Medicare Physician Reimbursement Issues: Through the Stark Looking Glass and More

Alice G. Gosfield, Esq.

To research payment issues, the only safe way is to research in the Carrier's Manual AND Claims Payment Manual.

Appendix includes emails and correspondence from CMS

I. Scope

A. “Referral by a physician ”
   1. To another physician in the group
      a. Rendered by a physician or paid for on the physician fee schedule
         i. MDs, DOs, podiatrists, dentists, chiropractors
         ii. Interns and residents outside the scope of their residency program
         iii. PAs, NPs, CNSs for services “not incident to” a physician's service—physician substitutes but not physicians -- Stark issues; what about when the CPT code says “physician supervision”? (See p. 5)
      b. A physician service
         i. Diagnosis, therapy, surgery and consultation
         ii. Physician must examine the patient in person or be able to visualize some aspect of the patient's condition without interposition of a third party (e.g., EKGs, EEGs, X-rays, etc.)
            • Interpretation of X-rays and EKGs in emergency room can only be billed by one physician, either treating emergency room physician or radiologist/cardiologist; left to hospital to see that only one claim submitted (CM §15023)
         iii. Performed in a home, office, institution or at the scene of an accident
      c. Using the premises of the group

B. In Office Ancillary Services: “Direct Supervision” and “Incident To”
   1. Ancillary services performed that are “incident to” physician's services: 42 CFR §410.10(b), 414.34(b) and 410.26
      a. Services of non-physicians must be rendered under the direct supervision of the physician -- on premises and in the office suite: See, Snider v. Blue Cross and Blue Shield of Michigan, (Civ. No. 8-72778, E.D. Mich., Feb. 8, 1979), CCH ¶29,905; Downtown Medical Center v. Bowen, 944 F.2d 75 (10th Cir. 1991) CCH ¶39,575
      b. Need not be employees or leased employees
      c. There must be a physician professional service to which ancillary services are incident
         i. supervision itself is not a physician service
         ii. cannot enter into a relationship with a physician merely to “bill
through”

d. Conundrum of diagnostic service benefit and “incident to”


1) ‘General’ means overall supervision and control
2) ‘Direct’ means in the office suite immediately available to assist
3) ‘Personal’ means in the room
4) See Jan 29, 2002 correspondence AGG to CMS; email reply
   * BUT now diagnostic services can never be “incident to” and a physician can be billed incident to another physician. See Correspondence Appendix

e. Services must be of a kind commonly furnished in a physician's office or clinic -- no use of PAs or NPs in hospital care for billable services “incident to”; do not confuse with Transmittal 1776 below, which appears to be the same

f. Services must be commonly rendered without charge or included in the physician's bill.

g. If 4 categories of advance practice personnel (physician assistants, nurse midwives, nurse practitioners and clinical nurse specialists) perform, can bill applicable E & M code; otherwise only 99211—but in no event can ancillary personnel provide counseling or coordination of care billing without physician involvement. (MCM §15501G)

2. Transmittal 1776: Physician and NPP working together—in hospital inpatient/outpatient ED, NPP can see patient first, physician can follow and perform only part of an E/M in an encounter with the patient face to face and total service may be billed at 100% under physician's number (see correspondence from CMS—January 21, 2003). But this is not incident to.

C. PAs, NPPs, CNSs, at 85% of Physician Fee Schedule

1. May order physical therapy, occupational therapy, and speech pathology services when state law authorizes them to do so;
2. They may certify and recertify plans of treatment, order diagnostic tests and perform consultations.
3. These individuals are authorized to bill for services which would be covered if provided by a physician or incident to a physician's services and which they are authorized to perform under state law.
4. In SNF: Physician must do initial assessment—NPs may substitute thereafter.
5. Must comply with state law: Medicare does not trump state license laws
6. They may perform diagnostic tests, but may not supervise them.; but see CMS letter re 93015 - Appendix
7. Services “incident to” NPP will be covered if they would be “incident to” a physician. (See CMS clarifying email 10-29-03, Appendix)
8. May bill time based codes for counseling and coordination of care.
9. Care plan oversight provided by non-physician practitioners is payable but they may not certify a patient as needing home health: 42 CFR § 414.39(c)
   a. May be billed if the physician who signs the plan of care provides regular ongoing care under the same plan of care as the NPP billing for care plan oversight and they are part of the same group or have a collaborative agreement or if the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of PA services for the practice.
   b. Payment may be made when the NPP has seen and examined the patient not functioning as a consultant and integrates his/her care with that of the physician.

D. Physical Therapy: Now may only bill for PTs and others who have training and are otherwise qualified in every way except licensure. (See 69 Federal Register 66351 et seq. Nov. 15, 2004)

E. Location of Service: shared facilities
   1. Outpatient services in Facility Settings: 42 CFR § 414.32 (HOPPS) Does not affect physician services themselves. The regulation addresses when hospital may bill as hospital services, not when physician may bill as office services; see also provider-based entity rules 42 CFR § 413.65.
      a. Considered Hospital services when
         • Integrated activities for off-site clinics
         • Serving the same populations: 35 miles or 75/75
         • Daily reporting relationship to CEO
         • Integrated medical records with hospital
         • Held out to the public as part of the hospital
         • Financially integrated
      b. Hospital usually provides the overhead provided by office-based physicians for physicians providing services in hospital outpatient department
      c. The practice expense RVUs are determined in accordance with § 414.22(b)(5).
      d. Whether site of service is determined to be physician office or hospital outpatient department depends on whether (AGG Rules—not documented anywhere by CMS)
         i. physician pays rent to hospital
         ii. no longer necessary that physician employs the ancillary personnel
         iii. service is held out to the public as physician practice
         iv. physician offices, even on the premises of a hospital, not subject to fee reductions
v. registration by patient as an outpatient for a service regardless of
ownership of equipment or employment of personnel, means physician
may only bill professional fee. If physician owns equipment, technical
component payments must be obtained from the hospital
e. No incident to billing for physicians in the outpatient hospital setting—
even for their own employees. HCFA Memorandum FKA43 (October
28, 1996); but NPs, PAs, CNSs not incident to can be billed by
physicians in hospital settings

