

MEDICARE

“Incident To”

Documentation and Billing of Mental Health Services

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BACKGROUND

The concept of “incident to” billing, used under Medicare Part B and sometimes adopted by private commercial third-party payers, is complicated to understand and challenging to implement for behavioral health organizations given the diversity of practitioners rendering services. For behavioral health providers, “incident to” is an attractive option because it increases patient access to services since practitioners without a Medicare billing number, or who are not recognized by Medicare, but also not excluded, can provide care and bill under the supervising physician. The organization is then reimbursed at 100% of the physician fee schedule, as long as the guidelines are followed.

Having auxiliary staff render services and the ability to bill them as if they were rendered by the physician is a privilege granted by Medicare that requires a thorough understanding of the “incident to” rules. This “incident to” fact sheet seeks to clarify the scope and limitations of “incident to” under Medicare as it pertains to mental health services. The intent is to assist providers and organizations avoid compliance pitfalls in the execution of “incident to” billing through a greater understanding of the following:

1

Definition of “Incident To”

2

Who May Render Services “Incident To” a Physician

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Key Components – Outpatient Office/Non-institutional Setting

4

Key Components – Institutional Setting/Hospital-based Outpatient Services

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Practical Application

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Compliance Tips



DEFINITION OF “INCIDENT TO”

“**Incident to**” means services or supplies are furnished as an integral, although incidental, part of the physician’s personal **professional services**.¹

The Centers for Medicare and Medicaid Services (CMS) does not provide an explicit definition of “integral, although incidental,” in its extensive description of “incident to” rules.² In brief, services that would normally be part of the treatment of a patient by a physician are rendered by an auxiliary person, functioning under the direct on-premise supervision of a physician. These services are integral to implementing the physician’s established plan of treatment of an injury or illness.



WHO MAY RENDER SERVICES “INCIDENT TO” A PHYSICIAN

Mental health services rendered “incident to” a physician’s professional services are performed by auxiliary personnel such as nurses (RN or LPN) and professional clinicians not recognized by Medicare such as licensed professional counselors (LPCs) and marriage and family therapists (MFTs). Certain non-physician practitioners (NPP) also provide services under “incident to” such as a physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM), licensed clinical psychologist (CP) and licensed clinical social worker (LCSW).

A word of caution; there is Medicare language that appears to support that certain NPPs such as NPs, PAs and CPs can also initiate care and have services rendered and billed under their supervision. Per a Medicare Med Learn Matters Article:



“**Incident to**” services are also relevant to services supervised by certain non-physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives or clinical psychologists. These services are subject to the **same requirements** as physician-supervised services. Remember that ‘incident services’ supervised by non-physician practitioners are reimbursed at **85%** of the **physician fee** schedule. For clarity’s sake, this article will refer to ‘physician’ services as inclusive of non-physician practitioners.³

Be aware that NPPs may be prohibited from delegating performance of their services to auxiliary personnel under their respective state licensure laws. The Social Security Act (SSA) also requires that auxiliary personnel providing services “incident to,” must meet “any applicable requirements to provide ‘incident to’ services, including licensure, imposed by the state in which the services are being furnished.”⁴

Should your organization choose to use an NPP as a supervising practitioner and have services performed by auxiliary personnel and billed under the National Provider Identifier (NPI) of the NPP, further legal consultation is recommended to avoid substantial compliance risk.

¹ CMS. Medicare Benefit Policy Manual. Chapter 15, §60.1.

² CMS. Medicare Benefit Policy Manual. Chapter 15, §60 - 60.4.

³ CMS. MLN Matters SE0441.

⁴ SSA. 42 CFR §410.26



KEY COMPONENTS - OUTPATIENT OFFICE/NON-INSTITUTIONAL SETTING

To appropriately bill and receive 100% of the physician payment under the Medicare Physician Fee Schedule (MPFS) in the outpatient office/non-hospital-based setting for mental health services, the following must occur:

1

The physician, (typically a psychiatrist), must initiate the course of treatment (direct, personal, professional service).⁵

- ✓ Physicians must see all new patients, whether self-referred or sent for consultation. This allows them to establish a plan of care or treatment for each problem identified.
- ✓ The initial visit by the physician may be done via telemedicine, assuming applicable Medicare rules are followed in the delivery of telemedicine. Documentation must reflect that it was a telemedicine visit and involved face-to-face contact with the patient.

2

Because “incident to” is “problem-centric,” if an established patient presents a new problem that results in a change in the plan of treatment, the physician must be involved to initiate the change in care.

- ✓ **EXAMPLE:** The supervising physician on-site must be contacted by the NPP or must see the patient to approve the change(s) for the new problem; this contact is documented by the NPP and/or physician.

Because billing “incident to” requires direct, on-site supervision, contact with the physician in this scenario cannot be done via telemedicine or phone consultation.

