

DANIEL F. SHAY, JD

# USING MEDICARE "INCIDENT-TO" RULES

NONPHYSICIAN PRACTITIONERS CAN EXPAND PRACTICE CAPACITY,  
BUT IT'S VITAL TO FOLLOW THE BILLING RULES.

---

Physicians have for years recognized the value provided by physician assistants (PAs), nurse practitioners (NPs), and other nonphysician practitioners (NPPs) to enhance their practices' efficiency and cost effectiveness. These practitioners can provide some of the same services performed by physicians, but at a substantially reduced cost. By working with NPPs, physicians may function at the top of their license, dedicating themselves to their best uses while improving quality of care and sustaining practice revenue. This article addresses how to use Medicare's "incident-to" billing rules to get paid for services provided by NPPs.

## What is an NPP?

First a note about terminology: Some professional societies disapprove of the term "nonphysician practitioners" because they believe it presupposes the superiority of physicians. But the concept of NPPs also reflects certain legal realities. Typically, state laws grant physicians a plenary license while restricting other providers' scope of practice to include only some of the activities physicians may perform. While anything an NPP may do typically falls within a physician's scope of practice, the opposite is not true. It is for this reason that this article uses the term

"NPP" to describe practitioners with a scope of practice more restricted than physicians'.

That said, Medicare defines "physician services" for some payment purposes as services performed not only by MDs and DOs but also by PAs, NPs, clinical nurse specialists (CNSs), physical therapists, occupational therapists, speech language pathologists, audiologists, certified registered nurse anesthetists, and others. Medicare recognizes PAs, NPs, and CNSs as equivalent to physicians for coverage purposes but only if their state licensure laws permit them to perform the service in question. PAs and NPs can bill under their own names and receive 85 percent of the Medicare physician fee schedule (MPFS) rate. Physicians often work with NPPs on an incident-to basis. That permits the practice to bill for services provided by an NPP and supervised by a physician at the full MPFS rate, as if the physician personally performed the service. Effectively using incident-to rules can allow a practice to enhance revenues by ensuring that much of the NPP's time rendering services is billed at a higher rate and is increasing the range of services the practice offers. But to qualify for incident-to designation, the services must meet certain requirements. These specific requirements only apply to Medicare, but some private insurance plans allow incident-to billing using similar rules. ►

---

## About the Author

Daniel Shay is an associate at the law firm of Alice G. Gosfield & Associates in Philadelphia. Author disclosure: no relevant financial affiliations disclosed.

BY WORKING WITH NONPHYSICIAN PRACTITIONERS,  
PHYSICIANS MAY WORK AT THE TOP OF THEIR LICENSE,  
DEDICATING THEMSELVES TO THEIR BEST USES WHILE  
IMPROVING QUALITY OF CARE AND SUSTAINING REVENUES.



### Incident-to services

Incident-to services must be an integral – although incidental – part of the physician’s personal professional services and be part of the patient’s normal course of treatment. The services must be of the type commonly furnished in a physician’s office or clinic (as opposed to physicians working in a hospital setting). For the services to be “integral,” the physician must provide the initial service while the NPP or other personnel provide subsequent services during a course of treatment. These services must be performed under direct supervision, meaning that the physician is physically present in the office suite and immediately available to provide assistance and direction when the service is performed. The physician need not be in the room with the supervised practitioner; an “office suite” generally is considered to include offices within one building, under a single lease. Buildings separated by a walkway, for example, would not qualify as an office suite. In a clinic setting, Medicare does *not* require that the physician who ordered the services be the one who supervises, as long as the other incident-to rules are met.

Incident-to billing is prohibited in two notable situations: Physicians cannot use incident-to billing when more than 50 percent of the service is counseling or coordination of care billed on the basis of time spent with the patient. For that, only “face time” with the physician qualifies. NPPs can bill for counseling or coordination of care in their own names at 85 percent of the MPFS. Also, while qualified NPPs may perform diagnostic tests and be supervised by physicians while doing so, diagnostic tests may never be billed incident-to.

It is essential that the physician be able to meet the requirements of the incident-to

rules, particularly with respect to supervision. Documentation should reflect that the supervision requirements were met at the time of service.