F. Assignment: 42 USC §1395u(b)(3)(B)(ii); §1842(b)(3)(B)(ii) of the
Social Security Act; 42 CFR §424.70 general principles
1. Physician agrees to accept carrier's payment in full
   a. Voluntary for each incident of service—e.g., by patient or by type of
      service, incident-by-incident or over time -- directories of physician
      rates of assignment will be published
   b. Rescission must be mutual:
      • prior to any determination of claim for which the assignment
        was made
      • attempt to rescind because of dissatisfaction will have no effect
        but will be considered a request for review
   2. A pattern of breach of assignment (billing for difference between
carrier payment and actual charge) punishable under fraud and abuse
statutes: 42 USC §1395nn(d); §1877(d) of the Social Security Act
      a. More than three instances
      b. Misdemeanor, fine of $2,000, potential expulsion from Medicare
   3. Reassignment: 42 USC § 1395u(b)(5); §1842(b)(5) of the Social
Security Act; 42 CFR §424.80
       Section 952 of HR1 liberalized b. and c., below to permit
reassignment where physician has a contract with an entity or person
which says the entity may submit regardless of where the services are
provided as long as there is a contractual relationship. Transmittal
and several liability between the entity and the rendering
practitioner, and the practitioner has access to claims submitted on
his behalf. See. 30.2 of the CPM, and new 42 CFR §424.80 (See
69 Federal Register 66314 , Nov. 15, 2004).
      a. Traditionally can't reassign from beneficiary to physician to another
entity except in three circumstances: physician gives right to receive
payment to another under a contractual agreement
         i. employer-employee relationship: (Social Security Act definition - W-
Supp. 1111 (E.D. Pa. 1979)
         ii. inpatient facility: physician assigns to hospital
         iii. health-care delivery system: e.g., clinic or prepaid plan—no longer
required to be tax exempt or 51% owned by physicians; outpatient
oriented
         iv. If relationship qualifies under one category it is sufficient even if other
physicians in same setting qualify on a different basis (e.g., W-2 physicians and 1099 physicians work for same clinic)

v. Where there are multiple subgroups in a facility, each can be a separate group paying to same tax ID number

vi. Indirect relationships (e.g., hospital contract with emergency group) now requires direct reassignment by physician to hospital.

vii. Indirect relationships may exist with entities which otherwise do not qualify for assigned payments

viii. Clinics need not have W-2 relationship, but if the relationship is with a 1099 independent contractor, the reassignment is only good for services on premises of the clinic—all others must be submitted by physician.

Transmittal 1644 August 1999 creates exception for University Faculty Practice Plans where services may be provided in hospitals and clinics where staffing is provided by FPP and on premises restriction does not pertain.

*Applies to PAS, NPs, CNSs ** CRNAs always had an exception (CM 16003.C)—But § 952 MMA eliminated need for on premises

ix. Where professional component is purchased (e.g., imaging center buys interpretation of radiologist), claiming entity must have performed technical component, test must have been “initiated” by someone unrelated to either the technical component provider or the interpreter, and the interpreter does not see the patient But consider how much of an impediment this is if the physician can be an independent contractor off premises.

x. Physician coverage arrangements

(1) Patient is first physician's
(2) He is unavailable
(3) Name and UPIN of performing physician included
(4) Not for more than 60 continuous days
(5) Use Q5 modifier when the relationship is reciprocal; use Q6 modifier if service is provided by locum tenens physician
(6) OBRA 94 permitted Secretary to recognize substitute billing arrangement between two physicians (locum tenens) • locum tenens physician must be paid on a per diem or similar fee-for-time basis • can be used for a physician who has left the practice

NOTE: When this relationship is used, claiming physician “certifies” that all conditions of coverage have been met by the substitute physician (e.g., “incident to”, etc.) and he accepts liability for “falseness” of any statements made

b. Right to receive assigned benefits will be revoked if
i. violation of assignment rules or reassignment rules
ii. continued violation after HCFA warning
iii. failure to furnish necessary information to establish compliance with requirements of § 424.80 -- 42 CFR §424.82  
c. Due process rights attach to revocation: 42 CFR §424.83

II. Specific Stark Issues

**Dollar for dollar credit may be given to physician to whom services are incidental. See 66 Fed Reg 909 (Jan 4, 2001)**

A. Non-incident to non-physician services don't count for compensation which incorporates “incident to”

B. Stark regs make it clear diagnostic services (See 69 Federal Register 16135 and J. Sinsheimer email 6/23/2004) are incident to interpreting physician in contradiction with new CMS “never” position

C. ‘Direct supervision requirement’ supervision is that level otherwise required under Medicare

D. Lab and drugs: without physician work RVUs

E. Teleradiology: Even if it works for § 952, it won't for independent contractors because referral for physician services must be to physicians “in the group” who, if independent contractors, are only “in the group” when they are furnishing services “in the group's facilities.” (42 CFR § 411.351; 66 Federal Register 955, Jan. 4, 2001; 69 Federal Register 16130, March 26, 2004)

III. Basic Reimbursement Issues

A. **Evaluation and management codes:** documentation (MCM §15501)

   The physician must have provided all the services necessary to meet the CPT description. A claim must reflect the service actually performed. Do not use modifier—52. (Transmittal 1690)

1. Rules create a matrix of factors to determine level of service
   a. scope of the history
   b. extent of the examination
   c. type of medical decision-making

2. Time is not relevant unless at least 50% of the service is counseling and/or coordination of care with other providers in which case time is determinative

3. Time significance varies by setting:
   a. Time means face-to-face physician-patient time only in the office/outpatient setting: unless NP, PA, CNS, bills on own number
   b. Time includes unit/floor time for hospital and other inpatient visits

4. Physicians in a group of the same specialty must bill and be paid as one physician. Combine two visits on the same day. (Transmittal 1690)—Can't be used for NPPs in hospital with physician following up. But see CMS correspondence May 29, 2002 re global period - Appendix

5. Services eligible for technical/professional split billing specified nationally by HCFA—preface to the Proposed Fee Schedule for 2003;
use of supervising physician number and split billing even when both components billed by the same practice but on different days—otherwise use number of supervising physician.

6. Consultations versus visits
   a. Specific request from a physician or NPP (Transmittal 1690)
   b. Written report to requesting physician
   c. Not legitimate to bill a consult when the patient is self-referred (“Dr. please send a note to my physician”)
   d. Until 9-97 (CM not made available until Feb. 1998 revised May, 1998) Consult and treat request meant only visits could be charged; now, elaborated with scenarios—
      “Pay for an initial consultation if all the criteria for a consultation are satisfied.” Payment may be made regardless of treatment initiation unless a transfer of care occurs. A transfer of care occurs when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral and the receiving physician documents approval of care in advance. (CM §15506B -- amended by Transmittal 1645, August 1999)
   e. Can cross-consult within a group -- what about two E & M codes on the same day issue? (See Email from C Scally, July 22, 2003, Appendix.)
   f. Consults may be billed for time. (Transmittal 1690)

7. Single-system specialists using comprehensive codes (CM §15501D)
   New E & M documentation requirements particularly for single-system specialists; see AMA and HCFA Joint Issuance May 1, 1997 (CCH ¶45,583) (Available at http://www.hcfa.gov/medicare/mcarpti.htm)

8. Critical care is a fully-time based code

B. New patient:
   1. A patient who has received no E&M services from a comparable specialist (specialty designations as determined by HCFA) in that group within the previous three years (Transmittal 1690)
   2. Based on group (assignment account) number submissions
   3. Even if physician has never seen the patient before

C. Global Surgery
   1. One day pre-op is included in all
   2. Standardized post-op: 0, 10 or 90 days
   3. All services by operating physician within global period are included in the global fee including services of NP, PA OR CNS in substitution (see CMS correspondence, May 29, 2002—Appendix)
   4. Exceptions subject to modifiers

D. Medically unnecessary concurrent care will be denied, but necessary concurrent care -- two physicians treating the patient in the facility on the same day -- will be paid for if justified

E. SNF visits (Transmittal 1690)
2. Coverage for visits once every 30 days for 3 months, then once every 60 days.
3. PA, NP or CNS may substitute for subsequent visits.
4. “Incident to” covered if ancillary personnel and physician are together at bedside or together in separate office.
5. Reference to time on non-counseling applies to preclude “gang visits.” (MCM §15509.1E)
6. Assisted living is nursing home care, not house calls.
F. House call: (Transmittal 1690) Medical necessity of house call in lieu of office visit must be documented even though patient need not be homebound. (MCM §15515B) Section 702 of HR 1 calls for a demonstration project to clarify definitions and distinctions in services to ‘homebound’ beneficiaries.

