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The perils and perplexities of CMS's incident-to billing rule

by Roz Cordini, JD, MSN, RN, CHC, CHPC

In 1977, the term "Rural Health Clinic Services" was added to Section 1861 of the Social Security Act, which set out the basis for incident-to billing within the Medicare program. The definition provided:

(aa) (1) The term 'rural health clinic services' means— (A) physicians' services and such services and supplies as are covered under subsection (s) (2) (A) if furnished as an incident to a physician's professional service, (B) such services furnished by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service . . .[1]

The intent was to expand access to care in underserved rural health areas by allowing nurse practitioners (NPs) and physician assistants (PAs) to care for Medicare patients under an established physician plan of care while avoiding financial penalties to physicians due to utilizing these providers. Twenty years later, the Balanced Budget Act of 1997 expanded coverage of NP and PA services to all settings, reimbursing them at 85% of the Medicare Physician Fee Schedule (MPFS). At the same time, the rural health site limitation for incident-to billing was removed, expanding the ability to bill for incident-to services in all locations.[2]

Of course, Medicare established criteria and limitations around what constitutes incident-to billing and the associated billing requirements. 42 C.F.R. § 410.26(b) provides that to bill Medicare Part B for services and supplies incident to the service of a physician (or another qualified practitioner), such services and supplies must be:

- furnished in a noninstitutional setting to noninstitutional patients;
- integral, though incidental, part of the service of a physician (or another practitioner) in the course of diagnosis or treatment of an injury or illness;
- commonly furnished without charge or included in the bill of a physician (or another practitioner);
- of a type that is commonly furnished in the office or clinic of a physician (or another practitioner);
- furnished by the physician, practitioner with an incident to benefit, or auxiliary personnel; and
- furnished in accordance with applicable State law.[3]

In addition, a physician (or other practitioner) may be an employee or an independent contractor.[4]

Although the regulation may seem straightforward, incident-to billing remains confusing to providers who may

have compliance and repayment concerns if they improperly bill these services.

This article does not exhaustively discuss Medicare's incident-to billing criteria or rules. Instead, it attempts to address certain problematic compliance concerns affecting physician practice groups and other healthcare entities billing the Center for Medicare & Medicaid Services (CMS) for services incident-to the physician's service.

'Integral, though incidental,' part of the service of the physician

This qualifying criterion is one of the most important criteria and one that can create compliance concerns when not adhered to. To be "integral, though incidental" means the services must be part of the patient's normal course of treatment, during which the physician performed an initial service and remains actively involved during treatment. These follow-up services rendered must be connected to the course of treatment the physician planned at the initial service.[5] At face value, this seems easy enough. The physician evaluates the patient initially and establishes the plan of care. During a subsequent visit, the nonphysician practitioner (NPP) can perform the service and bill under the physician's National Provider Identifier (NPI), who provided direct supervision on that date of service.

Initial patient visits

First and foremost, it is clear that under Medicare rules, an NPP may not perform the initial visit to a patient and bill the service incident-to. Certainly, they may render the service if they are credentialed under Medicare; however, if so, it is billed under the NPP's NPI, and reimbursement is 85% of the Medicare allowable under the MPFS. This is the clearest rule under Medicare. The physician must perform the initial visit if a practice desires to bill incident-to for Medicare patients. As straightforward as this is, this remains a frequent error identified in practices. Practices should develop a policy and create their scheduling systems to ensure a physician renders the initial patient service.

When this error is made on an initial visit—meaning it is billed under the physician's NPI when rendered by an NPP—this creates subsequent billing errors. Imagine a patient is seen initially by an NPP, and it is billed incident-to. The patient then has multiple subsequent visits and is seen by the NPP for each subsequent visit. Each subsequent visit is billed under the physician's NPI. If this is how these visits are scheduled and billed, one can identify the volume of billing errors created by this over time.

New problem identified during a subsequent visit

Consider the scenario where the physician renders the initial service and establishes a plan of care to be implemented by the NPP during a subsequent visit—so far, on track. During the subsequent visit, where the patient is in for follow-up on, for example, the ear pain addressed during the initial visit, the patient complains of abdominal discomfort. Under the state scope of practice rules, the NPP is authorized to evaluate, diagnose, and treat abdominal pain and, in fact, does so. So, the NPP treats ear pain consistent with the physician's established plan of care and evaluates and treats abdominal pain. How should this be billed? Once the patient complains of a *new problem*, the visit falls outside of an appropriately billed "incident-to" claim, regardless of the NPP's treatment of the ear pain. To bill this visit under the physician's NPI, the NPP must get the physician in the room to evaluate the new problem and create a new plan of care.

