Clover

Clover Health Incident To Services Reimbursement Policy Policy # RP-038

Policy Title	Incident To Services Reimbursement Policy
Policy Department	Payment Strategy & Optimization
Effective Date	10/1/2022
Revision Date(s)	
Next Review Date	

Disclaimer:

Clover Health applies The Center for Medicare and Medicaid Services (CMS) criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

This policy clarifies the coverage of services considered to be “Incident to Services”. These services must occur as incident to other procedures performed or directed by a physician. An Incident to service cannot be billed as a stand alone procedure.

Definitions:

- Incident To Services
  - “Incident to” services are defined as those services that are furnished incident to physician professional services in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home. These services are billed as Part B services and are paid under the physician fee schedule.

Policy:

This policy seeks to clarify “incident to” services billed by both physicians and non-physicians. “Incident to” services are defined as those services that are furnished as incident to physician professional services in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home. These services are paid under the physician fee schedule using the Medicare Part B fee schedule.

Any 'incident services' supervised by non-physician practitioners are reimbursed at 85% of the Medicare Physician Fee Schedule (MPFS).

Services of the practice employee are covered when:

1. The services are rendered under the direct supervision of the physician, CP, NP CNM, CNS, or in the case of a physician directed clinic, the Physician Assistant (PA).
2. The services are furnished as an integral, although incidental, part of the physician's, CP's, NP's, CNM's or CNS's professional services in the course of the diagnosis or treatment of an injury or illness.
3. Billing 'incident to' the physician, the physician must initiate treatment and see the patient at a frequency that reflects his/her active involvement in the patient's case. This includes both new patients and established patients being seen for new problems. The claims are then billed under the physician's NPI.
4. Billing 'incident to' the CP, NP, CNM, CNS or PA, the nonphysician practitioners may initiate treatment and see the patient at a frequency that reflects his/her active involvement in the patient's case. The claims are then billed under the non physician practitioner's NPI.

To qualify as “incident to,” services must be part of the member’s normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. The physician does not have to be physically present in the treatment room while these services are provided, but the physician must provide direct supervision (must be present in the office suite to render assistance).

The member record should document the essential requirements for incident to service. More specifically, these services must be all of the following:
• An integral part of the member’s treatment course;
• Commonly rendered without charge

• Of a type commonly furnished in a physician's office or clinic (not in an institutional setting);
• An expense to the provider

Examples of qualifying "incident to" services include cardiac rehabilitation, providing non-self administrable drugs and other biologicals, and supplies usually furnished by the physician in the course of performing his/her services (for example, gauze, ointments, bandages, and oxygen). The processes for billing vary somewhat depending on the place of service.

Office Setting
In the physician office, qualifying "incident to" services must be provided by a caregiver whom the physician directly supervises, and who represents a direct financial expense to the physician (such as a "W-2" or leased employee, or an independent contractor). The physician does not have to be physically present in the treatment room while the service is being provided, but must be present in the immediate office suite to render assistance if needed. If the physician is a solo practitioner, they must directly supervise the care. If the physician is in a group, any physician member of the group may be present in the office to supervise.

Institutional Settings
In institutions including SNF, the physician office must be confined to a separately identifiable part of the facility and cannot be construed to extend throughout the entire facility. Physician office staff may provide service incident to the physician service in the office to outpatients, to members who are not in a Medicare covered stay or in a Medicare certified part of a SNF. If your employee (or contractor) provides services outside of your "office" area, these services would not qualify as "incident to" unless the physician is physically present where the service is being provided. One exception is that certain chemotherapy "incident to" services are excluded from the bundled SNF payments and may be separately billable to the carrier.

References
CMS MedLearn Matters SE0441