IV. Medicare Modernization Act Issues

A. Welcome to Medicare. In the first six months of the patient's participation in Medicare, MDs, ODs, PAs, NPs, or CNSs can bill for the service.
B. Initial Preventive Physical Exam, 42 CFR § 410.16.
1. Review of the individual's comprehensive medical and social history.
2. Review of the beneficiary's potential risk factors for depression.
3. Review of the beneficiary's functional ability and level of safety.
4. Examination to include measurement of the beneficiary's height, weight, blood pressure, visual acuity and other factors as appropriate.
5. Performs an interpretation of an electrocardiogram.
6. Education, counseling and referral as appropriate.
7. Education, counseling and referral including a brief written plan for obtaining appropriate screening and other preventive services that are covered as separate Medicare Part B benefits.
C. Covered Screening and Preventive Services to which patients would be referred.
1. Administration of pneumococcal influenza and hepatitis B vaccine.
2. Screening mammographies.
3. Screening pap smear and screening pelvic exam.
4. Prostate cancer screening.
5. Colorectal cancer screening.
7. Bone mass measurements.
8. Screening for glaucoma.
9. Medical nutrition therapy services for individuals with diabetes or renal disease.
10. Cardiovascular screening, blood tests.
11. Diabetes screening tests.

D. ABNs
1. An ABN is not needed if you unknowingly give the patient welcome to Medicare services.
2. An ABN is needed if you think the patient may have been in Medicare for longer than six months when you provided the welcome to Medicare services or that the welcome to Medicare services were obtained from another physician.

E. A separate, necessary E/M service may be billed for the same patient on the same day as the welcome to Medicare exam but this would not be typical.

F. Cardiovascular disease screening tests are now covered. 42 CFR §410.17.
1. Includes a lipid panel consisting of a total cholesterol, HDL cholesterol and triglyceride performed after a 12 hour fasting period as well as other blood tests recommended by the US Preventive Services taskforce and other non-evasive tests as determined by the secretary.
2. Payment may be made for these tests performed for an asymptomatic individual only if the individual has not had the screening test paid for by Medicare during the preceding 59 months following the month in which the last cardiovascular tests were performed.

G. Diabetes Screening Tests. 42 CFR §410.18.
1. Diabetes screening tests covered for individuals with hypertension, dyslipidemia; obesity, defined as a body mass index greater than or equal to thirty (30) kg/m²; prior identification of impaired fasting glucose or glucose intolerance; any two of the following characteristics: overweight, defined as body mass index defined as body mass index greater than 25 but less than 30 kg/m², family history of diabetes, 65 years of age or older, history of gestational diabetes or delivery of a baby weight more than 9 pounds.
2. Available to individuals at risk for diabetes, covers two screening tests per calendar year for a patient with pre-diabetes, one screening test per year for patients previously tested who were not diagnosed with pre-diabetes or who were never tested before.
3. Test includes passing blood glucose; post-glucose challenges including but not limited to oral glucose tolerance with a glucose challenge for non-pregnant adults, two hour post glucose challenge test alone and other tests determined by the secretary.

H. Oncology Morass
1. ASP methodology (based on average manufacturer sale price); Medicare recognizes ASP plus 6%, as distinct from the old average wholesale price minus 15%.
2. New CPT codes for drug administration; infusion for hydration; non-chemotherapy therapeutic/diagnostic injections and infusions other than hydration; and chemotherapy administration other than hydration including infusion/injections.
3. Allowance made for multiple drugs administered in the same infusion episode.

4. Additional codes for management of nausea and vomiting, assessment for pain, and assessment for lack of energy (see Federal Register 66308, Nov. 15, 2004)

**Attachments:**

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<td>November 29, 2004</td>
<td>email from D. Shannon, re: Physician incident to physician</td>
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<tr>
<td>June 23, 2004</td>
<td>email from J. Sinsheimer, re: Stark Inconsistencies</td>
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<tr>
<td>June 22, 2004</td>
<td>email to CMS, re: Inconsistencies</td>
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<tr>
<td>June 22, 2004</td>
<td>email from D. Shannon, re: incident to memo to D. Shannon, re: Diagnostic test billed according to therules of the benefit with attached clarification letter</td>
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<tr>
<td>June 11, 2004</td>
<td>letter to T. Kay, re: “incident to” and diagnostic testing</td>
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<td>May 27, 2004</td>
<td>email from B. Bailey, re: “incident to”</td>
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<td>email from D. Shannon, re: HGSA position on “incident to”</td>
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<td>letter from S. Phillips, re: incident to instruction for asplit/shared E/M visit was published</td>
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<td>Email from T.Kay re: “incident to” NPP</td>
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<td>May 31, 2002</td>
<td>letter to T. Kay, re: Incident to and Diagnostic testing</td>
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<td>letter from T. Kay, clarifying email 5/31/02 re: incident to level of supervision [Now disavowed]</td>
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<td>January 29, 2002</td>
<td>letter to T. Kay, re: physician numbers on claims and incident-toservice</td>
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<td>January 22, 2003</td>
<td>Email from C. Scally re: consultations within groups</td>
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<td>January 21, 2003</td>
<td>letter from T. Kay, re: Transmittal 1776</td>
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<td>January 3, 2002</td>
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<td>May 29, 2002</td>
<td>letter from T. Kay, re: NPs/PAs during global period</td>
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<tr>
<td>August 24, 1999</td>
<td>letter from T. Kay, re: Evaluation and Management documentation guidelines</td>
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<td>August 9, 1999</td>
<td>letter from T. Kay, re: Current Procedural Terminology codes by nurse practitioners to bill Medicare</td>
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<tr>
<td>July 7, 1999</td>
<td>letter from T. Kay, re: Policy clarification on the correct use of guidelines by staff employed in a physician practice</td>
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The information here is presented as a service to readers. It is not intended as legal advice.
have attempted to provide information which is up to date, but rules often change. No one should rely on this information alone and should obtain current, informed legal guidance with regard to the issues contained herein. The author makes no representations, nor guarantees regarding the contents of the information contained herein.

