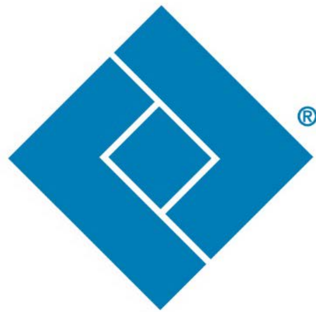
Reimbursement Opportunities for WOC Nursing Services: Medicare Part B "Incident To" Services Policy: A Fact Sheet



The Wound, Ostomy and Continence Nurses Society™ suggests the following format for bibliographic citations:

Wound, Ostomy and Continence Nurses Society. (2018). *Reimbursement Opportunities for WOC Nursing Services: Medicare Part B "Incident To" Services Policy: A Fact Sheet*. Mt. Laurel, NJ: Author.

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Reimbursement Task Force, "Incident to" Work Group, of the WOCN National Public Policy Committee, September 12, 2011.

<u>Updated/Revised:</u>
WOCN Society's Public Policy and Advocacy SWOT Team. The WOCN Society acknowledges Glenda Motta with GM Associates Inc for the creation of this peer-reviewed document, 2018.

<u>Date Approved by the WOCN Board of Directors:</u>
December 18, 2018

Reimbursement Opportunities for WOC Nursing Services:
Medicare Part B "Incident To" Services Policy: A Fact Sheet

Purpose:
To understand the Medicare Part B "incident to" billing as it applies to Wound, Ostomy Continence (WOC) Advance Practice Nurses (APRNs) and other WOC nurses providing care in various clinical settings.

Background:
"Incident to" refers to a Medicare policy that allows *providers* to bill Medicare under their *national provider identifier (NPI)* for certain services rendered by *non-physician practitioners* (NPPs) or *auxiliary personnel.* Services must be furnished under the provider's *direct supervision* as defined by Medicare. *Providers* who may bill Medicare for "incident to" services include: physicians, WOC APRNs (such as nurse practitioners and clinical nurse specialists), certified nurse midwives, physician assistants, clinical psychologists, clinical social workers, and physical and occupational therapists. *Non-physician practitioners* may include: WOC APRNs (such as nurse practitioners and clinical nurse specialists), certified nurse-midwives, physician assistants, audiologists, nurse anesthetists, clinical social workers, physical and occupational therapists, clinical psychologists, and registered dietitian/nutrition professionals. *Auxiliary personnel* are other individuals (such as non-APRN WOC nurses) who: a) act under the supervision of a provider; and b) meet any applicable requirements to provide "incident to" services, including licensure, imposed by the State where services are furnished. In many states the baccalaureate prepared WOC nurse and the graduate non-advanced practice WOC nurse would be considered auxiliary personnel.

Information in this Fact Sheet focuses on "incident to" services that may be billed to Medicare by physicians and WOC APRNs. When "incident to" services are covered, Medicare pays the provider who is billing at the applicable payment rate as if the practitioner furnished the service personally. Payments are subject to the usual beneficiary deductible and coinsurance amounts. Insurance companies known as *Medicare Administrative Contractors* (MACs) process and pay these claims based on the geographic region where services are provided.

Providers may bill Medicare for qualified "incident to" services in two ways:

- **Incident to physician services**: in which the physician bills for the services at 100% of the *Medicare physician fee schedule* (MPFS) even though the *NPP* or *auxiliary personnel* provided the service;
- **Incident to NPP services**: in which the NPP bills for the services at the designated allowed percentage of the *Medicare physician fee schedule* (i.e., the NPP's usual full payment amount) even though the *auxiliary personnel* provided the service. WOC APRNs bill at 85% of the MPFS and are required to accept the Medicare allowable amount as full payment for the service provided.

