REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-16

Subject: Billing of "Incident to" Services (Resolution 708-A-15)

Presented by: Robert E. Hertzka, MD, Chair

Referred to: Reference Committee G (Steven Hattamer, MD, Chair)

At the 2015 Annual Meeting, the House of Delegates referred Resolution 708, "Incident to" Billing and NPI Numbers on Claims, which was sponsored by the Iowa delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2016 Annual Meeting. Resolution 708-A-15 asked:

> That our American Medical Association (AMA) work to eliminate "incident to" billing so that all charges to patients accurately reflect the practitioners' care to avoid misrepresentation on a medical claim that the physician provided services, which will result in all payments being relevant to the skills and qualifications of the rendering practitioner; and
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> That our AMA work to ensure all National Provider Identifiers (NPI) on a claim form accurately reflect the practitioner who provided the care rather than reporting under the physician's NPI while maintaining that all such reimbursement be paid to physicians or their institutions.

This report provides background on billing of "incident to" services; highlights developments in "incident to" billing requirements included in the 2016 Medicare Physician Payment Schedule final rule; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

For services and supplies that are provided in a physician's office, a patient's home or other institution excluding a hospital and skilled nursing facility, the Medicare Benefit Policy Manual states that, in order "to be covered incident to the services of a physician or other practitioner, services and supplies must be:

- An integral, although incidental, part of the physician's professional service;
- Commonly rendered without charge or included in the physician's bill;
- Of a type that are commonly furnished in physician's offices or clinics; and
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision."

If services are provided incident to a physician's professional services, then they are billed as Part B services as if the physician provided them, and are paid according to the physician fee schedule. Depending on the service and physician judgment, "incident to" services can be provided by

non-physician practitioners (e.g., nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, clinical psychologists, or clinical social workers) or non-physician employees (e.g., nurses and technicians). Services provided incident to a physician's professional services by non-physician practitioners can be broader in scope, depending on state law. Depending on the non-physician practitioner, a range of services could potentially be provided "incident to," from basic clinical services including taking blood pressures and administering injections, to services usually performed by a physician allowed for under state law including minor surgery, reading x-rays, and other services that entail the non-physician practitioner evaluating or treating a patient's condition.[1] When non-physician practitioners furnish evaluation and management services incident to a physician's service, the physician bills the CPT code appropriate for the evaluation and management service provided.

When non-physician employees provide evaluation and management services incident to, and not part of, a physician's service, the physician bills code 99211 for the service, which is appropriate for an "office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional." The Council notes that "incident to" billing is the only way to obtain Medicare payment for services by: a) non-physician practitioners who are not enrolled in Medicare (including many who are employed by hospitals); and b) health professionals who are not permitted to enroll in Medicare (e.g., nurses, medical assistants, and pharmacists) or to bill directly for that service (e.g., psychologists, social workers, and chiropractors may not bill for evaluation and management services).[2]

Physicians should be aware that non-physician practitioners may be licensed under state law to perform specific medical procedures and services without physician supervision and have the service separately covered and paid for by Medicare as a service independently provided by them. For example, services billed separately and provided by nurse practitioners are paid at 85 percent of the physician fee schedule. In addition, while the majority of "incident to" billing is done by physicians, services and supplies may also be billed incident to certain non-physician practitioner's professional services, including clinical psychologists, physician assistants, nurse practitioners, clinical nurse specialists and nurse-midwives. In these cases, such services supervised by non-physician practitioners are paid as if they were performed by the supervising non-physician practitioners.[3]

The determination of whether services provided by non-physician practitioners may be billed as incident to a physician's professional services depends on whether the service was performed under the direct supervision of a physician as an integral part of the physician's in-office service. The Centers for Medicare & Medicaid Services (CMS) has clarified that direct supervision does not mean that the treating physician or any physician in the physician's group must be in the same room as the non-physician practitioner providing the service. Rather, a physician must be present in the larger office suite and immediately available to provide assistance and direction during the provision of "incident to" services. In addition, the physician billing "incident to" must have first seen the patient and initiated the course of treatment, and provided subsequent services at a rate that shows active participation in and management of the course of treatment. If services provided by non-physician practitioners do not meet the requirements of "incident to" billing, non-physician practitioners would bill under their own national provider identifier (NPI) number; the payment for most non-physician practitioners (except nurse-midwives and nurse anesthetists) is a percentage (65 to 85 percent) of the physician rate.[1]

There are some differences in supervision requirements depending on the site of care. For those services and supplies that are provided incident to a physician's service in a physician-directed

clinic, several physicians may provide supervision for "incident to" services versus an individual attending physician. There are also some exceptions to the direct supervision requirement for a limited set of services provided to homebound patients in medically underserved areas, and when services provided to homebound patients comprise an integral part of the physician's professional services to the patient, provided by personnel meeting relevant state requirements. In these exceptions, general physician supervision is required, which means "that the physician need not be physically present at the patient's place of residence when the service is performed; however, the service must be performed under his or her overall supervision and control."[1]