Subj: Re: Physician Incident To Physician
I am sorry to say that I have been forced to report that our “incident to” rules do allow one physician to provide services incident to another. Many people are as incredulous as you are. Since we recognize that there are many other policies besides the “incident to” policies that may make this a bad practice, I have added the caveat that we do not encourage this practice and we believe that anyone who engages in it should consult other experts as to the legality, ethics, and other Medicare policies that might make this a bad practice. Certainly, it raises the question of the qualification of the person performing the service, and the responsibility of the supervising physician. Also, it does not change the definition of an INCIDENTAL service. So a physician cannot perform services that are not incidental and have another physician bill them incident to their own service. The physician (same as anyone) must be qualified to provide the service, although one would hope that anyone with an MD would be at least as qualified as the other office staff.

However, as to the “incident to” provisions, alone, the final rule in Nov 1, 2001 pg 55267 says “Response: We have not further clarified who may serve as auxiliary personnel for a particular incident to service because the scope of practice of the auxiliary personnel and the supervising physician (or other practitioner) is determined by state law. We deliberately used the term any individual so that the physician (or other practitioner) under his or her discretion and license, may use the service of anyone ranging from another physician to a medical assistant…”

I still think this is a bad idea, but it’s in the rule.

Dorothy -- Happy Thanksgiving! It has come to my attention from one of my clients that there is a belief circulating in the industry that you have opined that a physician can render services ‘incident to’ another physician. I was incredulous, but there are so many changes taking place in long-standing CMS policy that perhaps this is true. Please confirm or deny whether one physician can provide services ‘incident to’ another physician.

If it is possible for this to occur, please provide me with the analysis as to what makes it legitimate; also please confirm that this approach could be used by a physician who has not yet received a Medicare UPIN number but is licensed to practice as a physician. Also, please confirm that this approach does not implicate the Medicare reassignment rules, since a physician rendering services ‘incident to’ another physician would be invisible on the claim form. If this is legitimate, do all the other incident to rules pertain (e.g., another physician who is part of the reassignment account is on premises and immediately available to assist at all times that the ‘incident to’ physician is providing services)?

I will very much appreciate your response to this matter which was surprising to me. Please let me know if this inquiry raises questions for you.

Alice

Subj: Re: Inconsistency?
First, do not mistake this note for anything but my personal interpretation. I never speak for the Agency and my musings are never to be considered legal advice.

The point of the paragraph to which you refer is that incident to services are not to be considered as services personally performed by a physician. The paragraph was first published in the January 4, 2001 physician self-referral final rule (Phase I) at the time that Terry Kay believed that diagnostic tests could be billed as incident to services. His position changed in the FY 2003 physician fee schedule but in preparing the March 26, 2004 physician self-referral final rule (Phase II) we failed to update the paragraph in accordance with Terry's newer policy. This issue has been brought to our intention and we intend to deal with it in the next physician self-referral final rule.

TO CMS Folks:
This dialogue on incident to has been far clearer than everything I have read in the Federal Register to date. However, one of the lawyers who has been privy to our inquiries and your answers offers the following observations:

In looking over the Stark Phase II regs, I note the following on page 16135 regarding the definition of “physician services”:

(3) All other “incident to” services (for example, diagnostic tests, physical therapy) are outside the scope of paragraph (a) of this section. How do these statements square with the recent dialogue?

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Alice

Subj: Re: Further on Incident To

Attached is our response to your recent inquiries concerning diagnostic tests billed incident to a physician's service. If you need further assistance, please contact me or the experts referenced in the response.

Great. I am happy to talk to whomever about whatever if it will help the dialogue. I appreciate your response.

Alice

TO: Alice Gosfield

FROM: Dorothy Shannon


Terry Kay has moved to OCSQ and asked me to clarify our position on the billing of diagnostic tests and services incident to a physician. I have reviewed all of your recent correspondence on the subject including Terry’s letters of May 29, 2002 and May 31, 2002. I have separated your concerns into several categories:

BASIS OF DIAGNOSTIC TEST POLICY

Program policy is that diagnostic tests have their own benefit and, therefore, must be billed according to the rules of that benefit. The policy stated in §1861(s)(2)(A) provides a benefit for services incident to a physician's service. The statute goes on to list other, separately identifiable benefits. There are benefits, specifically mentioned in statute, that may also be billed incident to a physician.

CMS interprets this as a clear indication that Congress intended the services with their own benefits to follow the rules of that benefit and services without their own benefit to follow the incident to rules, unless an exception is made. It is stated simply in 42 CFR 410.26(a)(7) that “Medicare Part B pays for services and supplies incident to the services of a physician (or other practitioner)... ‘Services and supplies means any services and supplies, (including drugs or biologicals that are not usually self-administered) that are included in §1861(s)(2)(A) of the Act and are not specifically listed in the Act as a separate benefit included in the Medicare program.”

Diagnostic tests are listed as a separate benefit in §1861(s)(3) and, they are not included in the exceptions noted below. Therefore, they must be billed following the rules applicable to diagnostic tests, found in Pub 100-02 Chapter 15, Section 80. The level of supervision, for example, is guided by the requirement for each diagnostic test. Each test has its own supervision requirement, which may be direct supervision or it may be more or less stringent. The expert on diagnostic tests is Roberta Epps (Repps1@cms.hhs.gov).

EXCEPTIONS

There are two exceptions to the rule that services with their own benefit must be billed according to the rules of that benefit. These exceptions are statutory and they have no affect on the policy concerning diagnostic tests. In 1862(a)(20), Congress indicates that rehabilitation therapy services, which have their own benefits, may be furnished incident to a physician's service. Also, the BBA added language that allows nurse practitioners, clinical nurse specialists and physician's assistants, who have their own benefit, to have their services billed incident to a physician's service, as reflected in 1861(s)(2). Only those two types of services, therapy and non-physician practitioner services, may be provided and billed according to the rules of either their own benefit or incident to a physician by following the most stringent rules of each benefit. These are referred to specifically in the last paragraph of the Federal Register of December 31, 2002 page 79994. That paragraph does not apply to diagnostic tests or to any other service with its own benefit except those two types of services that are specifically mentioned. All other services with benefits are billed according to the rules of the benefit.

DRUGS

Some drugs are covered under their own benefit. Those drugs are not paid as incident to a physician's service and, in fact, are excluded by the “incident to” rules for drugs and biologicals because they are usually self-administered. For example, these include the benefits in
1861(s)(2)(I) and (J) for blood clotting factors and immunosuppressive drugs. In contrast, drugs and biologicals that are not usually self-administered may be covered incident to the service of a physician, if all other coverage criteria are met. Please refer specific questions concerning drugs billed under their own benefit to Angela Mason (410-786-7452).

**BENEFIT CATEGORY**

You note that there is no list of the services that have their own benefit. That information is available in the statute at §1861(s) and generally repeated in the regulations. If you have questions about which services have their own benefits, please contact the Medicare contractor who manages the claim.