- ✓ Medicare is not prescriptive regarding what a “change” in a plan of treatment entails, so it will be important for organizations to establish the type of changes requiring physician involvement; e.g., a NP wants to prescribe a different medication for a patient or a LCSW decides their patient would benefit from eye movement desensitization and reprocessing (EMDR) to help treat a history of trauma.

3

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.⁶

- ✓ Examples to support physician active participation could include:

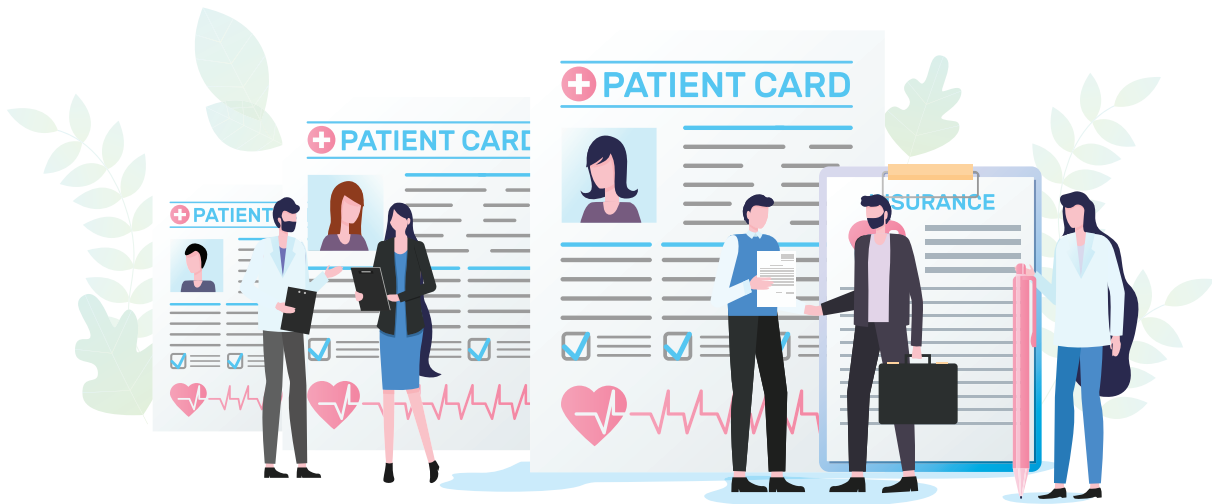
Documentation of face-to-face visits (can include telemedicine) with the physician as needed, notation made by a non-physician clinician that the case was discussed with the physician, and physician review and signature on the individualized plan of care.

4

In the office setting, qualifying “incident to” services must be provided by personnel whom you directly supervise, and who represents a direct financial expense to you (such as a “W-2” or leased employee, or an independent contractor).

⁵ CMS. Medicare Benefit Policy Manual. Chapter 15, §60.2.

⁶ Ibid.



5

Direct physician supervision of the NPP or auxiliary personnel is required.

- ✓ Physician must be present in the office suite (not necessarily in same room).
- ✓ Physician must be immediately available. Per the Centers for Medicare & Medicaid Services (CMS):

“**Immediate availability** requires the immediate physical presence of the supervisory physician. CMS has not specifically defined the word ‘immediate’ in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician is performing **another procedure or service** that he or she **could not interrupt**.⁷”

- ✓ If you are a solo practitioner, you must directly supervise the care. If you are in a group, any physician member of the group may be present in the office to supervise.

6

Effective 2016, the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) who is treating the patient more broadly. However, only the on-site supervising physician (or other practitioner) may bill Medicare for “incident to” services.⁸

Documentation practices that will support the appropriate rendering of “incident to” services are as follows:

- ✓ Evidence of required direct supervision of the services rendered, e.g., statement by therapist on a progress note such as “Therapy rendered today under the supervision of Dr. _____, who was on-site.”
- ✓ Individualized treatment plans that are reviewed per state requirements, signed and dated by a physician.
- ✓ Physician order or physician intent documented for nurse visits and patient injections.
- ✓ When a patient is seen by an NPP or auxiliary personnel and the patient presents with a new problem, the documentation supports that the physician was contacted regarding the new problem and determines the new course of treatment or the patient is seen by the physician prior to initiating a new course of treatment for that problem.

⁷ CMS. Medicare Benefit Policy Manual, Chapter 6, §20.5.2.

⁸ SSA. 42 CFR §410.26



APPLICATION

The following scenarios provide examples of “incident to” use in an outpatient office, non-hospital based, non-institutional setting.

SCENARIO 1: The psychiatrist performs the initial psychiatric evaluation of the patient and develops a plan of care that includes medication management and psychotherapy. Patient is diagnosed with depression and anxiety and prescribed Zoloft 50 mg. daily. The patient is then seen monthly by a NP who makes no adjustments in the medication. A supervising psychiatrist is on-site during each appointment.

