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Compliance Today - January 2024

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The perils and perplexities of CMS's incident-to billing rule

by Roz Cordini, JD, MSN, RN, CHC, CHPC

In 1977, the term "Rural Health Clinic Services" was added to Section 1861 of the Social Security Act, which set out the basis for incident-to billing within the Medicare program. The definition provided:

(aa) (1) The term 'rural health clinic services' means— (A) physicians' services and such services and supplies as are covered under subsection (s) (2) (A) if furnished as an incident to a physician's professional service, (B) such services furnished by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service . . .[1]

The intent was to expand access to care in underserved rural health areas by allowing nurse practitioners (NPs) and physician assistants (PAs) to care for Medicare patients under an established physician plan of care while avoiding financial penalties to physicians due to utilizing these providers. Twenty years later, the Balanced Budget Act of 1997 expanded coverage of NP and PA services to all settings, reimbursing them at 85% of the Medicare Physician Fee Schedule (MPFS). At the same time, the rural health site limitation for incident-to billing was removed, expanding the ability to bill for incident-to services in all locations.[2]

Of course, Medicare established criteria and limitations around what constitutes incident-to billing and the associated billing requirements. 42 C.F.R. § 410.26(b) provides that to bill Medicare Part B for services and supplies incident to the service of a physician (or another qualified practitioner), such services and supplies must be:

- furnished in a noninstitutional setting to noninstitutional patients;
- integral, though incidental, part of the service of a physician (or another practitioner) in the course of diagnosis or treatment of an injury or illness;
- commonly furnished without charge or included in the bill of a physician (or another practitioner);
- of a type that is commonly furnished in the office or clinic of a physician (or another practitioner);
- furnished by the physician, practitioner with an incident to benefit, or auxiliary personnel; and
- furnished in accordance with applicable State law.[3]

In addition, a physician (or other practitioner) may be an employee or an independent contractor.[4]

Although the regulation may seem straightforward, incident-to billing remains confusing to providers who may

have compliance and repayment concerns if they improperly bill these services.

This article does not exhaustively discuss Medicare's incident-to billing criteria or rules. Instead, it attempts to address certain problematic compliance concerns affecting physician practice groups and other healthcare entities billing the Center for Medicare & Medicaid Services (CMS) for services incident-to the physician's service.

'Integral, though incidental,' part of the service of the physician

This qualifying criterion is one of the most important criteria and one that can create compliance concerns when not adhered to. To be "integral, though incidental" means the services must be part of the patient's normal course of treatment, during which the physician performed an initial service and remains actively involved during treatment. These follow-up services rendered must be connected to the course of treatment the physician planned at the initial service.[5] At face value, this seems easy enough. The physician evaluates the patient initially and establishes the plan of care. During a subsequent visit, the nonphysician practitioner (NPP) can perform the service and bill under the physician's National Provider Identifier (NPI), who provided direct supervision on that date of service.