**GLOBAL BILLING**

Some diagnostic tests appropriately utilize the services of auxiliary personnel in the physician's office. If the physician's staff provides the technical component of the service, the physician would bill that portion of the service. If the physician provides the professional component of the service as well as the technical component furnished by a staff member, the global charge may be billed.

**MANUALS**

If you care to suggest additional language consistent with our policy in Pub.100-02, Chapter 15, Section 80, we would be happy to consider it.

**Subj:** Re: Further on Incident To

Your question has been referred to Glen Kendal for his input on billing. I will add this: Each of the tests requires some level of supervision. It may be general, direct or personal. The paper claim form only states the physician performed or supervised the service, and not what level of supervision was provided. For example, if it is a test that requires general supervision, the physician's signature would certify that general supervision was provided. If the physician did not provide supervision appropriate for the test, he should not bill for the test. Please address your diagnostic test questions to Roberta Epps.

Thank you for your clarifications regarding CMS's position on these issue. I am still confused by the following:

“GLOBAL BILLING Some diagnostic tests appropriately utilize the services of auxiliary personnel in the physician's office. If the physician's staff provides the technical component of the service, the physician would bill that portion of the service. If the physician provides the professional component of the service as well as the technical component furnished by a staff member, the global charge may be billed.”

Under this analysis when a physician bills globally for a diagnostic test, including the technical component of the service rendered in his office, for him to sign the CMS 1500 certifying that he rendered the service himself or the services were incident to his services. There are no other options. To certify he rendered the services himself would not be accurate when that component is performed by his ancillary personnel. It seems to me that the only rule available to allow this global billing (as recognized on the form itself) when the physician did not perform the service himself is the incident to rules. The rules are fairly binary on this point, it has always seemed to me. Either the physician did it himself, the service is provided by someone who has his/her own number and are billed that way or the services are incident to the physician. I remain confounded by how a physician bills globally and the significance of his certification on the claim form.

Thank you for your further assistance on this point.

Alice

Re: Further on Incident To

I have no trouble with the levels of supervision and the memo that lays them out by CPT code was a wonderful advance in the state of the art. I guess I am trying to square these interpretations with what has been the traditional understanding on these issues. I am unclear on what changed in the law that resulted in the changed interpretations but I am beginning to perceive that it emanated in part from the addition of additional benefit categories. If anyone has any additional insight on what the focus on this now I'd appreciate understanding that as well.

Alice

Mr. Terrence L. Kay Centers for Medicare and Medicaid Services Center for Medicare Management Purchasing Policy Group Division of Practitioner & Ambulatory Care

RE: Incident to Services and Diagnostic Testing

Dear Terry,

In follow-up to our several e-mails, I am attaching for you the prior written guidance which you provided in your correspondence of May 29, 2002. Since I remain somewhat confused about the
implications of your answer, I provided you with the follow-up e-mail of May 31st, copy enclosed of Bob Ulikowski's reply.  
I draw your attention to the language at 66 Federal Register 55268 (November 1, 2001) in which it is stated absolutely explicitly

“maintain at a separately and independently listed service can be furnished as an incident to service but is not required to be furnished as an incident to service. Further, even if a separately and independently listed service is provided as an incident to service, the specific requirements of that separately and independently listed service must be met. For instance, a diagnostic test under §1861(s)(3) may be furnished as an incident to service.”

The further clarification on December 31, 2002 at 67 Federal Register 7994 states that services having their own statutory benefit category are covered under that category rather than as incident to services. However, “in addition, they are not required to meet incident to implementing instructions, such as those in §2050. . . For example, diagnostic tests are covered under §1861(s)(3) of the Act and are subject to the requirements for diagnostic tests in MCM §2070.”

Further, in the same column on the Federal Register, CMS stated explicitly “we maintain that a separately and independently listed service can be furnished as an incident to service but is not required to be furnished as an incident to service.” This is directly contrary to Dorothy Shannon's statement with respect to a diagnostic test never being permitted to be billed as an incident to service.

There were statements in the preface to the register on December 31, 2002 which state explicitly to the supervision requirements, but does not preclude billing diagnostic tests as incident to services. Taken together, it is my belief that your own prefatory language states explicitly the recognition that diagnostic tests may be billed but are not required to be billed incident to service.

I will appreciate your additional clarification by e-mail or otherwise in response to this correspondence. Thank you for your assistance.

Subj: incident to and diagnostic testing

Terry -- I am contacting you because I have been contacted by other attorneys working in the field who know of the correspondence between us regarding the level of supervision which is relevant for diagnostic testing which is billed 'incident to'. You sent me a letter confirming that it is the level which otherwise pertains to that testing when billed as its own benefit (whether general or personal) and when I sought further clarification and confirmation. Bob Ulikowski confirmed this is an email. I have written articles which include references to these clarifications.

Because of my sharing this information, I have been contacted by someone who read one of my articles, because this individual, who has shared emails from your staff to him, has been told by Dorothy Shannon “a diagnostic test can never be billed as an incident to service.” This is an email of 4-38-2004 to Bryan Bailey (BSB@gknet.com).

As you know, I pointed out some time ago, the prefatory language says clearly that diagnostic tests may be billed as incident to if so desired. This is particularly important for Stark purposes. I am indeed concerned about this apparent contradiction, given both my spoken and written positions on point in follow up to what I thought was very clear guidance to me from both you and Mr. Ulikowski.

Can you clarify and confirm your earlier position? May thanks.

Alice

Subj: Fwd: Re: Incident to question Ms. Gosfield:

In your June 2003 article, “Diagnostic Testing and Medicare: How to Get Paid Without Getting in Trouble,” you indicate that diagnostic tests can be billed as incident to services. However, Dorothy Shannon and Roberta Epps from CMS have informed me that diagnostic tests cannot be billed incident to since diagnostic tests have a separate and independent benefit category under the SSA.

Attached is my email correspondence with them regarding this issue. As explained in the attached email to them, I believe this is contrary to CMS’ comments in the 2001 and 2003 final rules implementing the Physician Fee Schedule.

If Ms. Shannon and Ms. Epps are correct, this likely will change how many of my physician clients bill for diagnostic tests and may limit substantially how physician groups can pay profit shares and productivity bonuses under the in-office ancillary services exception to the Stark Law. Furthermore, this would require physician groups who provide and interpret diagnostic tests to
split bill the tests' technical and professional components, which seems absurd.

I would greatly appreciate any insight you can provide on this issue. Thank you very much.