Assuming all criteria under “incident to” are met, these visits by the NP can be billed under the name/NPI of the supervising physician.



SCENARIO 2: The psychiatrist performs the initial psychiatric evaluation of the patient and develops a plan of care that includes medication management and psychotherapy. Patient is diagnosed with depression and anxiety and prescribed Zoloft 50 mg. daily. The patient is then seen monthly by a NP. At the third visit, based on the NP’s assessment of worsening symptoms, the NP decides a change to Lexapro should be considered. The NP has a hallway discussion with the supervising psychiatrist who is on-site. The physician makes the decision to change to Lexapro. The NP documents the revised order by the physician.

In this scenario, the NP determines that a change in the initial plan of care is potentially appropriate regarding the medication change. Because the physician made the ultimate decision, this visit and future visits can be billed under the name/NPI of the supervising physician since the plan of care remained the product of the physician’s decision-making.

SCENARIO 3: Patient is seen weekly for psychotherapy by an LCSW. The patient calls requesting an additional appointment which the LCSW can accommodate. When the patient comes for this appointment, there is no supervising psychiatrist on-site.

The visit must be billed under the name/NPI of the LCSW and will be reimbursed at 85% of the physician fee schedule.



SCENARIO 4: Patient is seen for an initial psychiatric evaluation by the psychiatrist. The patient is diagnosed with depression and post-traumatic stress disorder. The initial plan of care includes medication management and psychotherapy.

The patient is seen for weekly psychotherapy by an LPC. During one session, there is no supervising psychiatrist on-site.

This visit is not billable as the LPC is not recognized by Medicare and does not have an NPI.



KEY COMPONENTS - INSTITUTIONAL SETTING/ HOSPITAL-BASED OUTPATIENT SERVICES

Policies for hospital outpatient therapeutic services furnished “incident to” physicians’ services differ in some respects from policies that pertain to “incident to” services furnished in the office and other non-hospital-based outpatient settings.

As noted previously, in the office or non-hospital setting, the supervising physician needs to initiate the treatment plan for each problem that the treating practitioner follows with the patient. Thus, the supervising physician has the first, initial visit with the patient.

In the hospital-based outpatient setting, however (POS 19, 22), CMS does not stipulate that the supervising practitioner must initiate the care of the patient, but states that “hospital outpatient therapeutic services and supplies must be furnished under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations and state law. They must be furnished by hospital personnel under the appropriate supervision of a physician or nonphysician practitioner as required in this manual and by 42 CFR 410.27 and 482.12.”⁹

This statement articulates the key requirements in rendering therapeutic services in a hospital-based outpatient setting:

1

Under the order of a physician, Medicare further stipulates that outpatient psychiatric services must be prescribed and provided under a treatment plan established by the physician:

“**Services** must be prescribed by a physician and provided under an individualized written **plan of treatment** established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated **goals**. (A plan is not required if only a few brief services are furnished.)¹⁰

2

Medicare addresses supervision requirements for psychiatric outpatient hospital services as follows:

“**Services** must be supervised and periodically evaluated by a physician to determine the extent to which **treatment goals** are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records and patient interviews. Physician entries in medical records must support this **involvement**. The physician must also provide **supervision** and **direction** to any therapist involved in the patient’s treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which **treatment goals** are being realized and whether changes in direction or emphasis are needed.”¹¹

⁹ CMS, Medicare Benefit Policy Manual, Chapter 6, §20.5.2.

¹⁰ CMS, Medicare Benefit Policy Manual, Chapter 6, §70.1(1).

¹¹ CMS, Medicare Benefit Policy Manual, Chapter 6, §70.1(2).

3

Furnished by hospital personnel under the supervision of a physician or non-physician practitioner.

- ✓ CP - May supervise services as Medicare will cover services “incident to” their services.¹²
- ✓ NP - May supervise services as Medicare will cover services “incident to” their services.¹³
- ✓ PA - May supervise services as Medicare will cover services “incident to” their services.¹⁴
- ✓ LCSW - CMS recognizes the LCSW as a non-physician practitioner¹⁵ but does not cover services rendered “incident to” their services.¹⁶



4

Level of supervision: Previously, most therapeutic services rendered in the outpatient hospital-based setting required direct supervision. Effective January 1, 2020, CMS changed the generally applicable minimum level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services furnished by all hospitals and Critical Access Hospitals (CAH).¹⁷

- ✓ “General supervision” means that the service is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure.
- ✓ Individual, family and group psychotherapy services as well as administration of intramuscular (IM) injections rendered in an outpatient, hospital-based setting have required general supervision under Medicare since March 2015.