For care to meet the "incident to" requirements it must be initiated or ordered by a physician or NPP who has assessed the patient, determined the diagnosis, and established a plan of care. The "incident to" provision provides multiple opportunities for a WOC APRN to direct the care of patients with wound, ostomy and continence issues and for WOC nurses who are not APRNs

(such as a baccalaureate WOC nurse) to provide "incident to" care. For example, after the WOC APRN or a physician initially evaluates the patient and develops a plan of care, the non-APRN *(auxiliary personnel)* providing ongoing care as "incident to" can be billed at the APRN payment rate (85% of the MPFS) or physician payment rate (100%) if the service meets all Medicare requirements.

Billing Incident to Physician Services

When *NPP* and *auxiliary personnel* services qualify as "incident to" physician services, the physician bills Medicare at 100% of the fee schedule payment. In this case services must be provided by an employee of a physician under the physician's *direct supervision*. The physician must be a) in the *office suite* or *on the facility premises* while the service is being provided; and b) immediately available to provide assistance and direction. The physician must also provide direct, personal professional services to initiate the treatment course and furnish subsequent services at a frequency consistent with active treatment management. A new patient initial visit or subsequent visits that present a new problem may **not** be performed by auxiliary personnel and billed as "incident to". In these cases, the physician must personally examine the patient to bill Medicare for services at the physician rate (100%); otherwise, if an NPP performs these services, Medicare must be billed at the non-physician practitioner rate (e.g., 85% if provided by a WOC APRN).

An example of a qualifying "incident to" billing under the physician is as follows:

A patient is evaluated and diagnosed by a physician who prescribes interventions for venous ulcer management, including wound management and compression. In this case, the prescribing physician must provide a written plan of care that includes the wound care and application of compression wraps by a WOC nurse with knowledge and expertise in these areas. The appropriate direct supervision must be provided and the physician readily available to provide assistance if needed, such as treatment for a wound infection.

Medicare "Incident to" Services Guidelines for WOC APRNs

WOC APRN nurses with a *national provider identifier (NPI)* may bill Medicare for qualified "incident to" services provided by *auxiliary personnel*. The same "incident to" guidelines that apply to physician services must be met. An initial office visit or subsequent visits that present a new problem may **not** be performed by auxiliary personnel and billed as "incident to". The WOC APRN responsible for the patient's care must conduct the history and physical, the examination portion of the service, and devise the treatment plan. Evaluation and management services for initial office visits or visits that present a new problem billed as "incident to" will be denied or down coded.

Medicare requirements that must be met to bill for "incident to" services are as follows[1]:

- Services must be an integral, although incidental, part of the WOC APRNs professional service;
- They must be commonly rendered without charge or included in the WOC APRN's bill;
- They must be of the type that are commonly furnished in the office or a clinic;
- They must be furnished under the "*direct supervision*" of the WOC APRN; and
- Furnished in accordance with applicable state law.

"*Direct supervision*" does not mean that the WOC APRN must be present in the same room when *auxiliary personnel* provide "incident to" services. However, the WOC APRN must be present on the premises and *immediately available* to assist and direct the personnel performing the services if needed.[1] it does not require the prescribing provider (in this case the WOC APRN) to see the patient and provide services during each visit. However, the WOC APRN must personally evaluate the patient on a regular basis to assess the patient's response to the prescribed course of treatment and modify the treatment regimen when indicated.

The medical record should include documentation of how Medicare requirements for "incident to" services are met. For example, it should provide a description of how the WOC APRN provided a direct, personal, and professional service that initiated a course of treatment as well as subsequent services to show continuing active participation in and management of the treatment course.[2,3]

An example of qualifying "incident to" billing under a WOC APRN is as follows:
A patient is evaluated by the WOC APRN who prescribes interventions for pressure injury wound management and provides a written plan of care that includes topical wound care. A WOC nurse with knowledge and expertise in wound care and assessment of healing progress may be directed to provide topical wound care, assess treatment progress, and perform a dressing change. The appropriate direct supervision must be provided and the WOC APRN readily available to provide assistance if needed, such as a change in the treatment plan.

