

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 87	Date: May 2, 2008
	Change Request 5288

SUBJECT: Incident to Policy Update

I. SUMMARY OF CHANGES: In response to frequent inquiry, this instruction provides clarification concerning policies for services incident to a physicians" or nonphysician practitioners" service in the office setting.

New / Revised Material

Effective Date: June 2, 2008

Implementation Date: June 2, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/Table of Contents
R	15/50.3/Incident To Requirements for Coverage of Drugs and Biologicals That Are Not Usually Self-Administered
R	15/60/Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service
R	15/60.1/Incident To Physician's/NPP's Professional Services in Office or Physician/NPP Owned and Operated Clinic
R	15/60.2/Services of Nonphysician Personnel Furnished Incident To Physician's Services
R	15/60.3/Incident To Physician's/NPP's Services in Physician/NPP Owned and Operated Clinics

III. FUNDING:

SECTION A: Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-02	Transmittal: 87	Date: May 2, 2008	Change Request: 5288
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SUBJECT: Incident To Policy Update

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I. GENERAL INFORMATION

A. Background: The number of services provided as incident to the services of physicians/NPPs has grown continuously. As the benefit is applied in various settings for different services, the original instructions appeared insufficient. This instruction is published in response to continued requests for clarification of policies related to Part B services provided incident to the services of physicians.

B. Policy: This represents no significant change in Medicare policy. It is intended to clarify current policy and, where local interpretations may differ, to add consistency.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A / B M A C	D M E M A C	F I	C A R E I E R	R H I	Shared-System Maintainers		
					F I S S	M C S	V M S	C W F	
5288.1	Contractors shall interpret a service as integral when it is both essential to the initial service and connected to the initial service.	X			X				
5288.2	When contractors are aware that a service is furnished by staff other than the physician/NPP overseeing the patient's care, contractors shall not pay for services incident to a physician's/NPP's service unless the services meet the requirements in Pub. 100-02, chapter 15, section 60 and its subsections.	X			X				
5288.2.1	When contractors are aware that a service is furnished by staff other than the physician/NPP overseeing the patient's care, contractors shall not pay for services incident to a physician's/NPP's service unless there is documentation authorizing the subsequent service.	X			X				
5288.3	Contractors shall not pay for services incident to the services of a physician/NPP if the services are for a new problem.	X			X				
5288.4	Contractors shall use clinical judgment in determining	X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	whether the record contains sufficient documentation to indicate that a physician/NPP is overseeing the provision of services appropriately for the patient's condition.										
5288.5	Contractors shall use clinical judgment in determining whether the person furnishing the incident to service is appropriately qualified.	X			X						
5288.6	When contractors are aware that a service was furnished by auxiliary staff rather than the physician/NPP who billed for the service, contractors shall not pay for services as incident to a physician's/NPP's service unless they determine that the staff was qualified to provide the service.	X			X						
5288.7	Contractors shall apply the policies for services incident to a physician's/NPP's services in the office only in the identifiable boundary of an office or in a single room.	X			X						
5288.7.1	Where services are provided in a home or in the SNF, outside the boundary of an office suite, contractors shall require that the supervisor be in the same room as the patient and the staff furnishing a service, providing the equivalent of personal supervision.	X			X						
5288.8	Contractors shall require that documentation in the medical record conform to the policy in this change request.	X			X						
5288.8.1	Contractors shall require for payment an authorization for services provided incident to their initial service.	X			X						
5288.8.2	Contractors shall require for payment that the name and professional identities of the people who furnished the services are in the medical record.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5288.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A D F C R H S H I M A C	B M E M A C	I I I I I I I I I I	R A R I E R	H H H H H H H H H H	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
	<p>the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>									

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5288.1	Services unrelated and not essential to the initial service shall not be paid as incident to the initial, covered service. Such services may represent new problems for which an initial physician/NPP service is required.
5288.2	Note that for Part B services, the authorization may be an "order" which may be part of the care plan. The authorization does not have to be in any specific form; e.g., it may be an order or part of a plan, treatment note, or team meeting note. The authorization should indicate the intent of the physician that further services will be provided. It is appropriate that the physician may plan to provide a follow-up service personally and later assign the service to qualified staff. It is not necessary that a formal order be written to the staff, but services may not be billed if staff has not been authorized to provide them and that authorization is in the medical record.
5288.3	Note that contractors are not required to perform medical review on all claims to determine whether there is a new problem, but if medical review reveals that there is a new problem, they shall not pay for that service incident to the physician's service without a prior physician's service.
5288.5	Staff may be overqualified to provide a service, but the service shall not be allowed as incident to if the service should have been provided under another benefit such as a physician's service or services of another professional. Contractors should take special care in determining whether services provided by a physician or other professional incident to the services of a physician are actually incidental services or they should be billed, e.g., as

X-Ref Requirement Number	Recommendations or other supporting information:
	physician services by enrolled physicians.
5288.8.1	The authorization will not be on the claim and therefore, will be identified only when the record is reviewed.
5288.8.2	By professional identity, CMS means to require that the professional title of the person who provides the service be written in the record in order that the contractor may know any professional qualifications or licensure the staff has attained. The examples are in the manual—"the identity of the person(s) who provided the service, including any professional credentials (e.g., Barbara Drew, R.N.).

