The Ins and Outs of "Incident-To" Reimbursement

If you work with nonphysician providers, you can't afford to ignore these rules.

Alice G. Gosfield, JD

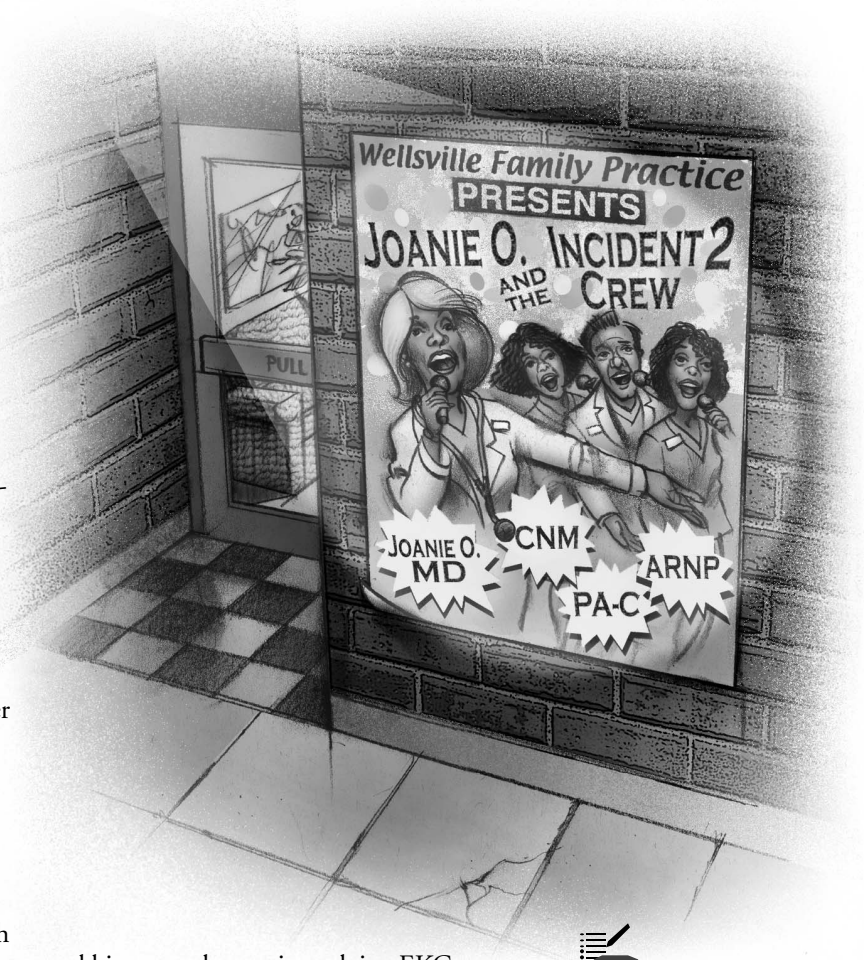

ILLUSTRATION BY JOHN FRETZ

Nonphysician providers of many stripes now work in family practices. This includes a variety of midlevel providers, nurses and medical assistants, among others. One way Medicare recognizes these individuals for payment purposes is by reimbursing physicians for services provided "incident to" a physician's care. As the use of nonphysician providers in family practices has evolved, it has become increasingly important to understand the incident-to rules. How can you afford not to? The reimbursement for a level-I established patient office visit according to the 2001 Medicare physician fee schedule is $19.89. If you provide even four such visits a day without billing for them, your practice could be losing nearly $400 per week, or approximately $20,000 per year.

The history

To understand the complexities of the incident-to rules, it's useful to reflect on the changes in family practice and the types of nonphysician providers that have worked with physicians over the years. In the late 1960s (when Medicare was enacted) and the early 1970s, most family physicians were in solo practice and had one support person who was often either a nurse, an aide who had been trained on the job, a laboratory technician who had graduated from a vocational program or even the wife of the physician. This person usually acted as the receptionist, handled the transcription and billing and performed some minor clinical tasks, such as taking vital signs and history and sometimes doing EKGs, injections or blood draws if they had received some training.

Today, in addition to nurses, there are nurse practitioners, physician assistants, clinical nurse specialists, biofeedback technicians, respiratory therapists, physical and occupational therapists, psychologists, social workers, ultrasound technicians, X-ray technicians, laboratory technicians and audiologists. These nonphysician providers

CME

Alice Gosfield is an attorney and principal of Alice G. Gosfield & Associates, PC, in Philadelphia, chairman of the Board of Directors of the National Committee for Quality Assurance, and a member of the Family Practice Management *Panel of Consultants. Conflicts of interest: none reported.*

SPEEDBAR®

The services of nonphysician providers that are performed "incident to" a physician's care can be reimbursed by Medicare.

Failing to bill for these services, even if they occur only four times a day, can cost a practice as much as $20,000 a year.