In the outpatient, hospital-based setting, documentation practices by auxiliary staff or clinicians that will support the appropriate rendering of services “incident to” a physician or NPP include:

- ✓ Evidence of general supervision of the services rendered, e.g., statement by therapist on a progress note such as, “Therapy rendered today under the supervision of Dr. _____.”
- ✓ Individualized treatment plans that are reviewed per state requirements, signed and dated by a physician.
- ✓ Physician order or physician intent documented for nurse visits and patient injections.

¹² SSA. 42 CFR §410.71(a)(2).

¹³ SSA. 42 CFR §410.75(d).

¹⁴ SSA. 42 CFR §410.74(b).

¹⁵ SSA. 42 CFR §410.27.

¹⁶ SSA. 42 CFR §410.73.

¹⁷ CMS. 84 FR 61142. X (A). November 12, 2019.



COMPLIANCE TIPS

1

Although “incident to” is a Medicare concept, non-Medicare payers may or may not follow Medicare’s rules for “incident to.” Be sure to contact your Medicaid and third-party payers regarding their rules for billing incident-to services and have their position in writing.

- ✓ Some confusion arises in that many people use the phrase “incident to” to describe billing NPPs or other people qualifying as “auxiliary personnel” under the physician’s billing number for private insurers. Since some private insurers do not give NPPs billing numbers, they instruct the practices/clinics to bill for the NPP services under the physician’s number.

2

Although Medicare may allow the rendering of services in the outpatient hospital setting “incident to” an NPP such as a CP, an NP or PA, state law must allow the practitioner the ability to delegate services.

3

The service being billed for must be within the scope of practice of both the rendering and supervising provider.

- ✓ State scope of practice laws prevail over Medicare provider requirements; if the service is not within the provider’s scope of practice defined by the state, it is not covered by Medicare.
- ✓ It is not permissible for the billing provider to hire and supervise a professional whose scope of practice is outside the provider’s own scope of practice as authorized under state law or whose professional qualifications exceed those of the supervising provider.

EXAMPLE: A CP may not hire an NP and bill for that NP’s medical services under the “incident to” provision, because a medical service by an NP is not integral to a psychologist’s personal professional services, is not regularly included in the CP’s bill, and is outside the CP’s scope of service to provide medical services.

4

Review any local coverage determination (LCD) of your Medicare Administrative Contractor (MAC) that addresses psychiatric services to see how they address “incident to” and who may provide and supervise incident to services.



CONCLUSION

“Incident to” billing allows non-physician practitioners and auxiliary personnel to report services as if they were rendered by a physician. For this reason, it is important that “incident to” rules are followed exactly. Doing so potentially increases patient access to providers and enhances revenue opportunities. Behavioral health organizations will need to weigh these benefits with the compliance risks inherent in the implementation of “incident to.”

To assist you, we have provided a listing of resources related to billing “incident to” and the provision of mental health services under Medicare. For additional information or questions, please contact the National Council for Behavioral Health at Communications@TheNationalCouncil.org.



MEDICARE RESOURCES

1. Medicare Benefit Policy Manual. Chapter 15, §60 – 60.4. This describes Medicare rules for the provision of services rendered “incident to” in office, clinic and hospital-based settings.
2. Medicare Benefit Policy Manual. Chapter 6, §20.5.2. This comprehensively describes coverage of outpatient, hospital based therapeutic services when rendered “incident to” a physician’s service.
3. Medicare Benefit Policy Manual. Chapter 6, §70 -70.3. This section describes coverage, supervision and documentation requirements for hospital based, outpatient psychiatric services.
4. Med Learn Matters. Article Number SE0441. Effective August 23, 2016. This article details rules for “incident to” with additional clarifications.
5. Med Learn Matters. Article Number SE0816. Revised May 22, 2018. This article provides an excellent summary explaining Medicare guidelines for payment of Part B mental health services.
6. Medicare Learning Network; MLN Booklet. Telehealth Services. January 2019. This publication addresses the core Medicare requirements in the delivery of telehealth services.
7. Code of Federal Regulations. 42 CFR 410.26. This section of the Federal Code describes the rules of “incident to” and provides definitions of key terms such as auxiliary personnel, direct and general supervision, practitioner and services and supplies.
8. Code of Federal Regulations. 42 CFR 410.71; 410.73-410.76. These portions of the Federal Code describe Medicare coverage of services to include qualifications rendered by clinical psychologists, clinical social workers, physician assistants, nurse practitioners and clinical nurse specialists. The rendering of services “incident to” a physician is also addressed under each section of the respective practitioner.
9. CMS. CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC), November 1, 2019. This link will go directly to the 2020 final rule. Of interest is Section X. (A) - Proposed Changes in the Level of Supervision of Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals where the change is noted to general supervision for most hospital-based outpatient services. <https://www.federalregister.gov/d/2019-24138/p-97>

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