Incident-To Billing: A Brief Review

Article Highlights

This article provides a brief review of Medicare's incident-to policy (sometimes adopted by other payers), including the following topics:

- Definition of the incident-to policy
- Criteria for incident-to billing
- Other considerations

Definition of the Incident-To Policy

The incident-to policy is included in the Medicare statute to allow billing for supplies that is incidental to a physician's or qualified health care professional's (QHP's) services or occurs in either of the following circumstances, in which services are provided by other clinicians:

1. A service is provided by clinical staff under the direct supervision of a physician or other QHP who bills for the service.
2. A service is provided by a QHP (eg, nurse practitioner, physician associate) who is otherwise qualified to provide and independently report the service but provides it under the direct supervision of a physician who bills for the service.

The first circumstance allows a physician to bill **99211** for evaluation and management services that do not include a physician's or QHP's personal presence at the time of service and for other clinical staff services, such as **94664** (demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered-dose inhaler [MDI] or intermittent positive pressure breathing [IPPB] device) by a nurse or medical assistant.

The second circumstance allows a physician practice to receive the full Medicare Physician Fee Schedule (MPFS) amount for services provided by a QHP. If the same services were provided by the QHP without meeting criteria for incident-to policy (discussed in the following section of this article), the payment would be reduced to 85% of the MPFS amount for the service.

Criteria for Incident-To Billing

To bill for a service based on the incident-to policy, all 7 of the following criteria must be met:

1. **Employment.** The physician's or QHP's practice must have an employment relationship with the individual providing the service. The employment relationship may be direct employment or contractual employment (eg, through a staffing agency).
2. **Place of service.** Incident-to policy applies only in a setting that is reported with place of service code **11** (office) or **10** (telehealth provided in a patient's home).
    a. Incident-to policy is not applicable when a facility or health system owns the practice and employs the clinical staff (eg, POS **19** or **22**, outpatient hospital clinics).
3. **Scope of practice.** The individual providing a service that is billed incident to must be working within the scope of practice that is supported by their training, state regulations, and/or licensure. For example, in some states, a medical assistant cannot provide an invasive procedure such as urinary catheterization.
4. **Incidental or integral service.** Services billed under incident-to policy must be clinically indicated, be a type of service typically provided as part of the physician's or QHP's management of the patient's condition, and be a continuation of the physician's or QHP's plan of care for an established patient.
    a. Services that address new problems or are provided to new patients do not meet the criteria of incident-to policy.
    b. Services that are commonly provided through a physician's or QHP's order but independently provided by a nonphysician qualified health care professional (NQHCP) (eg, **96156**, health behavior assessment or reassessment) are not reported as incident to.
5. **Direct supervision.** The reporting physician or QHP must be immediately available by being physically present in the office suite or virtually present via audio-video telecommunications during the provision of a service. The supervising physician or QHP may be the physician or QHP who ordered a service or another physician or QHP within the same group practice.
6. **Ongoing management.** The ordering physician or QHP must have provided an initial service to establish a plan of care and must personally provide care to the patient on a periodic basis. There is no specific frequency of personally provided services.
7. **Documentation**
    a. The physician's or QHP's documented plan of care for the patient should include services that will be provided incident to (eg, patient return for asthma education by clinical staff, follow-up visit within 2 weeks).
    b. The clinician providing the service must sufficiently document and authenticate a record of it to indicate continuation and/or adjustments to the plan of care and to support billing. The supervising physician or QHP may be required to authenticate/sign off on the clinician's documentation, depending on state regulations, payer policy, or practice policy.

Other Considerations

Individual payer policies and state regulations may influence use of incident-to billing.

...continued on page 10

Did You Know? Documenting Prescription Drug Management

When determining the level of medical decision-making (MDM) of an evaluation and management (E/M) service, a physician's or other qualified health care professional's (QHP's) decision-making concerning prescription drug management is one option for determining the risk element of the MDM (ie, the risk of complications and/or morbidity or mortality associated with patient management).

Risk is one of the following 3 elements of MDM:

- The number and complexity of problems addressed
- The amount and/or complexity of data to be reviewed and analyzed
- The risk of complications and/or morbidity or mortality associated with patient management

Of the elements of risk, 2 to 3 must meet or exceed the same level of MDM (straightforward, low, moderate, or high) to select a code based on the level of MDM. Moderate risk does not support a moderate level of MDM without at least 1 of the other 2 elements meeting or exceeding the moderate level.

Prescription drug management may seem like an easy way to support moderate risk. However, the documentation of the E/M service must support that a decision concerning medication was made at the current visit. The type of decision may be any of the following:

- A decision to prescribe a new medication
- Consideration and a decision to not prescribe a medication (eg, discussion of medication followed by selection of an alternative management option)
- A decision to continue a prescribed medication at the same or a different dose
- A decision to stop use of a medication
- A decision to prescribe off-label use of an over-the-counter medication (eg, prescribed for a child who is younger than any of the ages for which the product is labeled)
- A decision to prescribe use of an over-the-counter medication that poses a moderate risk because of the patient's known health conditions and/or because of potential for interaction with the patient's other medications

Documentation of decisions concerning prescription drug management need not be burdensome, but the decisions should be easily identified in the documentation. Documentation that may not support that a physician made decisions concerning prescription drug management includes the following:

- A checkbox or another indication that a medication list was reviewed
- Notation that a medication refill was approved without documentation of a current assessment of the problem for which the medication was prescribed
- Notation that "Continue medications as directed" was advised without documentation of the context of the indication, medication, and dose

Documentation of prescription drug management discussed with the individual patient and/or parents and the specific problem addressed (eg, alternative and/or complementary management options, potential risks and benefits, and guidance on medication adherence and potential for misuse, as indicated) is the clearest indication of prescription drug management.