Medicare's incident-to rules cover services that are "an integral, although incidental, part of the physician's personal professional services to the patient."

Incident-to claims are paid at 100 percent of the physician fee schedule.

don't just assist physicians with patients; they often see patients in the physician's absence. The advent of managed care, with a shift to capitation, spurred much of this development by creating incentives to save costs by using the least expensive, best-trained person to meet the patient's needs while saving the physician for his or her highest and best use.

The rules

When Medicare was enacted, Congress provided for payment to the physician who directly interacted with the patient but also recognized that physicians received help in their offices. The incident-to rules were established to cover services that are "an integral, although incidental, part of the physician's personal professional services to the patient." Because these services are so intertwined with those that physicians provide, a claim for nonphysician providers' services that are incident to the physician's service can be submitted as if the physician performed the service. The nonphysician providers are invisible on the claim form, and the claim is paid at 100 percent of the physician fee schedule. Keep in mind that the incident-to rules apply only to Medicare reimbursement. For information on how other payers reimburse for the services of nonphysician providers, see "Other payers" below.

Following are some of the key points of the incident-to rules that family physicians should be aware of: who can bill incident-to, what constitutes an incidental service, what the supervision requirements are and how to document incident-to services.

KEY POINTS

- Medicare provides reimbursement for nonphysician provider services that are "incident to" a physician's care.
- Failing to bill for incident-to services can cost a practice thousands of dollars.
- When billing incident-to, a practice can be reimbursed at 100 percent of the physician fee schedule for nonphysician provider services.

Personnel. There are no Medicare requirements regarding the qualifications of individuals who may provide incident-to services, but some state laws may require licensure or certification. For many years, the fundamental employment requirement to bill for incident-to services was that the nonphysician providers had to be the W-2 employees of the practice submitting the claim. In 1996, this standard was liberalized to benefit the office-staffing industry, allowing physicians to bill incident-to for the services of W-2 *and* leased nonphysician providers as long as physicians are able to terminate the engagement of the leased individuals as well as direct how and under what circumstances they provide the services that will be submitted to Medicare.

Incidental service. To bill incident-to, there must be a physician service to which the nonphysician providers' services relate. Section 2050 of the Medicare *Carrier's Manual,* which can be accessed online by going to www.hcfa.gov/pubforms/14_car/b00.htm and clicking on part III, chapter II, states that the incidental services must be "part of the physician's personal services in the course of diagnosis or treatment of an injury or illness." Therefore, the physician has to perform an initial visit on each new patient to establish the physician-patient relationship. Although some local carriers also require the physician to see established patients each time they present with a new symptom, national Medicare policy does not require this. Nonphysician providers may bill incident-to for their services during and after that visit. Even those who can bill

OTHER PAYERS

The incident-to rules described in the article pertain exclusively to Medicare reimbursement. Other payers may reimburse for nonphysician providers' services differently, so it's important to review the physician participation agreement for the managed care companies your practice contracts with as well as your state's laws. This will help you determine whether physicians have complete leeway, as is often the case, to delegate services that are within their scope of practice to nonphysician providers. If such an approach is explicitly recognized in the provider agreement, the claims for nonphysician providers' services should generally be submitted as if rendered incident-to, although the incident-to restrictions (e.g., required physician on-premises supervision) don't pertain unless the payer specified that they apply. Many state laws allow a general delegation of authority with responsibility retained by the physician *without* requiring on-premises supervision. In situations where you are not a participating provider, the safest course is to follow the Medicare rules, because the rules can vary from payer to payer.

Medicare directly using their own provider numbers must meet this requirement if they want to bill incident-to. After the initial visit, the physician does not need to be involved in each patient encounter. The *Carrier's Manual* states that "such a service [without physician involvement] ... could be considered to be incident-to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in management of the course of treatment." Some local Medicare carriers have interpreted these provisions restrictively (e.g., requiring that the physician see the patient every third visit), but national Medicare policy does not specify the frequency of physician involvement in the course of treatment.

To bill incident-to, there must be a physician service to which the nonphysician providers' services relate.

During subsequent visits in which a physician is not involved, most nonphysician providers' incident-to services may never be billed higher than a 99211. However, Medicare states that the services of certain nonphysician providers (nurse practitioners, physician assistants, certified nurse midwives and clinical nurse specialists) can be billed incident-to a physician's services using the highest level of evaluation and management (E/M) code they are licensed to render under state law, even when no physician has been involved in the visit at all on that day. It's also important to note that, when billing incident-to, nonphysician providers cannot be reimbursed for consultations or time-based E/M services when more than 50 percent of the service is counseling or coordination of care (according to the *Carrier's Manual,* the only time that counts is face-to-face time between the physician and the patient in the office). However, certain nonphysician providers can be reimbursed for these services when billing on their own provider numbers. [See "On their own: Direct billing by nonphysician providers" on page 26 to find out how certain nonphysician providers can bill on their own provider numbers.]

