## Incident-To Services

**Scope:** This policy applies to the following Medical (including Pharmacy/Vision) plans:
- All Companies: Moda Partners, Inc. and its subsidiaries & affiliates
- Eastern Oregon Coordinated Care Organization (EOCCO)
- OHSU Health IDS

**Types of Business:**
- All Types
- 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

<table>
<thead>
<tr>
<th>Originally Effective</th>
<th>Initially Published</th>
<th>Last Updated</th>
<th>Last Reviewed</th>
</tr>
</thead>
</table>

**Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?** No

**Last Update Effective Date for Texas:** 8/10/2022

### Reimbursement Guidelines

**A. For Commercial Plans**

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

**B. For Medicare Advantage Plans**

Moda Health follows 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

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

### 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. (AANP) 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.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Modifier Description &amp; Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifier SA</td>
<td>Nurse practitioner rendering service in collaboration with a physician</td>
</tr>
</tbody>
</table>
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

None.

References & Resources


**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. (Gosfield)
  - 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. (Gosfield)
  - For offices or clinics in institutions, the office must be confined to a well-defined and separately identifiable part of the facility. (CMS)

- Must be performed by a non-physician employee (direct or leased/contracted) of the practice submitting the claim. (Gosfield)
- Must be performed by someone whom the physician directly supervises. (Loya & Friederich)
- Must be performed on established patients only. (Balen)
• Type of problem.
  o Must be addressing established problems only. (Loya & Friederich\textsuperscript{12})
  o 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. (Balen\textsuperscript{4}, Stantz\textsuperscript{10})
• The physician must have personally performed an initial service and initiated the plan of care for
  the condition or problem being treated. (Stantz\textsuperscript{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. (AAPC\textsuperscript{8})
  o Being available by phone does not constitute direct supervision. (Stantz\textsuperscript{10}, Loya &
    Friederich\textsuperscript{12})
  o 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. (Balen\textsuperscript{4}, Loya
    & Friederich\textsuperscript{12})
• The physician must remain actively involved in the patient’s care and personally see the patient
  periodically. (Gosfield\textsuperscript{5})
• The essential requirements for incident to service are to be documented in the patient record.
  (Balen\textsuperscript{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.) (Gosfield\textsuperscript{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. (Dowling\textsuperscript{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

<table>
<thead>
<tr>
<th>Date</th>
<th>Summary of Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/12/2014</td>
<td>Policy initially approved by the Reimbursement Administrative Policy Review Committee &amp; initial publication.</td>
</tr>
<tr>
<td>7/25/2011</td>
<td>Original Effective Date (with or without formal documentation). Policy based on CMS policy for Medicare Advantage plans and administrative decision for Commercial plans.</td>
</tr>
</tbody>
</table>