Section B: For all other recommendations and supporting information, use this space: NA

V. CONTACTS

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VI. FUNDING

Section A: For Carriers:

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Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

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(Rev.87, 05-02-08)

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50.3 – Incident To Requirements for Coverage of Drugs and Biologicals That Are Not Usually Self-Administered

(Rev.87, Issued: 05-02-08, Effective: 06-02-08, Implementation: 06-02-08)

See Section 60 of this chapter for definitions that also apply to this section.

Section 1861 (ff)(2)(D) of the Social Security Act specifies that drugs and biologicals furnished for therapeutic purpose (which cannot, as determined in accordance with regulation, be self administered) are covered services provided in a partial hospitalization program (PHP). A Community Mental Health Center is recognized as a provider of services under the Medicare program only for the purpose of providing PHP services. The drugs and biologicals are included in the per diem rate under the OPSS payment system.

A. Drugs and Biologicals Furnished Incident To a Physician's/NPP's Services in an Office or Non-facility Based Clinic Setting

- In order to meet all the general requirements for coverage under the incident-to provision *for services and supplies provided in an office or physician/NPP owned and operated clinic setting, as detailed in section 60 and its subsections in this chapter*, an FDA approved drug or biological must *be* of a form that is not usually self-administered, *and* must be administered by a physician/NPP, or by auxiliary personnel employed by the physician under the physician's *direct* supervision.

- The charge, if any, for the drug or biological must be included in the physician's/NPP's bill, and the cost of the drug or biological must represent an expense to the physician. Drugs and biologicals furnished by other health professionals may also meet these requirements. (See [§§170](#), [180](#), [190](#) and [200](#) for specific instructions.)

- *When a patient purchases a drug that a physician/NPP or auxiliary staff administers in the office or clinic, 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/NPP. Therefore, administration of the drug is payable if the drug would have been covered had the physician/NPP furnished it. See Pub. 100-04, chapter 12, section 30.6.7, especially (D), for policies relevant to billing.*

B. Blood

Units of whole blood and units of packed cells are biologicals, which cannot be self-administered and are covered when furnished incident to a physician's services. Payment may also be made for blood fractions if all coverage requirements are satisfied and the blood deductible has been met. See Pub. 100-04, chapter 4, section 231, for policies related to billing for blood and blood products furnished by a hospital to an outpatient.

60 - Services and Supplies *Furnished Incident To a Physician's/NPP's Professional Service*

(Rev.87, Issued: 05-02-08, Effective: 06-02-08, Implementation: 06-02-08)

Reference: SSA 1861(s)(2)(A), 42CFR410.26

A. Definitions

Definitions that apply to this section, its subsections, and section 50.3 of this chapter:

- *CLINIC means a physician owned and operated clinic and is not a hospital or other facility based clinic. A group refers to a group practice as defined in 42CFR411.352.*
- *INCIDENT TO (with or without quotes) refers to services incident to the service of a physician or other professional permitted by statute to bill for services incident to their services when those services meet all of the requirements applicable to the benefit.*
- *PHYSICIAN includes physicians as defined in section 1861(r) of the Act and the following qualified nonphysician practitioners (NPPs) who may, within their scope of practice and consistent with section 1861(s)(2)(K(i) and with state and local laws and regulations, provide the same services and supplies that the physician provides: nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) and certified nurse midwife (CNM).*
- *NONPHYSICIAN PRACTITIONER (NPP) means a “qualified” NPP. This denotes that the NPP meets Medicare requirements and is enrolled in the program. The qualified NPP can provide a service incident to a physician and the physician may be paid at 100% of the physician fee schedule (PFS). The definition of nonphysician practitioners under this instruction does not include other practitioners who are not authorized to receive payment for services provided incident to their services, such as, clinical social workers, physical therapists and occupational therapists.*

B. The Incident To Benefit

- Medicare *Part B* pays for services and supplies (including drugs and biologicals which are not usually self-administered) that are furnished incident to a physician's/NPP's services, are commonly *furnished in physicians/NPP's offices, commonly either rendered without charge or* included in the physician's/NPP's bills, and for which payment is not made under a separate benefit category listed in [§1861\(s\)](#) of the Act *except as provided below. This section and its subparts present policy related to the services and supplies covered under this benefit.*

- *See §50.3 of this chapter for additional information on drugs and biologicals.*

- See §§220 and 230 of this chapter for policies regarding physical therapy, occupational therapy and speech-language pathology services billed incident to the services of a physician/NPP.