Supervision. Once the initial physician relationship has been established, incident-to services can be billed even when there is not a physician in the room. He or she must only be on the premises and immediately available to assist the nonphysician provider rendering the services. The supervising physician does not need to be the physician who performed the initial patient visit. In fact, any physician in the group who is in the clinic or office seeing other patients qualifies to provide the requisite supervision, even if he or she is not the patient's primary physician or not of the same specialty as the primary physician. Independently contracting physicians who reassign their right to payment to a group practice can also supervise nonphysician providers' services as the on-premises supervisor. However, hiring a moonlighting resident or other type of physician to do nothing more than supervise nonphysician providers will not meet the standard; he or she must also be treating patients.

When it comes to submitting the incident-to claim, many physicians are unsure whose physician number to indicate on the HCFA-1500 claim form. Logic would dictate that since the services are incident-to a specific physician, the number of that physician would be the one to use. However, some carriers have explicitly stated that the *supervising* physician's number should be put on the claim form rather than the primary physician's number. This can produce some odd profiling data, particularly when the supervising physician is a specialist of the type that never orders the service for which the claim is being submitted. For example, if a dermatologist happened to be the physician in the clinic on the day when a pulmonary function test was being performed, his billing for the test would be fairly unusual. Nonetheless, for expedience of claims submission, you should submit the number of the physician your carrier requires, even if it's the supervising physician.

Supervision requirements for diagnostic tests are different than those for office visits. The Centers for Medicare & Medicaid Services (CMS) has developed three levels of supervision requirements: general, direct and personal. The appropriate level of supervision is determined by the CPT code for the test. For example, an electrocardiogram (CPT code 93000) requires only general supervision, but a stress test (93015) requires direct supervision and a transesophageal echocardiogram (93312) requires personal supervision. General supervision means that

SPEEDBAR®

To bill incident-to, there must be a physician service to which the nonphysician providers' services relate.

The physician has to perform an initial visit on each new patient to establish the physician-patient relationship.

The physician does not need to be involved in each subsequent visit but should remain involved in the care through periodic visits.

Incident-to services must be supervised by a physician who is on the premises but not necessarily in the exam room.

SPEEDBAR®

Any physician in the group who is in the office seeing other patients can provide the requisite supervision.

Diagnostic tests have different supervision requirements – general, direct and personal – which are designated by CPT code.

Certain nonphysician providers can bill Medicare using their own provider numbers and be reimbursed at 85 percent of the physician fee schedule.

These nonphysician providers can bill on their own numbers in some cases and incident-to a physician's services in others.

ON THEIR OWN: DIRECT BILLING BY NONPHYSICIAN PROVIDERS

As part of the Balanced Budget Act (BBA) of 1997, Congress recognized the role that certain nonphysician providers (nurse practitioners, physician assistants and clinical nurse specialists) play in physician practices by liberalizing the conditions under which they can bill using their own provider numbers. They can also still bill incident-to a physician's service. For example, if the physicians in a group are at the office until noon but then all go to do rounds, the nonphysician providers' services may be billed incident-to a physician until noon and on their own numbers thereafter.

What's covered?

When these nonphysician providers bill on their own provider numbers, Medicare will pay them to perform any service it would pay a physician to perform as long as they are acting within the scope of their state license. The claims are paid at 85 percent of the physician fee schedule directly to the physician or physician group employing the nonphysician provider. Services that may be billed on the nonphysician provider's number include in-office services without physician supervision, in-hospital services without physician involvement, nursing-home visits (except for the resident assessment, which can only be performed by a physician), house calls, consultations, the ordering and provision of diagnostic tests and time-based evaluation and management services where more than 50 percent of the service is counseling or coordination of care. Services performed by other nonphysician providers incident-to these nonphysician providers' services are also covered by Medicare if they would be covered were they incident-to a physician's services.

What's required?

To bill Medicare using their own provider numbers, each of these nonphysician providers must follow different rules. Nurse practitioners (NPs) must have a collaboration agreement with the physician to whom they relate, even if one is not required under state law. Aside from that, the rules for NPs and clinical nurse specialists (CNSs) are the same. Both may assign the right to payment to the employer (this must be done in order for a practice to receive payment for their services), have independent contractor relationships when their services are billed on their own numbers and even establish independent practice groups. Keep in mind that if an NP or CNS is an independent contractor, their services can never be billed incident-to a physician's services. If the NP or CNS is your employee, you have the option.

Physician assistants must comply with state laws about physician supervision and the protocol by which they collaborate with a physician. They cannot establish independent practice groups, but they can have independent contractor relationships when their services are billed on their own numbers and payment is reassigned to a physician or physician group.

What's next?

