NOTES

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## The Not So Incidental "Incident to" Rules*

*"An integral, although incidental, part of the physician's professional service"*

From the inception of the Medicare program in 1966, by statute, Medicare has covered as part of the Part B physician benefit not only a physician's personal services but also those services and supplies which are an integral, although incidental part of the physician's personal professional service to the patient. If Congress had not done that, most physician offices in those days -- with one physician and "the girl" (typically then, a vocational school trained laboratory technician, a nurse, or the physician's wife) -- would not have participated at all. The incident to provision is what permitted ancillary personnel, from the earliest times, to take vital signs, do venipuncture, take EKGs and more. As the range of non-physician practitioners rendering services in physician practices has expanded with more and more of them requiring state licensure, but also recognized by Medicare to bill independently, how and whether to bill "incident to" has become far more challenging.

The challenges are not just philosophical. Failure to meet incident to standards has been the basis for false claims charges throughout the history of the Medicare program into the present. Some years ago I was involved in a case which charged a dermatologist with 63 *criminal counts* of false claims based on her failure to comply with the incident to rules. Today's claims, mostly civil, have been made across specialties including family medicine, orthopedics, neurology and more. Settlements abound and can be found easily on an internet search. They have been settled throughout the country; and they are fodder for whistleblowers, continuing today. The rules are encoded in federal regulation and are further interpreted in Medicare Manuals including the Benefit Policy Manual and the Claims Processing Manual.

This *Agg Note* not only elucidates the nine (!) requirements for billing incident to in the modern world, but also explains the major significance it represents in the application of the Stark statute to physician practice internal compensation. It goes further to explain that despite the two Supreme Court cases of *Escobar* and *Allina*, incident to violations continue to provide fertile ground for whistleblower false claims lawsuits.

**The 9 Regulatory Requirements**

There are 8 regulatory definitions which apply to the 9 requirements to qualify as incident to services. They will be addressed here as they are relevant. The first definition to note, however, is that incident to billing is available for services and supplies. This means any services or supplies (including drugs or biologicals that are not usually self-administered), are included in the specified provision of the statute if they "are not specifically listed in the Act as a separate benefit included in the Medicare program." (42 CFR §410.26 (a)(8))

The "separate benefit" language is relatively new, going back to 2016, and is confounding, to say the least. For example, for the initial history of the program, diagnostic testing was always billed incident to the physician. In 2007 as part of the Medicare Physician Fee Schedule, discussion was added that diagnostic testing might be billed on its own number and not incident to. By 2008, the government said diagnostic testing, which has its own benefit under the §1861 provision, could "never" be billed incident to. This change was sufficiently confusing that in 2014 a cardiology group in Syracuse got the pleasure of repaying to the government more than $1.3 million dollars under a Stark Act settlement for having compensated the ordering physicians during 2007 and 2008 for the technical components of diagnostic testing, which would have been perfectly fine two years earlier. This was the first Stark internal compensation settlement in the 22 years the Stark law had been in effect. Still further, nurse practitioners, physician assistants, certified registered nurse anesthetists, physical therapists, social workers, and more, can have their own numbers under Medicare because they all have their own benefits, but they can also be billed incident to. In the past, I have asked the government to supply a list of which services can 'go both ways' so to speak and their answer was to say "it's in the statute." The following are the requirements for service and supplies incident to a physician:

(1) They must be furnished in a non-institutional setting to non-institutional patients.

Non-institutional setting is defined as all settings except a hospital or skilled nursing facility. This means services rendered in a hospital outpatient setting may NOT be billed incident to the treating physician, even if the personnel are employees of the physician practice. Nor may services in a skilled nursing facility (SNF) be billed incident to when they are provided at the bedside. It is legitimate to bill incident to services in a separate office in a SNF where the physician is seeing patients. There are separate rules for hospital incident to services which will not be addressed here.

Incident to services may be rendered to homebound patients, but they require that the physician and the ancillary personnel, such as a nurse, visit the patient together at the same time. They must both be on the premises together for the services to be incident to the physician.

(2) They must be an integral, though incidental part of the services of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness.