C. Distinguishing Between Incident To Services and Other Part B Services

Policies that apply to Part B services and supplies which are incident to the services of a physician/NPP in physician's/NPP's offices and clinics are not necessarily consistent with the policies for services incident to the services of physicians/NPPs in a hospital or skilled nursing facility. For Hospital Services Covered Under Part B, see Pub. 100-02, chapter 6, Section 20.5.1 - Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After August 1, 2000.

Contractors shall not apply incident to requirements to services having their own Medicare Part B benefit category. These services shall meet the requirements of that benefit category, rather than the incident to requirements. Examples follow:

- *Diagnostic tests are covered under §1861(s)(3) of the Act and are subject to their own coverage requirements. Depending on the particular tests, 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/NPP services. Diagnostic tests need not also meet the incident to requirement in this section.*
- *Pneumococcal, influenza, and hepatitis B vaccines are covered under §1861(s)(10) of the Act and need not also meet incident to requirements.*
- *It is not appropriate to bill services and supplies incident to physician/NPP for services in a CORF or outpatient therapy facility/rehabilitation agency. In both cases there is a policy that requires that services of the staff are billed by the facility and not by physicians/NPPs as incident to their own services.*

There are statutory exceptions to the requirement that services follow the rules of their own benefit category when one exists. Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists have specific benefits enumerated under the Social Security Act. Those physicians/NPPs are allowed to: 1) bill directly for services they personally perform, or 2) have their services billed incident to the services of another physician/NPP, or 3) bill for the services of staff provided incident to their own services. The services provided as professional services incident to the services of another physician/NPP must represent the service covered under their statutory benefit and also comply with all the requirements for services incident to the services of a physician/NPP. Where the policies of the two benefit categories conflict and are not resolved in Medicare manuals, contractors shall apply the policies that, in the judgment of the contractor, best serve the beneficiary.

The benefit differs for therapists and clinical social workers. Due to statutory provisions, physical therapists, occupational therapists, and clinical social workers may 1) bill directly for services they personally perform, or, 2) have their services billed incident to the services of a physician/NPP. However, the benefit for their services does not allow them to bill for the services of staff under the policy for services incident to the services they personally provide. See section 230.1 and 230.2 of this chapter for policies on physical therapist assistants and occupational therapy assistants.

Speech-language pathologists may have their services billed incident to the services of a physician/NPP, but the benefit for their services does not allow them to bill for the services of staff as incident to the services they personally provide.

All of the requirements for services incident to must be followed before payment is appropriate.

The benefit category “incident to” is not identified only by the requirement for supervision of a service; i.e., not all services that are supervised are incident to a physician’s/NPP’s professional services. For example, certain technical portions of diagnostic tests have an assigned level of supervision, but they are not incident to services, because diagnostic tests have a distinct benefit category.

D. Basic Requirements

To be covered *as services and supplies* incident to the services of a physician’s/NPP’s professional services, *the* services and supplies *shall* be:

- *Covered and payable; for example, reasonable and necessary as described by Pub. 100-08, Program Integrity Manual, chapter 13, section 13.5.1.*
- *An integral, although incidental, part of the physician’s/NPP’s professional service (see §60.1 A and B); i.e.,*
 - *Preceded by a related physician/NPP service; and*
 - *Authorized by a physician/NPP; and*
 - *Furnished under the care of a physician/NPP during the course of diagnosis and treatment of an illness or injury; and*
 - *Furnished under the direct supervision of a physician/NPP; and*
- *Commonly rendered without charge or included in the physician’s/NPP’s bill (see §60.1.C); and*
- *Of a type that is commonly furnished in physician’s/NPP’s offices or clinics (see §60.1.D); and*

- An expense, or represent an expense incurred by the physician/NPP or by the legal entity billing for the services (see §60.1.E); and
- Furnished by *qualified* auxiliary personnel (see §60.1G) under the physician's/NPP's direct supervision (see §60.1.F for *direct supervision* and §60.4 for *exception for underserved areas*); and
- Appropriately documented (see §60.1J).

60.1 - Incident To Physician's/NPP's Professional Services *in Office or Physician/NPP Owned and Operated Clinic*
(Rev.87, Issued: 05-02-08, Effective: 06-02-08, Implementation: 06-02-08)

Services and/or supplies billed incident to a physician's/NPP's professional services are furnished by auxiliary personnel under direct supervision 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. Medicare pays only for covered services and/or supplies. See the Medicare Program Integrity Manual, chapter 13, section 13.5.1 for general descriptions of reasonable and necessary services. Services may not be billed incident to the physician/NPP to avoid denial of services that are not covered by Medicare.

A. Integral Part of the Physician's/NPP's Professional Service

An integral service shall be related to an initial covered service and both essential and connected to the physician's/NPP's delivery of care related to the initial service.

Initial Evaluation/Service. *A physician/NPP shall provide an evaluation or initial covered service to which the subsequent service is integral, but incidental. Therefore, each service incident to a physician's/NPP's service must be preceded by a physician's/NPP's service related to the same problem. If the patient presents with a new problem, the physician/NPP must first see the patient and provide a service before service by auxiliary personnel can be considered incident to the physician/NPP service. Where it is not clear, contractors shall determine what defines a "new problem."*

Authorization. *An authorization for the incident to service shall be established by a physician/NPP who has provided an initial service for a problem to which the subsequent services are integral and incidental. The authorization may be part of a plan or other part of the medical record. In most cases, the same physician/NPP who provides an initial service will write an authorization for subsequent services and supplies. If the subsequent service represents a new problem, a physician/NPP must first provide a service for the problem before a subsequent service may be authorized. The authorization is not required to be in any specific form, but must convey the intention of the physician/NPP that a subsequent service is requested.*

When a patient presents for a subsequent integral and incidental service that was unanticipated, the supervising physician/NPP may write an authorization or develop a plan for the subsequent service incident to the service of the physician/NPP who provided the initial service. An unanticipated subsequent service is a service that is appropriate, incidental and integral to care for the initial problem but undocumented (lacks an authorization or plan) by the physician/NPP who provided the initial service. For example, if the physician sees a patient for a service but does not anticipate the need for further services and the next day the patient returns concerning the same problem and requires an incidental service integral to the service furnished the preceding day, the supervising physician may write an authorization for that subsequent service.

Under the Care of a Physician - Patient Care Management. During any course of covered treatment rendered by auxiliary personnel, a physician/NPP who provides patient care management must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen. A service or supply would not be considered incidental to a physician's service if the physician/NPP merely wrote an order authorizing the services or supplies without being involved in the management of that course of treatment. The physician/NPP may determine the timing and nature of the management is consistent with reasonable and necessary services as defined in Pub. 100-08, chapter 13, section 13.5.1 as interpreted by contractors.

Active participation of the authorizing physician/NPP is required and is demonstrated, e.g., by documentation by physicians/NPPs indicating review of the record and/or periodic services to the patient for the same condition at a frequency consistent with the patient's needs (as determined by the contractor). Note that review of a medical record without seeing the patient and performing some aspect face-to-face with the patient does not qualify for an E/M service. Contractors shall use clinical judgment in determining whether the record contains sufficient documentation of periodic visits to indicate that a physician/NPP is overseeing the provision of services.

In the office or clinic setting, the physician/NPP who provides patient care management shall be a member of the same group that employs or contracts with the auxiliary personnel who furnishes the service incident to that physician's/NPP's service.

B. Incidental Service

*A physician/NPP may supervise auxiliary personnel assisting him/her in rendering services to patients and include the charges for the services in his/her own **physician/NPP office or clinic bills to contractors.** In that case, the services of such personnel are considered incidental to the physician's/NPP's service if there is an **initial** physician's/NPP's service rendered to which **subsequent** services of such personnel are an **integral (as defined above) although incidental part of the physician's/NPP's planned treatment of the same condition.** The incidental service shall be:*

- An important part of the initial covered treatment; and*

- *Subsidiary or supplementary; and*
- *Not a significant or substantive service of its own (as interpreted by CMS manuals and Medicare contractors – also see section 60B and*
- *Not a service for a new symptom or different condition than the one initially treated.*

Certain services and supplies may require contractor interpretation to determine whether the service is actually an incidental service that can be safely and effectively provided by auxiliary staff, or is a service requiring a specific professional skill, for example, the skill of a psychologist, an audiologist, a radiologist, or a therapist. Also, contractors may have to be consulted to determine if a new problem(s) alters the original treatment and care plan such that a new physician visit and authorization is required.

This does not mean, however, that to be *billable as* incident to *a physician/NPP service*, 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/*NPP*. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician/*NPP* 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 service *provided as incident to a physician/NPP service in the office setting.*)

For example, if a patient sees a physician for a service and the physician writes an authorization for the nurse practitioner to provide an important part of that same service; the nurse practitioner's service may be billed as incident to the physician's service. However, if the patient returns 2 weeks later to the nurse practitioner with symptoms of a different problem, the physician may not bill that nurse practitioner's service as incident to the physician's service without another physician service and a new authorization for the service for the new problem. This service may be billed as a service of the nurse practitioner, but not as a service incident to the service of the physician.

