

## Incident to Services Policy, Professional

### **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 Medicare Advantage 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 Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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 Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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*\*\* For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.*

### **Application**

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

### **Policy**

#### **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.”

As a condition for United Healthcare Medicare Advantage payment all “incident to” services and supplies must be furnished in accordance with applicable state law and the individual furnishing “incident to” services must meet any applicable state requirements to provide such services.

In some cases the physician or practitioner supervising the service may not be the same individual treating the patient more broadly; in these cases only the supervising physician or practitioner may bill for the “incident to” services. It is required that auxiliary personnel providing “incident to” services have not been excluded from Medicare, Medicaid, or other Federal health care programs or have had their enrollment revoked for any reason at the time they provide such services or supplies.

### 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 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 United Healthcare Medicare Advantage 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 UHC 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 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 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 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 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 United Healthcare Medicare Advantage 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 United Healthcare Medicare Advantage**

Pharmacies, suppliers and providers may not bill United Healthcare Medicare Advantage 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 United Healthcare Medicare Advantage for drugs furnished to a physician for administration to a United Healthcare Medicare Advantage beneficiary. When these drugs are administered in the physician's office to a beneficiary, the only way these drugs can be billed to United Healthcare Medicare Advantage 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 United Healthcare Medicare Advantage under the "incident to" provision.

### Definitions

<b>Established Patient</b>	An established patient is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous three years.
<b>New Patient</b>	A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.
<b>Same Specialty Physician or Other Qualified Health Care Professional</b>	Physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.

### Resources

[www.cms.gov](http://www.cms.gov)

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

### History

3/1/2019	Annual Anniversary Date and Version Change <ul style="list-style-type: none"> <li>Application section verbiage updated and removed references to other policies</li> <li>Title section: Removed Annual Approval information &amp; moved policy # to the header</li> <li>History Section: Entries prior to 1/1/2017 archived</li> </ul>
8/31/2018	Added the word "Professional" to the policy title (no new version)
3/14/2018	Annual Review (new version) Archived through 11/18/2015
3/8/2017	Policy Approval Date Change (no new version)
10/10/2012	Policy Created