Outpatient hospital services may also be covered "incident to" the outpatient services of physicians or certain non-physician practitioners. Partial hospitalization services can also be billed "incident to" the services of a physician or other practitioner. In these cases, payment for these services would be made to a hospital under Part B.[1,4]

THE 2016 MEDICARE PHYSICIAN PAYMENT SCHEDULE FINAL RULE

In the 2014 Medicare Physician Payment Schedule (MFS) final rule, CMS set explicit requirements that "incident to" services must be furnished consistent with applicable state law, including state licensure and other requirements for the "auxiliary personnel" providing the services. In the 2016 MFS, CMS modified existing language around its requirement that "the physician or other practitioner who bills for incident to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident to services." The change removed a sentence explaining that the physician supervising the services did not need to be the physician who initiated the patient's treatment and is overseeing their general care. The AMA and other physician groups argued that this change could be interpreted as prohibiting this practice which is common for certain types of services such as periodic drug injections or infusions where one physician is managing the overall plan of care but another may supervise the provision of individual services during the course of that care. Fortunately, CMS clarified in the MFS that the supervising physician (or practitioner) for a particular incident to service does not have to be the same person who is "treating the patient more broadly" and added clarifying regulatory language to that effect.

RELEVANT AMA POLICY

Policy H-35.992 states that reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel, and stipulates that such personnel should be under the supervision of practicing physicians. Policy H-360.988 supports provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician's supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. Policy H-35.993 opposes legislation or programs that would provide for Medicare payments directly to physician extenders, or payment for physician extender services not provided under the supervision and direction of a physician.

Policy defines the valued role of non-physician practitioners within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety. Payment mechanisms for such physician-led team-based care are outlined in Policy H-160.908, which states that our AMA advocates that physicians who lead team-based care in their practices receive the payments for health care services provided by the team and establish payment disbursement mechanisms that foster physician-led team-based care. The policy advocates that

payment models for physician-led team-based care should be determined by physicians working collaboratively with hospital and payer partners to design models best suited for their particular circumstances. The policy stipulates that physicians should make decisions about payment disbursement in consideration of team member contributions, including but not limited to: volume of services provided; intensity of services provided; profession of the team member; training and experience of the team member; and quality of care provided. Finally, Policy H-160.908 states that our AMA advocates that an effective payment system for physician-led team-based care should:

a. Reflect the value provided by the team and that any savings accrued by this value should be shared by the team;
b. Reflect the time, effort and intellectual capital provided by individual team members;
c. Be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and
d. Be sufficient to sustain the team over the time frame that it is needed.

DISCUSSION

Payment resulting from "incident to" services can be an important revenue source for physician practices that choose to fulfill the conditions and administrative requirements to do so. Medicare "incident to" billing provides several advantages to physicians. For some services, it yields a higher rate of payment. For other services, it is the only way to receive any payment under Medicare. As such, it may serve as a disincentive for additional non-physician practitioners and employees to seek provider status so they can bill independently. Overall, "incident to" billing values physician leadership of the health care team and the supervision they provide over the members of the team, with the ultimate responsibility of "incident to" services and the patient's treatment generally resting with the physician. As such, the Council recommends the reaffirmation of Policy H-160.908, which outlines parameters for payment mechanisms for physician-led team-based health care.

The Council notes that "incident to" billing is a construct of Medicare's fee-for-service payment system. As outlined in Council on Medical Service Report 9-A-16, "Physician-Focused Alternative Payment Models," being considered at this meeting, some physician-focused alternative payment models may transition away from fee-for-service payment toward value-based payment, such as episode-based payment. The transition toward value-based payment may reduce the need to bill services "incident to," as the care provided by all members of a physician-led health care team may be included in the same payment. The Council believes that physicians who choose to participate in alternative payment models that incorporate aspects of Medicare fee-for-service should retain the ability to bill services provided by non-physician practitioners and employees incident to physician professional services.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 708-A-15, and that the remainder of the report be filed.

That our American Medical Association reaffirm Policy H-160.908, which outlines parameters for payment mechanisms for physician-led team-based health care. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual, Chapter 15: Covered Medical and Other Health Services. Revised November 6, 2015. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.
[2] Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 12: Physicians/Nonphysician Practitioners. Revised November 6, 2015. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.
[3] Centers for Medicare and Medicaid Services. MLN Matters SE0441. "Incident to" Services. April 9, 2013. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf.
[4] Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual, Chapter 6: Hospital Services Covered Under Part B. Revised December 18, 2015. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf.