Coding for "Incident-to" Services

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Practice Points

- Direct supervision of a nonphysician provider by a physician must be demonstrated for incident-to services. Not every type of visit is eligible for incident-to billing.
- Only management of established problems on established patients by nonphysician providers may qualify as incident-to services.
- Refer to state and payer regulations and rules for proper incident-to coding.

Services that physicians bill to Medicare but do not perform themselves are called "incident-to" services. These services usually are performed by nonphysician medical providers under close physician supervision. The authorization to bill for these incident-to services derives from the Social Security Act,[1] which provides for Medicare coverage of services and supplies offered incident to the professional services of a physician. The underlying logic is that incident-to services are delivered as a necessary but incidental part of the physician's professional services during diagnosis or treatment.

Eligibility Criteria

One key qualification for incident-to services is direct supervision of a nonphysician provider by a physician. When services are delivered in an office setting (place of service 11), the physician must be present in the office and immediately available to offer direction to nonphysician providers. Some states do include telecommunication in their definition of direct supervision, wherein the physician is accessible by telephone or some similar medium.

Another element necessary in the criteria for incident-to services is that initial care must be personally provided by the physician who also writes orders for ongoing care. In general, incident-to services include ongoing physician involvement in the provision of care. Importantly, the physician who first saw a patient, initiated service, or ordered a test is not the only one who can supervise subsequent incident-to visits with a nonphysician provider. In office settings where several physicians are responsible for overseeing a nonphysician provider, any of these physicians who are in clinic at the time can act as the supervising physician. In such cases, each of the other physicians should be listed in appropriate documentation as substitute physicians for the nonphysician provider.

The Centers for Medicare & Medicaid Services recognize a variety of nonphysician providers, but in dermatology these providers typically include physician assistants, certified registered nurse practitioners, or clinical nurse specialists. When services offered by these nonphysician providers are reported as incident-to services, Medicare reimburses them at 100% of the physician fee schedule; conversely, a non–incident-to service reported under a nonphysician provider's National Provider Identifier (NPI) number is reimbursed at 85%. Only approved mid-level nonphysician providers may bill evaluation and management services with codes above 99211 under incident-to guidelines. Even then, the services delivered must be appropriate for

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This article provides general information. Physicians should consult *Current Procedural Terminology (CPT)* guidelines, state regulations, and payer rules for coding and billing guidance relevant to specific cases. The opinions represented here are those of the author and have not been reviewed, endorsed, or approved by the American Medical Association, the American Academy of Dermatology, or any other coding or billing authority.
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the given nonphysician provider based on training and licensure.

Not every type of visit is eligible for coding as an incident-to service. For instance, it is not appropriate to code new patient visits or new services provided to existing patients as incident-to services. Similarly, visits with established patients that address new diagnoses or problems cannot be considered incident-to services. The only visits or services that may potentially be classified as incident to are those that address existing problems in established patients with an established care plan.

When an established patient presents with a new problem, there are at least 2 coding approaches that may be appropriate. First, the physician could choose to see the patient and code the visit as a standard physician visit under the physician's own NPI number. Alternatively, if the supervising physician in the practice is not available to see the patient, the nonphysician provider could code the entire service, including new and old problems, under his/her own NPI number as a non–incident-to service.

Regulations by State and Payer

State regulations and rules promulgated by specific payers also must be considered to ensure incident-to coding is proper. Each state may have guidelines that define the scope of practice of particular nonphysician providers, including what services can or cannot be coded as incident-to services. Additionally, states typically regulate the number of nonphysician providers that a physician can supervise; by extension, no more than this number of nonphysician providers could bill incident-to services under a given physician's NPI number. Private payers may have comparable rules, and specific Medicare guidelines apply to Medicare patients. When there is ambiguity regarding incident-to coding, it may be prudent to check with major payers regarding relevant guidelines. It also may be helpful to confirm when supervision via telecommunication is acceptable.

Billing Tips

Common sense also can guide appropriate use of incident-to coding. Although occasional coding errors are likely unavoidable, periodic review of billing patterns will keep these errors to a minimum. For instance, if a nonphysician provider is the only provider of any type seeing patients in the office during particular days of the week, then incident-to coding would be unlikely. In another example, the number of nonphysician providers working with a given dermatologist and billing incident-to services should not exceed the number of nonphysician providers allowed per physician in that state. An interesting twist is the case in which a dermatologist is working in an ambulatory surgery center while a nonphysician provider is seeing patients in an adjacent office suite. Even when the 2 sites of service are physically contiguous, the physician in the surgery center generally is not deemed to be in office and is not able to supervise the nonphysician provider, unless telecommunication is allowed.

Final Thoughts

Attention to correct coding for incident-to services is particularly salient, as the Office of Inspector General (OIG) for the US Department of Health & Human Services has expressed concern that these services may be routinely coded incorrectly. Specifically, the OIG work plan for the 2013 fiscal year stated, "We will review physician billing for 'incident-to' services to determine whether payment for such services had a higher error rate than that for non–incident-to services." The same report also cited a 2009 OIG review that found that "unqualified nonphysicians performed 21 percent of the services that physicians did not personally perform."[2] In short, coding for incident-to services is under scrutiny, and it may be useful for dermatologists to review their internal policies regarding incident-to services.

REFERENCES

1. Social Security Act, 42 USC §1861 (1935).
2. Work plan for fiscal year 2013. Office of Inspector General, US Department of Health & Human Services Web site. http://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf. Accessed May 5, 2015.