Bryan Bailey

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Subject: Re: Incident to question Ms. Shannon:

I don't want to be argumentative, but I believe your comments are taken out of context. For example, I don't believe the last paragraph in the middle column on 79994 is exclusive to PT, OT and SLP services. Rather, I believe this paragraph states that since section 4541(b) of the BBA allows PT, OT and SLP services to be provided as incident to services, then all services with their own benefit category can be billed as incident to services; provided, the services satisfy their own requirements and the incident to requirements. This was expressly stated in the 2001 Final Rule and restated in the 2003 Final Rule:

"We maintain that a separately and independently listed service can be furnished as an incident to service but is not required to be furnished as an incident to service. Furthermore, even if a separately and independently listed service is provided as an incident to service, the specific requirements of that separately and independently listed service must be met. For instance, a diagnostic test under section 1861(s)(3) of the Act may be furnished as an incident to service. Nevertheless, it must also meet the requirements of the diagnostic test benefit set forth in [section] 410.32. " See 67 FR 79994, first column, last paragraph.

If what you're saying is that a diagnostic test cannot be billed as an incident to service if the test only satisfies the incident to requirements, then I agree. However, if you're saying that a diagnostic test cannot be billed as an incident to service if the test satisfies both the incident to and the diagnostic test requirements, then I disagree. This would be directly contrary to the language cited above and the rule you cite below - i.e., “Diagnostic tests may be furnished under situations that meet the incident to requirements but this is not required.” Thanks again for clarifying this issue.

Bryan

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The rule does not state that diagnostic tests may be provided incident to a physician. In fact, the rule states that “only services that do not have their own benefit category are appropriately billed as incident to a physician service. Examples of benefit categories are diagnostic x-ray tests. . . “

The next paragraph concerns PT, OT and SLP services exclusively. It does not apply to diagnostic tests. There are statutory references to PT, OT and SLP services incident to a physician. There is no statutory or regulatory reference that allows diagnostic tests to be provided incident to a physician.

As we explained in the Dec. 31, 2002 reg on Page 79994 in the middle column, we believe that the Congress intended for services with their own benefit to be provided under the rules of that benefit and not incident to a physician. Diagnostic tests have their own benefit. They may not be billed incident to a physician's service.

Ms. Shannon and Ms. Epps:

Thank you for your response to my inquiry; however, your response appears contrary to commentary in the preamble to the final rule to the 2003 (and 2001) Physician Fee Schedule, which states that diagnostic tests can be billed incident to if both the incident to and the diagnostic test requirements are satisfied. See 67 FR 79965, 79994-95.

The preamble states:

“However, since section 4541(b) of the BBA allows certain services with their own benefit category . . . to also be provided as incident to services, we cannot prohibit physicians and practitioners from billing these services as incident to. However, when these services are billed as incident to, requirements in Medicare Carriers Manual section 2050 must also be met.”

Moreover, the rules your cite below state: “Diagnostic tests may be furnished under situations that meet the incident to requirements but this is not required.”
In light of these comments, please reconfirm that a physician cannot bill diagnostic tests incident to if the physician satisfies the incident to and diagnostic test requirements. It would be odd that a physician could not bill a diagnostic test incident to, since this would require the physician to split bill the professional and technical components.

Bryan Bailey

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A diagnostic test can never be billed as an incident to service. Since diagnostic tests have their own benefit, they follow their own rules for diagnostic tests. Roberta Epps is our expert in the area. The rules are in pub 100-02 Ch 15 Sec 80.


Ms. Shannon:

Can you confirm whether diagnostic tests can be billed as incident to services if all of the incident to requirements are satisfied? For example, if a diagnostic test requires “general supervision,” can the service be billed incident to if all of the other incident to requirements are satisfied?

Similarly, if a diagnostic test requires and the physician provides “personal supervision,” can the test be billed incident to if all of the other incident to requirements are satisfied? Any help you can provide would be appreciated. Thanks.

Bryan Bailey

Subj: Re: HGSA position on “incident to”

So, as I understand this answer, you confirm what I have said about incident to billing and RNs. They aren't NPPs and can't use that provision. As to the physician directed clinic answer, your reply is at variance with specific guidance Terry provided some time ago in response to a letter I wrote on January 29, 2002. He advised me that there was at that time no specific instructions to carriers regarding using the supervising physician's number versus the number of the treating physician. This information acknowledges that the services be definition are incident to the treating physician and the 1500 makes it clear that the services have to be supervised or provided in accordance with the incident to rules by the billing physician. The reason using the supervising physician's number makes no sense are several:

If five physicians are in the clinic treating patients on the day the incident to services are being performed who is the supervising physician?

If the physician on premises is of a decidedly different specialty (e.g., an orthopedist is having office hours under the physician directed clinic rules) while the nurses are doing follow up visits with the diabetics, or the echos are being performed on the cardiology patients, billing under his number will create utilization anomalies that are inappropriate he is treating the patient and the patient's services aren't by definition incident to his.

These are not inconsequential problems and HGSA is saying stuff that doesn't even jibe with the answers Ms Shannon provides in her email.

Thanks for the follow up. Feel free to be in touch further in I can clarify these thoughts. I'm attaching the letter I sent in January. If there has been specific carrier guidance of the type Terry indicated to me, please provide that with respect to the supervising physician's number.

Alice

Subj: Re: Fwd: HGSA position on “incident to”

The following information applies to the questions in this e-mail and a follow-up concerning incident to supervision.

1. If a service is provided by the physician's staff as a service incident to the physician, all the rules for incident to services must be met. Those are found in Pub 100-02 Ch 15 Sec 60 (specifically 60.1) The physician not only needs to be present in the suite for the entire time the service is rendered, but the service must be one that is incidental to a service initially performed by the physician and part of that physician's plan for the care of the patient. The services provided by a nurse cannot be billed if a physician is not present (IN THE OFFICE SUITE--the physician is not required to be in the same room with the staff and patient), or if the physician has never provided an initial service and ordered the incidental service as part of that care. A service cannot be billed by a physician if the service has nothing to do with the service for which the physician initially saw the patient.

Incident to rules, including supervision, apply when a 99211 E&M service is rendered. The 99211 service may not be billed by a physician for a service that was performed when the physician (or a supervising member of the same physician group) was not in the office suite at the time of the
service.

If a NPP performs a service while the physician is present in the suite, the physician may bill for the service of the NPP if that service meets the other rules for incident to (e.g., is a service related and incident to the ordering physician's initial service). In the case of an E&M service performed by the NPP under physician direct supervision, the physician may bill any level of E&M service that appropriately describes the level of the service performed. The same is not true of E&M services provided by nurses or other auxiliary staff; these may only be billed as 99211 services regardless of the service delivered. Only the services of NPPs who are eligible for a Medicare PIN may be billed at levels above 99211.

In a group setting (as per the FR Volume 66 November 1, 2001, page 55267) the ordering and supervising physician do not have to be the same physician. However, the claim should be submitted under the PIN of physician who provided the incident to supervision. Technically, the service is still incident to the ordering physician who provided the initial service, but it is billed by the supervising physician member of the same practice.

On the electronic claim form there is a place to enter both the referring and the supervising physician.