C. Commonly Rendered Without Charge or Included in the Physician's Bill

Many incidental services and supplies are relatively insignificant and are not separately payable. A nurse's assistance in dressing the patient after the physician/NPP performs a service is an example.

However, there are specific services billed incident to the services of a physician/NPP that are payable when billed by the person who furnished them. For example, the services of a nurse practitioner could be independently billed by the enrolled nurse practitioner, or alternately could be included in the physician's bill as services incident to a physician, if provided according to the rules of that benefit.

Also, some services have been specifically assigned to the benefit category “Incident to” by national coverage determinations. See, for example, diathermy treatment in Pub. 100-03, chapter 1, Part 2, section 150.5.

D. Commonly Furnished in Physicians’/NPPs’ Offices

Services and supplies commonly furnished in physician’s/NPP’s offices are covered under the incident to *benefit* provision *when they meet the requirements for coverage (including medical necessity) and the other requirements for billing incident to a physician’s/NPP’s services.* Where supplies are clearly of a type a physician/NPP 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.

If a physician’s office is in the same building as a separate provider of services, such as a SNF, the policies for services incident to a physician’s/NPP’s services in the office apply only in the identifiable boundary of the office, and not in the SNF.

E. Representing an Expense

Supplies usually furnished by the physician/NPP in the course of performing his/her services, e.g., gauze, ointments, bandages, and oxygen, *may also be* covered. Charges for such supplies must be included in the physician’s/NPP’s bills. (See [§50](#) regarding coverage of drugs and biologicals under this provision.) To be covered, supplies, including drugs and biologicals, must represent an expense to the physician/NPP or legal entity billing *for* the services or supplies.

Services may represent an expense to the physician/NPP or other legal entity (the group) billing for the services when the salary of the staff performing the service is either paid directly to the staff or to the entity employing the staff.

The physician/NPP *who has authorized the service, who has* personally furnished the services or supplies, *or has* supervised the auxiliary personnel furnishing the services or supplies, must have a relationship with the legal entity (*the group*) billing and receiving payment for the services or supplies that satisfies the requirements for valid reassignment. As with the physician’s/NPP’s personal professional services, the patient’s financial liability for the incident to services or supplies is to the physician/NPP 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/NPP or legal entity billing for the services or supplies.

F. Direct Supervision in an Office or Physician/NPP Owned and Operated Clinic

Coverage of services and supplies incident to the professional services of a physician/NPP in private practice is limited to situations in which there is direct

physician/*NPP* supervision of auxiliary personnel. *See section 60.4 for an exception to direct supervision for certain services to homebound patients in underserved areas.*

Direct supervision in the office *or physician/NPP owned and operated clinic setting has the same meaning as it does for diagnostic tests (see 42 CFR 410.32(3)). Direct supervision means* the physician/*NPP* must be present in the office suite and immediately available and able to provide assistance and direction throughout the time the *service is performed*. Direct supervision does not mean that the physician/*NPP* must be present in the same room with *the employee providing the service, if the supervisor is in the office suite. In cases where the definition of “office suite” is questionable, contact the Medicare contractor concerning acceptable locations for the supervisor.*

The physician/NPP who had the responsibility for supervising the major part of the service shall be identified as supervisor. The major part of the service may be identified either by the complexity of the service supervised or the time required for the service supervised, whichever the contractor determines is most appropriate for the service provided.

*If the physician/NPP who authorized the service also supervises that service, that physician/NPP is considered the person responsible for the appropriate rendering of the service. In cases where the authorizing physician/NPP is not in the office at the time the service is furnished, another **member of the same group** shall supervise and be responsible for the appropriate rendering of the service.*

*A member of the group is one whose services are billed **under the same group PIN/NPI** (or legacy number if still allowable), and who has filled out an 855R reassigning his/her benefits to the group.*

G. Auxiliary Personnel and Employee Relationship

Auxiliary personnel means any individual *employee or contractor* who is acting under the supervision of a physician/*NPP*, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician/*NPP*, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician/*NPP* may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies. *However, the supervisor must have sufficient authority to ensure that necessary corrective actions will be taken by the employer of the supervised employee to assure the services and supplies are furnished appropriately.*

Qualifications of Staff. The individual must have sufficient training or qualifications to provide the service so that the contractor may ascertain that the coverage requirements of Pub. 100-08, Medicare Program Integrity Manual, chapter 13, section 13.5.1 have been met, including: “. . . safe and effective. . . furnished in accordance with accepted standards of medical practice. . . furnished by qualified personnel. . .” For some services, such as physical therapy services, the qualifications of staff who perform the

services are defined by statute and regulation and are in this chapter, section 230. Where there is a question concerning the qualifications of a member of the staff to perform a service in any setting, the Medicare contractor who pays the claim shall determine the appropriate qualifications that best serve the beneficiary.