Settings where "Incident to" Services may be Payable by Medicare

A. **Office Setting**
   Direct supervision in an office setting does not mean that the physician or WOC APRN must be physically present in the same room as the *auxiliary personnel* performing the service. However, the provider must be present in the *office suite* and *immediately available* to provide assistance and direction throughout the time the auxiliary personnel is performing the service. In the office setting, "incident to" services must be provided by personnel whom: a) the physician or WOC APRN directly supervise; b) are qualified to provide the service; c) and represent a direct financial expense (such as a W-2 or leased employee, or an independent contractor). If the physician or WOC APRN is a solo practitioner, care must be directly supervised; if the provider is part of a group practice, any qualified member of the group may be present in the office to supervise.

B. **Physician Directed Clinic or Group Association**
   In clinics, particularly those that are departmentalized, *direct supervision* may be the responsibility of several clinicians, as opposed to an individual attending practitioner. In this situation, medical management of all services provided in the clinic is assured. The physician or WOC APRN nurse ordering a particular service need not be the practitioner who is supervising the service. Therefore, services performed by *auxiliary personnel* are covered even though they are performed in another department of the clinic. The service would be billed under the *NPI* of the supervising practitioner.

C. **Offices in Institutions**

"Incident to" services may be provided in an office located inside an institution, including a SNF, if the office is confined to a separately identifiable part of the facility. Services cannot extend throughout the entire facility. *Auxiliary personnel* may provide "incident to" service to outpatients, patients who are not in a Medicare covered Part A SNF stay or who are not in the Medicare certified part of a SNF. If these services are provided outside of the office area, they would not qualify as "incident to" unless the physician or WOC APRN is physically present where the service is being provided.

D. Homecare Services

In general, the physician or WOC APRN must be present in the patient's home for a service provided by *auxiliary personnel* to qualify as "incident to." An exception to this direct supervision requirement applies to *homebound patients* **in medically underserved areas where there are no available home health services**.[4] The direct supervision criterion is **not** applicable to *auxiliary personnel* meeting any pertinent State requirements if the patient is homebound and the following criteria are met:

- The service is an integral part of the physician or WOC APRN's service to the patient and is performed by an employee of the practitioner or clinic under "general supervision." General supervision means that the physician or WOC APRN need not be physically present at the patient's residence when the service is performed; however, an "incident to" service must be performed with overall supervision.
- The physician or WOC APRN orders the service and maintains contact with the *auxiliary personnel* in case additional instruction is needed.
- The service is an integral, although incidental, part of the physician or WOC APRN's professional service.
- The service is included in the physician or WOC APRN's bill and an expense has been incurred.
- The service is reasonable and necessary as defined in the Medicare Benefit Policy Manual, chapter 16, "General Exclusions from Coverage."[3]
- The service **is not** covered when it can be furnished on a timely basis by a home health agency in the local area.

Billing for "Incident to" Services

Claims for Medicare "incident to" services are submitted to the Medicare Administrative Contractor (*MAC)* assigned to the geographic region where the service is provided. Some MACs provide an "incident to" self-service tool to help providers understand the requirements, apply the rules to their specific circumstance, and determine if the service is eligible for billing.[5] These types of resources are extremely valuable to help ensure that the provider meets Medicare policy requirements.

Services rendered "incident to" those of a physician or WOC APRN should be billed under that practitioner's *NPI* as the employer. In the case of a physician-directed clinic, the service would be billed under the supervising practitioner's *NPI*. Any services billed "incident to" by a WOC APRN must be billed to Medicare as *assigned services* (meaning the provider accepts Medicare payment as full payment for the service).