What if the NPP evaluates the abdominal pain and establishes a plan of care, and the physician peeks his head in the room, the NPP describes the situation and plan, and the physician verbally states he agrees? Can it now be billed incident-to? The answer is no. The physician must examine the patient and create a plan of care. What if the physician peeks his head in and documents his agreement with the plan of care in the medical record? Does

this change things? No. The visit may still only be billed under the NPP's NPI, as well as any subsequent visits in follow-up to the NPP's new plan of care.

Medication adjustment during a subsequent visit

This is a perplexing issue. How is the issue handled when the patient comes in for a subsequent visit, and the NPP adjusts the dose of a drug the physician prescribes during the initial visit? For example, during the initial visit, the physician diagnoses the patient with high blood pressure and prescribes blood pressure medicine "A." During the subsequent visit rendered by the NPP, the NPP increased the dose of blood pressure medicine "A." Is this a new problem? Certainly not. The problem is high blood pressure; the patient still has high blood pressure. The medication adjustment is well within the NPP's state scope of practice.

Can the visit be billed "incident-to"? Well, it depends. At least one Medicare administrative contractor (MAC) provides the following information: "[T]he need for medication adjustment does not represent a 'new problem.' These visits may be billed by an NPP as incident-to the original plan of care *when the physician includes that instruction in the original plan* (emphasis added)."[6] The previous example is the following: "Have started patient on Losartan 100 mg. po qd for BP 160/90; patient to RTO [return to office] in two weeks for f/u [follow up]. Dosage may be adjusted by NP." How often do you see physicians writing that instruction in their initial plan of care? I can honestly say I never have. However, certainly, in the National Government Services region, providers should understand that its MAC has given this guidance via its frequently asked questions.

Physician ongoing involvement

Just as the physician must perform the initial service, the physician must continue to be actively involved in the patient's care. According to the *Medicare Benefit Policy Manual*, "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."[7] Consider how you may be able to ensure this ongoing participation by the physician and implement a policy within the practice to ensure the physician remains involved.

Direct supervision

A discussion of incident-to billing is incomplete without addressing the direct supervision requirements of incident-to billing. Direct supervision in the office setting means "the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary."[8] It does not mean that the physician (or other supervising practitioner) must be present in the room when the procedure is performed.[9] If physician A is scheduled in the office on a certain day—assuming all other incident-to billing requirements are met—these visits may be billed incident-to. What if the supervising physician runs out to an hour lunch and the NPP continues to see patients during that time? Can they be billed incident-to? Clearly not. The physician is not in the office and is not immediately available to assist if needed. What if the practice has an attached ambulatory surgery center (ASC), and the supervising physician performs services in the ASC? Can the office visits be billed incident-to? The ASC is accessible by walking across the waiting room. Absolutely not. The physician must be in the office suite where services are provided and immediately available to assist. Let's say that under state medical board regulations, a physician may supervise a PA who is providing services across town at a location different from the physician. This is an example of where state medical board regulations regarding the role of supervising a PA must be distinguished from the Medicare billing rules. In this example, the claims of the PA may not be billed incident-to.

COVID–19 threw a wrench on the otherwise (fairly) clear, direct supervision requirements of incident-to billing. During the public health emergency (PHE) for COVID-19, CMS changed the definition of direct supervision to

allow the supervising provider to be immediately available through virtual presence using two-way, real-time audio/video technology instead of requiring the typical physical presence.[10] This definition is in effect through December 31, 2023. It is proposed to continue in the 2024 MPFS proposed rule, CMS citing concern over abruptly changing practice patterns implemented during the PHE.[11]

As noted in the calendar year (CY) 2021 MPFS final rule,[12] direct supervision could be met by the supervising physician (or another practitioner) being *immediately available to engage via audio/video technology* (excluding audio-only) and *would not require real-time presence* or observation of the service via interactive audio/video technology throughout the performance of the procedure (emphasis added). This new interpretation of direct supervision essentially turns the long-standing direct supervision definition on its head. Now, what happens if the physician is in the office but out for lunch? Can those visits now be billed "incident-to" if the physician is "immediately available to engage" via audio/video communications? What about the PA practicing at a different office than their supervising physician? As long as the supervising physician is "immediately available to engage" via audio/visual technology, can these now be billed "incident-to"? The physician does not have to engage during every episode of care, just when needed. Does this new definition change the supervision requirement to general supervision?

On July 26, 2023, the U.S. Department of Justice (DOJ) announced the False Claims Act (FCA) settlement of a Lansing Michigan Health System agreed to pay $671,310 to resolve FCA allegations related to the misuse of incident-to billing. The government alleged that services were rendered by midlevel providers at the health system's locations where the criteria for incident-to billing were not met.[13] The detail is not provided on which criteria were not met; surely it would not be the requirement of direct supervision requiring the physician to be "in the office." They should have only needed to be "immediately available to engage." There have been numerous similar DOJ FCA settlements around the direct supervision requirement, many with dates of service prior to the PHE.[14] And what about the original intent of why direct supervision required the physician to be in the office suite and immediately available to assist in the first place? Was it for patient safety reasons? It is a curious change of approach, and as we look forward to the MPFS final rule, perhaps CMS can provide clarity once and for all.