When all other requirements for services incident to have been met, the qualifications of the person performing the service are highly relevant. For example, if the service provided requires the skills of a nurse practitioner and that service is provided by a person with an MD degree who does not have a license to practice medicine in the state, that person does not have the scope of practice equivalent to a nurse practitioner regardless of any skills the person possesses. The incident to benefit may not be used to circumvent the policies of other Medicare benefits.

The billing of one physician for the services of another physician, may be appropriate only when all the requirements for incident to services are met. For example:

- There must be an initial covered service by an enrolled physician/NPP; the services of a physician may not be billed incident to unless the initial service and authorization for subsequent services have been completed.*
- The subsequent service must be incidental and integral to the initial service. It may not represent a service that should be performed and billed as a physician service since this service is delivered by a person who is not working as an independent practitioner, subject to the policies that apply. There is no policy against a physician using the services of another qualified physician as they would use an aide to provide a service that does not require the skills of a physician.*
- The service must represent a cost to the billing entity. Although the amount paid the physician performing the service incident to another's service is not relevant, there must be a cost to the billing entity for the services; it may not be provided free for training or other purposes and may not be provided in the context of a voluntary position.*
- The physician performing the service must be supervised in the office suite, the same as any aide would be supervised; and*
- The performing physician must be qualified to provide the furnished service.*

There may statutory, regulatory, state or local policies that make it inappropriate for physicians to bill incident to other physicians' services, e.g., policies outside the incident to benefit, also legal, financial or ethical reasons.

H. Services Outside the Office or Physician/NPP owned and Operated Clinic Setting

Under some circumstances, auxiliary personnel employed in an office or by a physician/NPP owned and operated clinic may perform services outside the office or physician/NPP owned and operated clinic setting. Examples include in a patient's home

or in a *facility where the practice is allowed* (other than hospital). The services are covered incident to a physician's/NPP's service only if there is direct supervision by the physician/NPP who provided the initial service, or a member of the same group. *Services referred by a physician/NPP are not incident to a physicians/NPP's services if they are provided outside the office or clinic without the presence of a supervisor from the same office or clinic where the initial service was furnished.*

If the service is provided outside of the office, or there is only one room in the office, the supervisor shall be in the room where the service is being rendered. Although the policy requires direct supervision in the office suite, when there is no suite of rooms, the supervisor must be in the same room to meet the requirement, which is then equivalent to personal supervision.

For example, if a *registered nurse or licensed practical or vocational nurse* accompanied the physician/NPP on house calls and administered an injection, the nurse's services are covered *if all the other rules for an incident to service are met*. If the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician/NPP) since the physician/NPP is not providing direct supervision.

Services provided by auxiliary personnel in *a facility* (e.g., nursing, or convalescent home) *demonstrate the importance of* determining whether direct physician/NPP supervision exists. The availability of the physician/NPP by telephone and the presence of the physician/NPP *elsewhere* in the facility does not constitute direct supervision. (See [Pub. 100-03, chapter 1](#), Medicare National Coverage Determinations Manual §70.3 for instructions used if a physician/NPP maintains an office in an institution.)

The policies in this section refer to services provided in or by employees of an office or clinic. For hospital *inpatients* 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/NPP's 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 *contractor*. (See §80 concerning physician/NPP supervision of technicians performing diagnostic x-ray procedures in a physician's office.)

I. Definition of Participants for Claims

The following instructions apply only to claims that are being billed to contractors for services and supplies incident to the services of a physician/NPP in an office setting. They do not apply to services or supplies incident to the services of a physician/NPP that are billed by facilities (hospitals), because in facilities, payment for services and supplies incident to the services of a physician/NPP are part of the payments to those facilities.

Follow the implementation guide instructions for completion of the ordering and supervising loops in the HIPAA version of the X12 837-P electronic claim. For this purpose, the "ordering" physician is the same as the authorizing physician. Chapter 24

of Pub. 100-04, Medicare Claims Processing Manual, contains further information on use of the X12 837-P format including how to obtain a copy of that implementation guide and how to obtain a copy of the Medicare Companion Guide to that implementation guide. Those physicians still permitted to submit paper claims (see the Administrative Simplification Compliance Act requirement in sections 90-90.6 of chapter 24 concerning the requirement that claims be sent to Medicare electronically) should consult chapter 26 of Pub. 100-04 for information on entry of this information in a Form CMS-1500 paper claim.