Terry I am hoping you can clarify immediately the attached inquiry sent by an auditing and consulting firm with which we do a fair amount of business. The attached FAQs posted by HGSA on their website fly in the face of everything I have ever known about ‘incident to’ billing. This is one of the many reasons I think CMS needs to put a stop to carriers interpreting national policy on incident to in any way. Please clarify the matters at hand and confirm my long standing understanding of appropriate billing for the following two issues:

1. If an RN sees a patient and the physician does not see a patient for a 99211, to bill the service as incident to any physician, there must be a physician member of the practice on premises throughout the time the service is being performed. To do otherwise would be a most liberal application of the rules, but is contrary to basic incident to policies.

2. When the physician is part of a group, under the very long standing physician directed clinic rules, the physician who is supervising for incident to purposes need not be the treating physician, regardless of what type of service (e.g., E/M) is being provided incident to the treating physician. The answers indicated below are at variance with these very long standing policy understandings. Thank you in advance for your attention or that of someone else in your department to this issue.

   Apparently there are very disquieted physicians around the state, since HGSA representatives have been reporting their interpretation as above at training programs on NPP billing in the physician practice.

   As always, let me know if my inquiry is unclear. Many thanks for your assistance.

   Alice

Dear Ms. Gosfield:

This is in response to your letter to Terry Kay requesting clarification on the status of “incident to” payment policy since the instruction for a split/shared evaluation and management (E/M) visit was published October 25, 2002 and implemented. There is no change to the long-standing “incident to” payment policy for E/M services.

Medicare provides coverage for services (and supplies) furnished “incident to” professional services of a physician when provided in a physician's office. All the requirements for “incident to” must be met. These requirements are in the Medicare Carrier's Manual paper based manual at section 2050.1, 2050.2 and 2050.3, Part 3 Claims Processing and also in the internet only manual (IOM), in manual 100-02, chapter 15, sections 60.1, 60.2 and 60.3.

The E/M visit is reported as if the physician had personally rendered it. If a medically necessary service is provided by the physician's ancillary employee (e.g., RN, LPN, medical assistant) the physician may only report CPT code 99211 when all the “incident to” requirements are met. Typical services that may be provided by ancillary staff could include activities such as documenting portions of the patient's history, wound dressings, taking vital signs, administering a B12 injection, etc.

During your recent telephone conversation with Kit Scally discussing these policies, you presented a scenario where an experienced RN inspects and examines a patient's wounds. The physician does not examine the wound but reviews the RN's documentation and provides his/her medical decision and treatment plan based on the RN's documentation. In this scenario the physician should appropriately report CPT code 99211 and not a higher level of service. An RN, no matter how experienced or qualified, is not permitted to perform and be paid for physician services in Medicare. The components of an E/M service, which include a history (other than the review of systems and past/family/social history), an examination and medical decision-making, must be performed personally by the physician or non-physician practitioner in order to support the level of service billed.

I hope this information is helpful to you. Thank you for your interest in the Medicare program.
Dear Ms. Gosfield,

Thank you for your letter concerning “incident to” billing in a physician-directed clinic. Terry Kay has asked me to respond to you. You pose two specific questions:

1. May nurse practitioners perform the on-premises, within the office suite supervision function for incident-to billing consistent with the physician-directed rules when the services are incident-to another nurse practitioner (in the same group practice)?

NPs are authorized by law as part of their professional services benefit to have services performed as an incident to their professional services. Services performed incident to the professional services of a NP must meet all of the “incident to” requirements. Accordingly, NPs can provide the direct supervision as required under the “incident to” benefit for services furnished incident to the professional services of another NP in the same group practice.

Payments for services furnished incident to the NP's professional services may be paid either to the NP or to the clinic to which the NP assigns payment at a rate of 85% of the physician fee schedule.

2. May a physician who otherwise meets the physician-directed clinic requirement provide the requisite supervision for services being provided incident-to a nurse practitioner?

I am not sure which “physician-directed clinic” requirement you are referring to, however, a physician could not provide direct supervision of services furnished incident to the professional services of a NP. The NP or an NP under the same group practice would have to provide personally, the requisite direct supervision.

If you have further questions concerning the role of nurse practitioners, please contact Regina Walker-Wren. For questions about services provided incident to a physician or nurse practitioner, please contact Dorothy Shannon.

Subject: Incident to and Diagnostic Testing

Terry -- Many thanks for your recent answer on global surgery. It confirmed my analysis and was very helpful. In addition I think thanks are in order as well for your letter which is responding (I presume) to my concluding question in my correspondence pertaining to diagnostic testing billed as incident to. In the preface to the fee schedule for 2002 there is a discussion which states that the level of supervision for diagnostic services is stated in the diagnostic services policy. The manual incorporates that and includes a sentence which says because the diagnostic tests benefit set forth in §1861(s)(3) of the Act is separate and distinct from the incident to benefit set forth in §1861(s)(2) of the Act, diagnostic tests need not meet the incident to requirements of §2050 of the manual. Diagnostic tests may be furnished under situations that meet the incident to requirements. However, the carriers must not scrutinize claims for diagnostic tests utilizing the incident to requirements.

The 2002 Preface goes on to say that diagnostic tests may be billed incident to, as they always have been. I read your letter to confirm that even when billed incident to the level of supervision which applies to a diagnostic test is the 2070 level. Is that right?

Thanks.

Alice

Subject: Your email on diagnostic tests and incident to.

Yes.

Dear Ms. Gosfield:

I am responding to your inquiry concerning “incident to” services and diagnostic tests.

We are working with other affected CMS components on the matter of which individual physician's PIN within a physician group must be used as the supervising physician's PIN on a claim. You may contact Bob Ulikowski at (410) 786-5721 for status of this effort.

With regard to diagnostic tests, regulations at 42 CFR 410.26(a)(7) state that “incident to”services means services not having their own separate statutory benefit category. MCM2070
clearly states that diagnostic tests are covered under their own benefit category and are subject to the supervision requirements in section 2070, and are not subject to the “incident to” requirements in section 2050.

Sincerely,

Terrence L. Kay
Director
Division of Practitioner and Ambulatory Care
Purchasing Policy Group
Center for Medicare Management
Centers for Medicare and Medicaid Services
(Formerly known as the Health Care Financing Administration)

Mr. Terrence L. Kay
Director, Division of Practitioner and Ambulatory Care
Center for Health Plans and Providers
Center for Medicare and Medicaid Services

Re: Physician Numbers on Claims and Incident-to Services

Dear Terry,

I am writing to you with regard to a significant conundrum which has been created by the recent publication in the 2002 fee schedule regulations regarding appropriate billing for services where the physician who is supervising incident-to services is not the physician to whom the services are incidental. This is particularly problematic in the physician directed clinic context. You may be aware of the fact that I have had some conversations with Paul Kim pertaining to these matters, but the issues have not been resolved.