Since these changes were made in the BBA of 1997, Medicare charges for these nonphysician providers rose from $55 million to $202 million in 1999, according to a June 2001 report by the Office of the Inspector General (OIG). The charges and the number of services provided by these nonphysician providers quadrupled, prompting the OIG to consider "other additional controls for Medicare payments to nonphysician practitioners."

although the services must be under the general quality control of physicians, a physician does not need to be in the office. Direct supervision, which is the typical standard for incident-to services, requires that a physician is on the premises in the "office suite." Although the definition of the "office suite" is relatively vague, at a minimum it means a single structure that's usually under a single lease where offices are rented. For example, walkways, pathways and sky bridges between the office building and the hospital do not meet the on-premises supervision requirement. Personal supervision means the physician must be in the room with the nonphysician provider when the test is being performed. You can find out about more tests and which level of supervision they require on the CMS Web site (www.hcfa.gov/pubforms/transmit/B0128.pdf).

Coding and documentation. Even if all the aforementioned requirements are met, a practice can still run into problems when it comes to actually billing Medicare for the incident-to service. Medicare offers physicians little coding and documentation guidance for incident-to services other than the following:

• The "Documentation Guidelines for Evaluation and Management (E/M) Services" state that the patient, family member or nonphysician provider can record the past, family and social history and a review of systems, provided the physician reviews

the information and documents that he or she has done so.

• The *Carrier's Manual* suggests that when a physician and nonphysician provider are involved in providing services the code -999 (a "dump code") should be submitted.

A recent attempt by Medicare to clarify some issues related to reimbursement for physician services added to the confusion. The communication didn't address incident-to services specifically but indicated that, to bill for a service, the physician must perform the "complete" service.

Here's the advice we give our clients: Avoid submitting a dump code whenever possible, because using one ensures that the service will be defined and priced by a claims processor. Instead, if the claim doesn't meet all the incident-to standards, bill only for that portion of the service that has been completely documented and could stand alone if submitted by *either* the physician or nonphysician provider. The result might be that you get reimbursed for a lower level service than what was provided or that you get reimbursed at 85 percent of the fee schedule rather than 100 percent because the nonphysician provider bills using his or her own provider number rather than yours. If there is no clear choice, take your chances with the -999 code or don't bill the service at all.

"Scribing," defined by CMS as "entering data in the record," is another issue that creates confusion when documenting incident-to services. Gathering information created by others (e.g., laboratory values, X-ray reports) into the medical record in a more convenient place is a legitimate way of entering data in the record. Simultaneously transcribing the physician's dictated information is also permissible. It is *not* permissible for a nonphysician provider to round on hospitalized patients and enter data in the record (including the history of current illness or vital signs) and for the physician to then round on the patients himself or herself later and bill for full visits. This would constitute incident-to billing in the hospital, which is strictly prohibited. Even if the physician employs his or her own personnel and the services are rendered only in a hospital outpatient setting, no claim may be submitted for incident-to services.

Potentially false incident-to claims are punishable for up to $11,500 per claim.

The bottom line

Incident-to billing is the only way the services of some nonphysician providers can be billed in a physician practice. It is an option for others. Submitted incident-to claims that do not meet the rules are considered to be potentially false claims. Such claims are punishable by the Department of Justice and the Office of the Inspector General (OIG) for up to $11,500 per claim – plus triple the charges if they determine the physician should have known the rules. Criminal punishment, though quite unlikely, is also possible. The OIG has also targeted incident-to claims in its work plans for both 2001 and 2002.

Since the positive financial implications from using nonphysician providers can be significant and the penalties for using them the wrong way can be dire, you should ensure that everyone in your practice understands how to bill and be reimbursed for incident-to services. FM

Send comments to fpmedit@aafp.org.

THE INCIDENT-TO RULES IN SHORT

Following is a summary of the incident-to rules that must be followed when billing Medicare for nonphysician providers' services performed incident-to a physician's service:

- The nonphysician providers must be W-2 or leased employees of the physician, and the physician must be able to terminate the employee and direct how the Medicare services are provided by that employee.
- The physician must perform the initial patient visit and ongoing services of a frequency that demonstrate active involvement of the physician in the patient's care, thereby creating a physician service to which the nonphysician providers' services relate.
- A physician must be on the premises, but not necessarily in the room, when incident-to services are performed.
- Diagnostic tests must be done under the testing supervision requirements: general, direct and personal, which are designated by CPT code.
- Incident-to services cannot be performed in the hospital.

SPEEDBAR®

If a claim does not meet all the incident-to standards, only the portion of the service that can be fully documented should be billed.

Incident-to billing is strictly prohibited in the hospital.

Physicians who submit false incident-to claims can be fined up to $11,500 per claim – plus triple that if the physician should have known the rules.

Everyone in a physician practice needs to understand how to bill and be reimbursed for incident-to services.