Individual Providers in Solo Practice: When the physician/NPP who provided the initial service is an individual provider (not in a group), and incident to services are subsequently provided by auxiliary personnel, the solo physician/NPP shall both authorize and supervise the incident to service.

Group Practice, Ordering: The physician/NPP who performed the initial service and authorized an incidental service is the “ordering” physician/NPP regardless of whether or not that same person also supervised the service. (See also section 60.3)

Group Practice, Supervising: The physician/NPP who directly supervises the service is responsible for the appropriate rendering of the service. A physician/NPP who is a member of a group may authorize the incidental service and also supervise that service. In cases where the authorizing physician/NPP is not in the office at the time the service is furnished, another member of the same group shall be the supervising physician/NPP. The supervising physician/NPP shall be identified in the records and on the claim as the supervisor. Only one supervisor may be submitted per claim, although there may be multiple auxiliary personnel who are supervised by the same supervisor. If one supervisor leaves and is replaced by another before the end of the service, identify on the claim the one who supervised the major part of the service. Identify the major part either by time or complexity, according to contractor instruction. The supervisor must be in the office suite at the time of the service. (See also section 60.3)

For services provided prior to May 23, 2008, the NPI, if available, and the UPIN of the physician/NPP in the group who is responsible for supervising the service furnished incident to the initial service of another physician/NPP (i.e., the supervisor) should be reported on the claim. Effective on May 23, 2008 and later, the NPI alone of the supervising physician/NPP must be reported. This assures that the person responsible for supervising the service is qualified to render a Medicare service. The claim shall be priced at a rate appropriate to the physician/NPP who is supervising the service.

Furnishing the Service in Individual or Group Practice: Certain personnel who have NPIs and/or PINs (prior to May 23, 2008) i.e., NPP, physical and occupational therapists, may furnish services incident to a physician/NPP. Also, auxiliary personnel who have no NPI or UPIN may render a service incident to a physician.

Contractors analyze data to determine if services are billed more frequently than is logical. For example, claims are often reviewed if data shows a single physician/NPP

billing for an unusual number of services in the same day. Suppliers may voluntarily utilize a taxonomy code on the electronic claim to identify the rendering auxiliary personnel. This voluntary identification of the rendering personnel allows the contractor to determine, without medical review, that billing for services is not excessive, because more than one person is rendering the services billed by the physician/NPP in the same day. If the auxiliary personnel is not identified on the claim, data analysis may indicate excessive services billed by one physician, requiring medical review to verify appropriate billing.

J. Documentation

The 1995 and 1997 Evaluation and Management (E/M) Documentation Guidelines apply to all E/M services including those performed incident to. The hyperlink: http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Documentation requirements apply to all settings to which the incident to policies apply e.g., office and physician/NPP owned and operated clinics. Policies are consistent with appropriate documentation for all Medicare covered services. Payment requires that the services are documented in the patient's record. Documentation shall verify that the information on the claim is accurate and justify that the service was appropriately rendered as a covered service incident to the services of a physician/NPP. The identity of the people who authorized, supervised and rendered the service shall be identifiable in the medical record and/or in policies and records of the place where services are performed. Documentation shall be available for medical review and shall indicate:

- Reference to the initial problem and service to which the subsequent service is incidental. The initial problem and initial service does not need to be indicated on every note related to every subsequent service, but the medical record must clearly indicate that there was an initial service to which the subsequently provided and billed services are integral and incidental.*
- Integral but incidental service. The subsequent service must be integral (i.e., both essential and connected) to the initial service and incidental as described above.*
- Authorization. A physician's/NPP's authorization for incident to services shall be recognizable in the medical record.*
 - o Authorization may be in any form, e.g., verbal, written, or electronically transmitted. The authorization may be part of other medical record documents or may be a separate document. The authorization does not have to be recorded as a formal order, but may be part of evaluation and treatment notes or plans of care. The provision of a service by a physician/NPP for a particular problem or condition does not qualify as an initial service to which every subsequent service to that patient for that problem or condition is necessarily incidental. There shall be an order, plan, or other identifiable authorization for the subsequent service.*

- *The authorization for a subsequent service may be written by the physician/NPP who provided the initial service. Alternatively, the authorization may be written by the supervisor in the office on the day that the patient presents for a service that was unanticipated but is still incidental and integral to the initial service.*

- *Identification of the physician/NPP who is overseeing the care of the patient. The physician/NPP in an office setting who provides the initial service must be a member of the same group in which the subsequent incident to services are provided.*