Under this requirement, the physician or other practitioner, like an NP, PA or CNS, to whom services can also be incidental when

billed on their own numbers, must have a prior treating relationship with the patient, to make the incident to services part of a course of treatment. Practitioner in these rules means a clinician who is not a physician and is authorized to receive payments incident to their own services. It is for this reason that an NP or PA seeing a new patient on an initial visit, cannot be billed incident to a physician unless the physician is directly involved in the care during that initial visit, because otherwise there is no physician service to which the incident to services apply. The new evaluation and management visit rules also apply here in terms of determining who can bill for the service –e.g., the physician with incident to additional services or the NP or PA. (We addressed the specific challenges of these split/shared visits in our last AGG Note, which we commend to you.) *[link: https://www.gosfield.com/images/PDF/AGG_Note_SplitShared_Visit_Revisions.cln.012122.pdf]*

(3) They must be commonly furnished without charge or included in the bill of a physician (or other practitioner).

There may be local variations among regions of the country in terms of what is commonly furnished without charge. But, Medicare is a national health insurance program; and it should cover the same services in Florida, Iowa, Maine and California. Here, if it can be shown that some practices do provide the services without additional charge, even if not locally, that would be a legitimate defense. The services or supplies must represent an expense to the practice. If the patient buys a drug and the physician administers it in the office, the cost of the drug is not covered.

(4) They must be of a type that are commonly furnished in the office or clinic of a physician.

This is similar to condition (3) in that an issue could be raised as to whether this is often a physician service. These issues can arise as various types of technology move from hospital-based contexts to being available in physician offices. The larger and more sophisticated a practice, the greater the likelihood that more complex technologies will be available there. This requirement must be considered. This provision contributes to the flexibility of incident to, but can also present a problem if a practice goes too far in what it bills, to the consternation of their Medicare Administrative Contractor (MAC)

(5) They must be furnished under the direct supervision of the physician.

The regulation permits general supervision (no physician on premises) where it is specifically provided for as ‘designated care management services’ such as chronic care management and transitional care management. Direct supervision means that a physician in the group, whether W-2 or 1099, must be in the office suite (not on the first floor of the building when the offices are on the fifth floor) while the auxiliary personnel render the incident to services. This is the basis for most of the false claims suits brought regarding incident to failures.

The supervising physician need not be the treating physician. That said, only the supervising physician’s NPI number goes on the claim form. In the long history of incident to billing, this also is a relatively recent development, against which I argued at the time. I lost that argument. Understand that the services are not ‘incident to’ the supervising physician who may have zero treating relationship with the patient at all. The services remain incident to the treating

physician who will not even appear on the claim form if he was not in the office when the services were provided.

The treating physician must render services with sufficient frequency that it can still be said that he has created the course of treatment. If the non-physicians take over the care, the services will cease to be incident to. In the past, MACs have published coverage determinations, later rescinded, stating that the patient's development of a new symptom requires the reinsertion of the physician in the course of care to continue to bill incident to. This analysis is not documented in regulations or Manual provisions. The rules merely say that the frequency must reflect the physician's "continuing active participation in and management of the course of treatment."

(6) They must be furnished by the physician or a practitioner with an incident to benefit or auxiliary personnel.

Here, the distinction is between the physician furnishing the services directly or by a practitioner who is in a category which can have incident to benefits such as NPs, PAs and CNSs. Licensed social workers, for example, do not have an incident to benefit. To qualify where the practitioner is not a physician, it is important to verify that there is an incident to benefit available.

(7) They must be furnished in accordance with state law.

Under this condition, a wrinkle might arise if state law has a more stringent supervision requirement for the rendered services than Medicare. For example, if state law requires certain types of ancillary personnel to be subject to personal supervision (a physician in the same room with them) that would trump Medicare's more liberal rules.

(8) The physician to whom the services are incidental may be an employee (W-2) or an independent contractor.

In the earliest days of incident to, the only ancillary/auxiliary personnel who might be billed incident to were required to be W-2 employees of the physician practice. Not only is that no longer the case, but in addition, services can be incident to an independent contractor who otherwise reassigns his right to payment to the physician practice. This also is a change from the earliest iterations of the rules.

(9) Finally, claims for drugs to refill an implantable pump may only be paid to the physician incident to the physician's service and not to a DME supplier or pharmacist.

This provision was added to clarify that where physician practices refill implantable pumps, they typically do so in the office. Those drugs can be billed incident to the physician. If the pump is filled in the patient's home with no physician involvement, the physician cannot bill for the service or the supply (the drugs).

**The Stark Whammies**

The incident to rules are directly relevant to Stark compliant internal compensation within groups because the definition of a group practice includes rules for compensation for services personally performed by physicians or incident to their services.