### Shared visits

Medicare also permits physicians who provide evaluation and management (E/M) services to hospital inpatients, to hospital outpatients, or in the emergency department to bill for “shared visits.” In a shared visit, the physician performs an E/M service, including face-to-face time with the patient, but “shares” the visit with an NPP who also works in the physician’s group. The physician is then allowed to bill for the service at 100 percent of the MPFS rate as if he or she personally performed the entire visit. Either the physician or the NPP may perform the bulk of the visit, while the other practitioner follows up with the patient on the same day. They need not be in the facility at the same time, so the NPP can round on the patient and the physician

■ Medicare’s incident-to rules allow supervised NPPs to bill at much higher rates.

■ Incident-to services must be integral, but incidental, to the physician’s services and part of the patient’s normal course of treatment.

■ Practices can’t bill incident-to for diagnostic tests or if more than half of the service is counseling or time-based coordination of care.

### INCIDENT-TO SERVICES

- Are paid at 100 percent of the Medicare physician fee schedule.
- Must relate to a service initially performed by the physician.
- Must be performed under direct supervision – when the physician is in the office suite/building.
- Cannot be billed when more than 50 percent of the visit is for counseling or care coordination.
- May not include diagnostic testing.

can go to the hospital later in the day. The physician must do something clinical, such as perform an examination or make a clinical decision to bill for a shared visit. A social visit with the patient or review of the record, even if documented, will not suffice. Sharing visits this way permits physicians to provide more services, both in and out of a hospital setting, and reduces the amount of time they must spend rounding.

### Additional considerations

Besides the preceding rules, practices must consider several other issues if they want to use incident-to billing and shared visits. For example, an NPP must first be enrolled in Medicare in order to bill for services in his or her own name or participate in shared visits. The NPP must then reassign the right to receive payment to the physician or group that is employing or contracting with him or her. The physician or practice group must be diligent in keeping its own enrollment information updated, depending on the type of NPP involved. For example, terminating a PA requires an enrollment update, although there is no similar requirement for adding a PA to the practice. Most changes to Medicare enrollment must be reported within 90 days, so practices must remain vigilant. Also, not all NPPs can enroll in Medicare. For example, medical assistants are usually not licensed and are not recognized by Medicare as an NPP type, but practices can still bill their services incident-to.

The Stark prohibition on physician self-referrals of “designated health services” can also affect how physicians use NPPs. Physicians in what Stark defines as a “group practice” may receive productivity bonuses both for services they personally perform (including designated health services) as well as for services provided incident-to those services. However, those bonus payments cannot be based directly on the volume or value of referrals.

Also, physicians must abide by billing restrictions. For instance, because diagnostic tests may never be billed incident-to, physicians must personally perform diagnostic testing if such tests are included in their productivity bonus. The physician’s supervision of diagnostic testing cannot be included

in the productivity allocation, either. Note that the physician could still be paid if the billed service is itself supervision, such as for a stress test. He or she may also be paid for personally performing the interpretation of a diagnostic test.

Stark also can affect how NPPs perform services with respect to the “in-office ancillary services” exception. This exception permits the referral of designated health services when, among other requirements, those services are performed by an individual supervised by either the referring physician or another physician in the same group. Medicare rules determine the degree of physician supervision required:

- General supervision – The physician need not be on-site,
- Direct supervision – The physician must be in the office suite but not necessarily in the same room,
- Personal supervision – The physician must be in the same room with the patient and NPP.

Therefore, physicians may take advantage of their ability to supervise NPPs to meet the “in-office ancillary services” exception.

### Conclusion

The use of NPPs may increase physicians’ revenues, promote quality of care, and improve practice efficiency in today’s pre-dominately fee-for-service environment as well as in emerging value-based payment models. Under incident-to and other similar Medicare billing concepts, physicians can increase their bottom line while reducing the number of patients they must personally see. However, physicians must adhere to the rules governing incident-to billing, and must navigate the process of hiring and maintaining Medicare enrollment information for NPPs. Failure to comply with the incident-to rules can lead to problems ranging from claims denial to being placed on pre- and/or post-payment review or even false claims liability reaching back up to six years. **FPM**

Shared visits allow physicians to bill for an entire service even if an NPP performs part of it.

NPPs must enroll in Medicare and reassign their payments to the practice in order to participate in incident-to or shared visits.

Stark laws can affect how physicians and NPPs comply with incident-to rules.

Send comments to [fpm@afp.org](mailto:fpm@afp.org), or add your comments to the article at <http://www.aafp.org/fpm/2015/0300/p15.html>.