NOTES

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Vol. 23, No. 1 **December, 2015**

"Incident to" Hidden Whammy

With the publication of the 2016 Medicare Physician Fee Schedule, effective January 1, 2016, there has been a change in the rules regarding billing 'incident to' services to Medicare. There are many myths and confusions about 'incident to' billing. And 'incident to' billing has been the basis for false claims liability. The settlement in the summer of 2014 for $1.33 million by a private practice cardiology group for compensation within the group in 2007 and 2008 happened because in 2007, despite more than 40 years of permitting it, CMS published an about face that said diagnostic testing may *never* be billed incident to. We are aware of practices that permit physicians to be given credit for global billing, allocating the technical component revenues to the ordering physician or even the interpreting physician. Both are wrong and non-compliant.

The most recent change in the rules looks fairly innocuous but has a hidden whammy in it. To bill 'incident to' requires the direct supervision by a physician in the office suite when the services are being provided. Now the rule is that the services may not be billed by the physician to whom they are incidental – the ordering physician who established the plan of care. They must be billed by the supervising physician. If this is the same physician who ordered the services, then there is little change. But the supervisor can be a different physician as well.

In a single specialty practice, this is not particularly problematic, although it now means that someone must be designated as the supervisor for a specific claim. It is permissible for any physician to fulfill the supervision responsibility. But there will have to be both a decision as to which physician in the office qualifies as the supervising physician and the records will have to support that. The hidden whammy will arise for multi-specialty groups. If, for example, the office offers its infusion clinic for rheumatology or hematology while the supervising physician is a dermatologist, the likelihood of that dermatologist being audited will increase, since all physicians are compared normatively to their peers in the Medicare Administrative Contractor's records. A dermatologist billing infusions would make his utilization profile aberrant by comparison with other dermatologists. This impliedly means the supervising physician should be someone who would ordinarily establish a similar plan of care, although the rules do not require that.

To review some of the basic 'incident to' principles, there must be a physician service to which the incident to services are incidental. The physician must see the patient with sufficient frequency (unspecified) as to demonstrate involvement in the patient's care. No

physician need see the patient at all on the day of service to bill incident to. Incident to services performed by ancillary personnel are invisible on the claim form. The service is submitted as if the physician rendered it. Now that physician who will appear to have rendered the service must be the supervising physician.

This change in the incident to billing rules does not change the Stark compensation principle that physicians may be compensated directly for designated health services that are incident to their services. So the oncologist can be given direct dollar for dollar credit for the chemotherapy, the drugs, and the administration of the drugs. The orthopedist can be given direct dollar for dollar credit for the physical therapy provided in accordance with the incident to rules.