The issue typically arises with respect to how to allocate profits generated by designated health services (DHS) ancillary

services including imaging and clinical laboratory services (which as diagnostic services can never be allocated incident to), outpatient prescription drugs including those infused in the office, physical and occupational therapy, speech and language pathology services, radiation therapy and supplies, parenteral and enteral nutrients, prosthetics and orthotics, (but not durable medical equipment). Most of these may be provided incident to.

The profits from technical components of imaging services and clinical laboratory services may be allocated directly to the radiologist in the first case and the pathologist in the second, not because they are incident to, but because the statute explicitly states that their ordering of the noted services is not a referral under the Stark law. There is no requirement to allocate those profits that way; and they may also float up into an overall profit-sharing pool for the whole group.

For the other services, most of them may be provided incident to the treating physician, and therefore, even though she may not be on the claim for the service as not supervising, the profits may be allocated directly to her, dollar for dollar. Because supplies are also incident to, the drugs that are administered and dispensed in the office, may also be incident to. Parenteral and enteral nutrients administered in the office may be treated the same way. While Part D drugs are included as Stark designated health services, their profits may not be allocated incident to because they have their own benefit that is not even in the same title of the Social Security Act as the physician benefit.

Prosthetic shoes, braces and the like (POS) that are fitted and provided from the office can be provided incident to; but durable medical equipment (DME) (canes, wheelchairs, walkers, beds, etc.) may not, even though the Stark regulations allow them to be provided by physician practices, as distinct from all other DME. Many of our clients confound DME and POS as being treated the same way under the law because they are administered by the same MAC. DME and POS are treated differently under Stark.

The various therapies – physical, occupational, speech pathology-- may all be rendered incident to. Further, there is no requirement that any physician practice treat any modality the same way all the time. For example, if there is a physician on premises sufficient to meet the incident to standards most of the day, but not for first appointments, those first appointment visits may be billed on the non-physician clinician's number because there is no direct supervision available. There is no difference in payment when these therapy services are paid to the physician practice not incident to. That is as distinct from NPs and PAs whose services are paid at 85% of the physician fee schedule when they are billed on those clinicians' own numbers, not incident to. That said, when they are billed on their own numbers, as long as what they are billing for is not DHS that the physician ordered, the profits from their visits (visits not being DHS) may be allocated dollar for dollar to the treating physician.

One wrinkle in applying the incident to rules under Stark arises where the physician to whom the services are incidental is an independent contractor, paid on a 1099 by the group or through another entity (a leasing company, an MSO, etc). For Stark purposes, a 1099 physician is only considered to be a physician in the group when he is on the premises of the group. This is relevant to when he can accept

referrals from other physicians in the group as well as when and where he can supervise other physicians' incident to services. This restriction does not apply to employee (W-2) physicians. So a member of a group (employee, partner, or shareholder) can read imaging studies off premises and the group can bill for them when he is working remotely at home, but if he is a 1099 physician, that won't work because he is not providing the DHS on the premises of the group.

**The Supreme Court Cases**

In the last few years, two cases decided by the United States Supreme Court have called into question which types of rules may be relied upon by the government and whistleblowers for false claims cases:

The *Escobar* case involved the issue of what is implied in a claim that is submitted for payment to a federal program. There, the patient received care from an unlicensed mental health worker and the whistleblower argued that implied in the claim was compliance with payment rules and other laws. So, they asserted, the claim was false because the treating clinician was not licensed. In a unanimous opinion about which both sides claimed victory (!), the court enunciated an opaque standard as to what is implied in a claim: namely whether the issue with which the claim does not comply is "material" to whether the government would have paid the claim had it known the fact was false.

There is no need to worry about implied claims with respect to incident to failures. The back of the paper CMS-1500 form and included in the electronic 1500 is an *explicit* attestation that the physician signing the claim attests that he rendered the services himself or they were 'incident to" his services. This makes the incident to rules an explicit assertion under penalties of falsity in every single Medicare claim that a physician files.

Similarly, another controversial case decided by the Supreme Court was the *Allina* case which confronted what types of sub-regulatory guidance (e.g., Manual provisions, newsletters, MedLearn Matters articles, LCDs) are a permissible basis for false claims liability. Again, there is no need to confront the implications of the decision because the regulations addressed in this *Note* were published in accordance with the Administrative Procedures Act and have the unquestionable force of law for false claims liability.

**Conclusion**

The incident to rules have morphed over the years and continue to represent a vital requirement for physician claims to the Medicare program. They have become more detailed; and their significance extends beyond compliance and false claims liability to fundamental internal compensation formulae as well. Every physician practice is well advised to review their compliance with this web of requirements.