pharmacies may not bill Medicare Part B under the "incident to" provision.

References Included (but not limited to):

CMS NCD

NCD 70.3 Physician's Office Within an Institution--Coverage of Services and Supplies Incident to a Physician's Services (70.3)

CMS Benefit Policy Manual

Chapter 6; § 20.4.1 Diagnostic Services Defined

Chapter 15; § 60.1 Incident To Physician's Professional Services, § 60.2 Services of Non physician Personnel Furnished Incident To Physician's Services, § 60.3 Incident To Physician's Services in Clinic, § 60.4 Services Incident to a Physician's Service to Homebound Patients Under General Physician Supervision

Chapter 16; § 20 Services Not Reasonable and Necessary

UnitedHealthcare Medicare Advantage Coverage Summaries

Evaluation and Management Services

MLN Matters

Article MM7397, Pharmacy Billing for Drugs Provided "Incident To" a Physician Service

Article SE0441, "Incident To" Services

Others

Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 405, 410, 412, 419, 475, 476, 486, and 495, Society of Nuclear Medicine and Molecular Imaging (SNMMI) Website

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History

Date	Revisions
12/18/2013	<ul style="list-style-type: none"> • Policy re-review completed • Research found a MLN release providing direction on Pharmacy Billing for Drugs Provided "Incident To" a Physician Service • Policy updated and presented to MRPC for approval
04/24/2013	Policy split for new policy version presented to MPRC for approval
04/02/2013	Decision to split the New Patient Visit, Incident To, and Same Day/Same Service Reimbursement Policy (NPISD10102012RP) into 3 separate policies: Each topic deserves its own document to maintain clear transparency
10/10/2012	NPISD10102012RP approved at MRPC: 3 topics-New Patient Visit, Incident To, and Same Day Same Service-are all addressed in this policy