- *Indication of active involvement of a physician/NPP in the treatment, as evidence of their patient care oversight. The frequency of this involvement shall be determined by the contractor, based on the condition of the patient and complexity of the case. Such evidence may be e.g., notes, correspondence, phone contact reports, team meeting reports, or reports of visits to the physician/NPP. For example, physician/NPP oversight may be evidenced by physician/NPP visits, or a report sent to the referring physician/NPP during treatment at a frequency determined by the Medicare contractor to be consistent with the severity and complexity of the patient's condition.*

- *Each time a service is provided, a note in the medical record shall verify the service provided (consistent with the service billed) and the identity of the person(s) who provided the service, including any professional credentials (e.g., Barbara Drew, R.N.)*

- *Guidelines in Pub. 100-08, Program Integrity Manual chapter3, section 3.4.1.1 for documenting signatures have been followed.*

- *Evidence that the supervisor was present and available (e.g., on the physician/NPP owned and operated clinic roster throughout the time the service is delivered) in both office and physician/NPP owned and operated clinic settings.*

- *The services are reasonable and necessary.*

K. Reasonable and Necessary Incident to Services

To be covered and payable services, incident to services must conform to the policies for reasonable and necessary services. For example, services must be safe, effective, furnished in accordance with accepted standards of medical practice, furnished by qualified personnel, and at least as beneficial as an available alternative (such as the provision of the service by a physician). See also Pub. 100-08, Medicare Program Integrity Manual, chapter 13, section 13.5.1. Therapy services provided incident to a physician/NPP's service must be provided according to the policies in this chapter including sections 220 and 230.

60.2 - Services of Nonphysician Personnel Furnished Incident To Physician's Services

(Rev.87, Issued: 05-02-08, Effective: 06-02-08, Implementation: 06-02-08)

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 (as discussed in §60.1), a physician may also have the services of certain *qualified* nonphysician practitioners covered as services incident to a physician's professional services. These nonphysician practitioners, who are licensed by the States under various *certification* programs to assist *and in some cases furnish* "physician" *services* include certified nurse midwives, clinical psychologists, physician assistants, nurse practitioners, and clinical nurse specialists. (See §§150 through 200 for coverage instructions for *the* allied health/nonphysician practitioners' services *to whom this applies*.)

Services performed by these nonphysician 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.

A *qualified* nonphysician 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 (see §§190 or 200, respectively) to perform the procedure without physician supervision and have the service separately covered and paid for by Medicare 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 *meet all the requirements for an incident to service specified in §§60 through 60.3*. *For example*, they must be performed under the direct supervision of the physician as an integral part of the physician's personal in-office service *with* subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment.

Note also that a physician might render a physician's service that can be covered even though another service furnished by a nonphysician 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 nonphysician practitioner performs a noncovered service such as acupuncture.

60.3 - Incident To Physician's/NPP's Services in Physician/NPP Owned and Operated Clinics

(Rev.87, Issued: 05-02-08, Effective: 06-02-08, Implementation: 06-02-08)

Services and supplies incident to a physician's/NPP's service in a physician/NPP owned and operated clinic or group are generally the same as those described above for the office setting.

A physician/NPP owned and operated clinic is one where:

1. A physician (or a number of physician's) 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; and
3. The nonphysician services are under medical supervision.

In highly organized *physician/NPP owned and operated* clinics, particularly those that are departmentalized, direct physician supervision may be the responsibility of *one of* several physicians/NPPs. The physician/NPP authorizing a particular service need not be the *same* physician/NPP who is supervising the service. Services performed *according to the incident to policies* by auxiliary personnel are covered even though they are performed in a *different* department of the *physician/NPP owned and operated* clinic *from the supervisor, as long as the contractor determines the situation is consistent with the policy that the supervisor shall be present in the physician/NPP owned and operated clinic and immediately available and able to provide assistance and direction throughout the service.*

The requirement for direct supervision in the physician/NPP owned and operated clinic is not satisfied unless there is a specific physician/NPP responsible for the supervision of the billed service. The physician/NPP owned and operated clinic may meet this requirement by assigning one supervisor for the day or by assigning individual supervisors for specific services. In the case where a long service requires more than one supervisor, the physician/NPP who had the responsibility for supervising the major part of the service shall be identified on the claim. The major part of the service may be identified either by the complexity of the service supervised or the time required for the service supervised, whichever the contractor determines is most appropriate for the service provided. The supervisor is responsible for the appropriate rendering of the service. This information shall be entered on the electronic claim as instructed in section 60.1.

Supplies *that meet the incident to requirements* provided by the *physician/NPP owned and operated* clinic during the course of treatment are also covered.