Conclusion

CMS's incident-to billing rules have been in place for several years and were originally intended to promote access to healthcare by using NPPs in rural areas. Since its expansion beyond rural communities, it remains in frequent use across the country and continues to create compliance concerns and overpayments when done incorrectly. There are several ways to utilize it compliantly within a physician's practice and avoid penalties and repayments:

- Create scheduling processes where new patients are scheduled with the physician.
- Periodically audit new patient compliance by running a new patient report where the NPP was the rendering provider and the billing provider was the physician.
- Train providers and billing staff on incident-to billing rules, particularly for patients with "new problems" during a subsequent visit.
- Create language for use in physician documentation addressing future medication adjustments by the NPP.
- Develop scheduling protocols that schedule the patient with the physician from time to time to demonstrate the physician's ongoing and active participation in the patient's care.

- Ensure the physician providing direct supervision is the billing provider on the claim.
- Ensure a supervising physician is scheduled daily and develop a mechanism to document the supervising physician.
- Keep abreast of CMS's future guidance via the CY 2024 MPFS.

Takeaways

- Medicare's "incident-to" billing rules are complicated and remain a compliance risk to healthcare providers.
- Nonphysician practitioners (NPPs) may not render services to new patients and bill the service under the physician's National Provider Identifier (NPI).
- Patients complaining of new problems during established patient visits must have those new problems evaluated by a physician for that visit to be billed under the physician's NPI.
- Medication adjustments by an NPP may—depending on jurisdiction—require documentation of the parameters for such an adjustment by the physician when the treatment plan is established for medication adjustments to be billed under the physician's NPI.
- Direct supervision is required to bill incident-to. The COVID–19 changes to direct supervision proposed in the calendar year 2024 Medicare Physician Fee Schedule may have significant implications for this definition.

1 Rural Health Clinic Service Act. Pub. L. No. 95–210, 91 Stat. 1485, § 1 (aa)(1)(A)—(B) (1977).
2 Balanced Budget Act. Pub. L. No. 105–33, 111 Stat. 442, §4511(a) (1997).
342 C.F.R. § 410.26(b)(1)-(7).
442 C.F.R. § 410.26(b)(8).
5 Centers for Medicare & Medicaid Services, "Chapter 15 – Covered Medical and Other Health Services," § 60.2, *Medicare Benefit Policy Manual*, Pub. 100-02, revised October 12, 2023, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf.
6 National Government Services, "'Incident to' Office Guidelines," reviewed October 10, 2023, https://www.ngsmedicare.com/web/ngs/incident-to-services?lob=96664&state=97178&rgion=93623&selectedArticleId=817326.
7 Centers for Medicare & Medicaid Services, "Chapter 15," § 60.2, *Medicare Benefit Policy Manual.*
8 Centers for Medicare & Medicaid Services, "Chapter 15," § 60.2, *Medicare Benefit Policy Manual.*
9 Centers for Medicare & Medicaid Services, "Chapter 15," § 60.1(B), *Medicare Benefit Policy Manual.*
10 85 Fed. Reg. 19,245, 19,246.
11 88 Fed. Reg. 52,301.
12 85 Fed. Reg. 84,539.
13 U.S. Department of Justice, U.S. Attorney's Office for the Western District of Michigan, "Lansing-Area Health System Agrees to Pay $671,300 to Settle False Claims Act Allegations Relating to Improper Billing," news release, July 26, 2023, https://www.justice.gov/usao-wdmi/pr/2023_0726_Sparrow.
14 U.S. Department of Justice, U.S. Attorney's Office for the Eastern District of Tennessee, "Family Physician Pays $285,000 to Settle False Claims Act Allegations of Billing Services at Inflated Rate," news release, January 24, 2020, https://www.justice.gov/usao-edtn/pr/family-physician-pays-285000-settle-false-claims-act-allegations-billing-services. "The government alleged that Dr. Chen's practice unlawfully billed government

payors at the physician rate even when services were rendered by unsupervised nurse practitioners." See also, U.S. Department of Justice, U.S. Attorney's Office for the Northern District of New York, "Watertown Medical Practice to Pay $850,000 to Resolve False Claims Act Allegations," news release, August 3, 2022, https://www.justice.gov/usao-ndny/pr/watertown-medical-practice-pay-850000-resolve-false-claims-act-allegations. The practice "submitted or caused to be submitted claims for payment to Medicare that improperly listed a physician as the rendering provider for services rendered by a physician assistant when no physician was physically present in the office and immediately available to furnish assistance and direction throughout the performance of the procedure."