The following is an example of an appropriate service that may be billed under Medicare as "incident to":

A WOC APRN sees a patient, develops the plan of care and monitors the patient's status on an ongoing basis. On a subsequent visit, the WOC APRN directs the baccalaureate WOC nurse to remove the dressing ordered, evaluate the healing progress, measure and document wound characteristics and redress the wound per written orders. This service provided by *auxiliary personnel* may be billed under the WOC APRN's *NPI* and if approved is paid at the Medicare allowable rate of 85% of the *Physician Fee Schedule.*

Key Points

Documentation in the patient's medical record should support the medical necessity for the "incident to" service and demonstrate that all Medicare policy requirements are met, including: 1) continued involvement by the physician or WOC APRN who initiated the plan of care; 2) the relationship of the "incident to" service to the plan of care; 3) provision of direct supervision; 4) care rendered by the *auxiliary personnel*, date of service, and signature with credentials (for example, licensure and certification).

When billing for "incident to" services, it is essential to follow Medicare guidelines and review the policies of the geographically designated *Medicare Administrative Contractor (MAC)*. Practitioners who do not follow these rules may be prosecuted for billing fraud. Providers should not assume that Medicare policy applies to other insurers, such as Medicaid and commercial payers. Each payer's rules may vary and it is the responsibility of the WOC APRN to be knowledgeable about each insurer's policies and bill accordingly.

Summary

"Incident to" services may be billed to Medicare if the provision meets all policy requirements. Direct supervision is the responsibility of the physician, WOC APRN or other appropriate provider. Documentation in the patient's medical record should support the medical necessity for the service, how the supervising provider is involved in patient care, and information on who performed the "incident to" service. Claims that do not meet Medicare policy requirements are potentially false claims punishable by the Department of Justice and the Office of the Inspector General. Lastly, WOC APRNs who bill or intend to bill Medicare for "incident to" services should review policy manuals, MAC bulletins, and other reliable sources on a regular basis.

Glossary

Assigned services: Services billed to Medicare for which the provider agrees to accept the amount allowed by Medicare as full payment.

Auxiliary Personnel: Any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner), has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked, and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished.

Direct Supervision: The requirement that the WOC APRN or other appropriate provider is present in the *office suite* and immediately available to provide assistance and direction throughout the time *auxiliary personnel* perform an "incident to" service. It does **not** require physical presence in the same room.

Homebound Patient: An individual confined to the home whose condition does not normally permit leaving home without a considerable and taxing effort. Medicare considers beneficiaries to be homebound who: 1) cannot leave a place of residence except with the use of special transportation; 2) require the assistance of another person to leave home; or 3) who have a condition such that leaving home would further endanger their health.

Immediately Available: Defined by CMS as "without delay"; the supervising WOC APRN or other appropriate provider must be readily available and without delay, if necessary, to assist and take over "incident to" care being provided by *auxiliary personnel*.

Medicare Administrative Contractors (MACs): Private insurance companies that have been awarded a geographic jurisdiction to process Medicare claims for fee-for-service beneficiaries.

Medicare Physician Fee Schedule (MPFS): Allowable rates for services provided to Medicare beneficiaries by physician and non-physician practitioners. WOC APRNs that bill Medicare under their own *NPI* are allowed 85% of the physician fee schedule and must accept assignment; i.e., agree that the allowed Medicare amount is full payment.

National Provider Identifier (NPI): A unique ten-digit identifier assigned by the National Plan and Provider Enumeration System to qualified physician and non-physician practitioners who bill Medicare and all other insurers for services.

Non-physician Practitioner (NPP): A health care provider who meets State licensing obligations to provide medical services. For Medicare purposes, the term includes: nurse practitioner, clinical nurse specialist, certified nurse-midwife, physician assistant, audiologist, nurse anesthetist, clinical social worker, physical and occupational therapist,

clinical psychologist, and registered dietitian/nutrition professional. The scope of practice, licensure, and credentialing requirements for each practitioner are established by State law.

Office Suite: A dedicated area designated by records of ownership, rent or other agreement with the owner in which the supervising provider maintains a practice or provides services as part of a multi-specialty clinic.

Providers: Qualified healthcare personnel eligible to bill Medicare for services rendered to beneficiaries.

References/Resources

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