Incident To (Billing for Mid-level Providers)

To bill “Incident To” in which the Mid-level Provider (MLP) provides the service, but the claim is filed under the physician’s Medicare number:

1. The services must be part of the patient’s normal course of treatment.

2. The physician MUST have personally performed the initial service and remain actively involved in the course of treatment (Medicare does not define what “actively involved” means).

3. The physician must provide direct supervision (must be in the office suite and immediately available to render assistance). If there are no physicians in the office, then any services performed by the Mid-Level Provider (MLP) must be billed under the MLP’s own Medicare number.

4. In a group practice, the supervising physician does not have to be the patient’s personal physician or the physician that initiated the initial service.

5. If the visit qualifies as “incident to” the record must state who the supervising physician was and the service(s) must be billed under that physician’s Medicare number. The documentation must clearly indicate the supervising physician’s presence in the office suite during the service.

6. If a patient is being seen for a new problem, the MLP cannot bill the service as “incident to.” These visits would have to be billed under the MLP’s Medicare number.

7. New problems must be billed under the MLP’s own Medicare number. If however, a MLP is seeing a patient in follow-up for the physician and a new problem is identified at that time, that visit can be billed “incident to.”
8. In the hospital setting, “incident to” does not apply. Split/shared visits are possible as hospital E&M visits are reported according to the level of work done per day. Only one visit can be reported per DOS for any given provider, but the level of service billed may actually be comprised of the work done by a NPP and a physician from the same group practice done on separate encounters on the same DOS. This would typically be seen in the performance of a subsequent hospital visit. The visits would have to be medically necessary, performed separately, and documented separately. In the performance of an initial hospital visit, if the patient is new to the GROUP practice, the physician would be expected to perform the entire encounter.

9. Unless required by state law, physicians are not mandated to read and/or co-sign a MLP’s history and physical, progress note or other documentation.

10. Incident-to services are reimbursed by Medicare at 100% of the 80% of the allowable, while services billed under a MLP’s Medicare number are reimbursed by Medicare at 85% of the 80% of the allowable. Here’s an example:
   • Your charge is $150.00 for the service provided.
   • The Medicare allowable for that service for your locality is $120.
   • Medicare will pay 80% of the allowable, or $96.00, and the patient will pay 20% of the allowable, or $24.
   • If you filed this under a physician’s Medicare number as “incident-to”, the practice will receive 100% of the 80% of the allowable, or $96.00.
   • If you filed this under a MLP’s Medicare number, the practice will receive 85% of the 80% (85% of $96.00) or $81.60 and the patient’s portion would remain $24.00.
   • You will write off $30 as non-allowable if billing incident-to and you will write-off $44.40 as non-allowable if billing under the MLP’s Medicare
11. Other payers allow MLPs to apply for and bill under their own provider numbers, while some only recognize the physicians and MLPs will bill under those physician numbers. Check with each payer with whom you contract.

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