Although not required, a distinctly documented assessment and plan for each problem addressed at a visit can link the assessment of a problem to the related plan of care that includes prescription drug management. Some physicians and QHPs also reference pertinent findings from the patient's history, their examination, the data reviewed, and/or the discussion with both patient and parents/caregivers in the assessment and plan to create a brief summary of the visit.

Regardless of where it is documented in the note, support for a decision for prescription drug management should be clearly stated in the context of the problem for which the medication is prescribed.

To learn more about prescription drug management and MDM, refer to *Coding for Pediatrics 2027,* Chapter 6, "Evaluation and Management Documentation Guidelines" (www.aap.org/en/shopaap/shop-by-topic/coding).

Incident-To Billing: A Brief Review*...continued from page 9*

- Medicare policy exempts certain services from the direct-supervision requirement. For example, chronic care management services may be reported by the physician or QHP who provides general supervision of clinical staff performing the required care management activities (ie, is not immediately available at the time of each care management activity).
- Not all payers have adopted Medicare's incident-to policy for billing of QHP services by a supervising physician. In this case, direct billing by the QHP is required, often resulting in payment at the QHP's contracted rate. Payment may be reassigned to a group practice.

...continued on page 11

Incident-To Billing: A Brief Review...continued from page 10

- Payers that allow incident-to billing for QHP services may require use of a modifier to indicate that a service was provided by a QHP but billed by a physician (eg, **99213 SA**).
  - Modifier **SA** (NP rendering service in collaboration with a physician) may be required regardless of the credentials of the QHP who rendered the service.

Dig Deeper

To learn more about incident-to policy, refer to *Coding for Pediatrics 2027,* Chapter 7, "Non-Preventive Evaluation and Management Services in Outpatient Settings" (www.aap.org/en/shopaap/shop-by-topic/coding).

To learn more about the differentiation of physician's and QHP's services from those of an NQHCP, refer to the May 2025 *AAP Pediatric Coding Newsletter* article "Procedure Codes for Nonphysician Qualified Health Care Professional Services" (https://doi.org/10.1542/pcco_book253_document002).

Key Takeaways

As discussed in this article,

- Incident-to policy allows physicians and QHPs to report certain services provided under their direct supervision as if the service were personally provided. However, there are distinct criteria that must be met.
- Billing under incident-to policy may allow a physician practice to receive the full MPFS amount for services provided by a QHP rather than 85% of the MPFS amount.
- Services that address new problems or are provided to new patients do not meet the criteria of incident-to policy.
- Services that are independently provided by an NQHCP through a physician's or QHP's order are not reported as incident to.
- Adoption of incident-to policy by other payers may vary.

Coding Hotline

ICD-10-CM: Dental Problems

Our practice has received denials when reporting services provided to patients who present with symptoms that are found to be caused by or include dental problems (eg, toothache, broken tooth). Can pediatricians report codes from categories K00–K14, or are these codes only for dental health care professionals?

Yes, pediatricians should report codes from categories **K00–K14** when the problem is evaluated at the visit and the documented diagnosis at the time of the visit is described by a code from categories **K00–K14** (eg, **K08.89**, other specified disorders of teeth and supporting structures [toothache]). However, be sure to report injury codes (eg, **S03.2XXA**, dislocation of tooth, initial encounter) in lieu of codes **K00–K14**, when applicable. Additionally, external cause codes may be reported to describe the cause of an injury (eg, **W01.10XA**, fall on same level from slipping, tripping and stumbling with subsequent striking against unspecified object, initial encounter), place where the injury occurred (eg, **Y92.031**, bathroom in apartment as the place of occurrence of the external cause), and activity during which the injury occurred (**Y93.E1**, activity, personal bathing and showering).

Note that, because dental services are usually covered under a patient's separate dental benefit plan, claims adjudication systems may automatically deny claims that include a code for a dental problem (eg, any code from categories **K00–K14**). When electronic claim attachments are an option, it may be helpful to submit documentation along with the claim for services to avoid denial. When a claim for services to diagnose or manage a dental problem is denied, pediatric practices should appeal the denial by including medical records supporting the clinical indication(s) for the medical service as well as the reported level of service.

It is important to follow the individual payer's processes for submission of records and/or appeals (eg, within a specified period after the date of denial). Currently, a payer may accept standard electronic claim attachments (Version 6020 of the X12N 275, Additional Information to Support a Health Care Claim or Encounter—006020X314) or may require submission via the payer's provider portal. The US Department of Health and Human Services has set an implementation date for use of the X12N 275 transaction standard by all physicians, other health care professionals, and payers with compliance required by May 26, 2028. See the Administrative Simplification; Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures Final Rule CMS-0053-F fact sheet (www.cms.gov/newsroom/fact-sheets/administrative-simplification-adoption-standards-health-care-claims-attachments-transactions) to learn more about implementation of the X12N 275 standard.

Got a coding question? Submit it to the experts at the AAP Coding Hotline at **www.aap.org/en/practice-management/child-health-finance-payment-strategy/coding-payment-hotline.**