To me, the physician directed clinic rules make it perfectly clear, and have for many years, that the physician under whose name a claim is submitted as incident-to his services need not be the physician supervising the service. In fact, the specific language pertaining to incident-to makes it clear that these services are an “integral although incidental part of the physician's personal professional service to the patient.” Since the inception of the Medicare program, and certainly as of the mid 1970's I believe, this methodology pertaining to incident-to services has been in effect. Because the services of ancillary personnel are incident-to, and must be incident-to a course of treatment by a specific treating physician, that physician's number is the number that traditionally should be listed on the claim form. I do not understand how ancillary services can be billed under the number of a physician in the physician-directed clinic who has no involvement in the care of the patient.

With the 2002 Fee Schedule, there is a major change in the analysis with regard to diagnostic services. I take issue with both the analytical construct, as well as the practical implications of the position set forth in the Federal Register. Still further, the discussion that appeared in the Federal Register is insufficient to address the practicalities of compliance with it.

The elimination of the requirement of an employment relationship between the ancillary clinical personnel and the claiming practice is a good movement towards a modern approach to dealing with these issues. However, the following statement is extremely troublesome:

“When a claim is submitted to Medicare under the billing number of a physician (or other practitioner) for an incident-to service, the physician is stating that he or she either performed the service or directly supervised the auxiliary personnel performing the service. Accordingly, the Medicare billing number of the ordering physician (or other practitioner) should not be used if that person did not directly supervise the auxiliary personnel.” (66 Federal Register 55267, November 1, 2001)

The dilemma here is that in the physician directed clinic context, the physician who is on premises functioning as the supervising physician for these purposes is not necessarily the physician to whom the incident-to services are incidental. When the treating physician certifies on the HCFA-1500 Claim Form that the services were done by him or under his direct supervision, the definition of incident-to services is such that the ancillary personnel are invisible on the claim form since they are part of his services. Therefore, the treating physician has the right to say that the services were performed by him, when they were in fact performed by ancillary personnel incident-to him, and, therefore, by definition an integral part of his services. The ancillary personnel have always, throughout the history of the program, been invisible on the claim form.

The dilemma that the new claiming requirement creates is that in a multi-specialty group practice, the physician who is on premises as part of a physician directed clinic, performing the supervision that meets the standards for incident-to services, may not have had any relationship with the patient whatsoever. There is nothing in the rules that requires an on-going relationship between the supervising physician and the patient. In fact, a physician supervising must be performing other medical services. As a result, in a multi-specialty group practice, you may have a situation, for example, in which a dermatologist is managing a dermatology clinic on Wednesday afternoon. He is on premises and immediately available to assist during the time that echocardiograms are being performed on a cardiologist's patient. As I understand the rules, as now modified by the Fee Schedule, he would be submitting claims for echocardiograms. Obviously, a dermatologist does
Taken together, I have clients who need specific direction on the following issues as soon as you can provide it:

1. In the physician directed clinic context, which physician's number is to be included on the claim form as the supervising physician when multiple physicians are on premises, and none of them is the treating physician? This is relevant to more than diagnostic testing, which seems to completely subvert that basic understanding.

A related problem is raised by the interpretation of the diagnostic testing rules in the context of incident-to. Although Mr. Kim and I have discussed the fact that the preface to the regulations sets forth that diagnostic testing is seen as a separate benefit from physician services, it would be my interpretation that the diagnostic testing benefit is one that exists so that free standing laboratories, independent diagnostic testing facilities (formerly independent physiology laboratories), free standing imaging centers and the like can submit claims to the Medicare program. I suspect if I researched the legislative history, it could be demonstrated that the diagnostic testing benefit is not to permit physicians to be paid for these services which they have no problem with independent diagnostic testing facilities being subject to physician supervision. The dermatologist's supervision would, in every other respect, meet the standards of a physician directed clinic.

In evaluating these issues, it should be noted that for many, many years in Medicare there has been an exception to the incident-to rules that pertains to physician billing for skeletal films and abdominal films without the use of contrast media. These have always been billed as incident-to services, but subject to an exception which provides for "general supervision". As is stated in the Federal Register, now these services can be billed as incident-to but need not be, although the level of supervision in Transmittal B-01-28 of April 19, 2001 is the relevant statement as to the level of supervision that must be provided. In fact, prior to the issuance in the Fee Schedule of the diagnostic testing discussion, there have been a number of instances in which incident-to services have had different levels of supervision required, for example, the exception for homebound patients for thirteen covered services, the exception for sleep disorder clinics, and the longstanding exception for skeletal films and abdominal films without the use of contrast media. All have been paid for as incident-to services with varying degrees of supervision. Still further, other incident-to services have historically had higher levels of supervision required, as in the old standards for cardiac rehab which required that the physician be in the exercise area. My point in all of this is that the tortured analysis that all diagnostic testing under the Fee Schedule is under incident-to services, but subject to an exception which provides for "general supervision" contains inappropriately driving and also skewing the incident-to analysis. I believe for anything other than testing, the services are incident to the treating physician. For diagnostic testing (meeting the B-
01-98 level of supervision), they are incident-to and should be billed by the interpreting physician.

2. Are physician practices to split bill the technical component and the professional component when they are supervised by a different physician from the interpreting physician but performed on the same day?

3. A related question would turn on which number is to be used when a physician practice bills technical component only for a service (which could only be provided if it were incident-to the treating physician), but the supervising physician is not the ordering physician, and an interpreting physician outside the practice is billing for that service. My guidance to my clients for the last twenty-five (25) years has been that this service should be billed under the number of the treating physician to whom the services are incidental by definition, and not the supervising physician. I am aware that some carriers in local medical review policy have taken contrary positions, but for all of the reasons indicated above, it is my belief that their analysis is inconsistent with the long standing history of the program, and even the logic of what incident-to services are about.

Finally, I applaud the position you have repeatedly taken that interpretation of incident-to rules ought not be subject to local medical review policy. There is no policy reason whatever to allow such variation in a national insurance program. I would encourage you to mandate a prohibition on such variation. This extremely important problem is one which I have tried to set forth in a manner that will facilitate your understanding as to why it is so significant. I would welcome the opportunity to discuss this matter as soon as possible so that we can come to an appropriate resolution for my clients and others. Thank you in advance for your assistance. I look forward to talking with you.

Sincerely yours,
Alice G. Gosfield

Ms. Gosfield,

This response is in reply to your letter to Terry Kay asking for clarification on consultations to the same patient provided by physicians of the same specialty in the same office practice on the same day.

Physician specialty is the self-designated primary specialty under which the physician bills Medicare and is known to the carrier. Carriers, generally, do not know or track the sub-specialty designations that physicians may possess. When claims are processed, the review is primarily computer driven. Therefore, claims for the same patient with the same diagnosis, on the same day by physicians having the same specialty from the same group or another group will likely be denied. On appeal, the carrier will conduct a medical review of the claims and make a determination regarding the concurrent care.

It is correct that Medicare will pay for a consultation if one physician in a group practice requests a consultation from another physician in the same group practice as long as all of the requirements for use of the CPT consultation codes are met and the service is medically necessary.

In deciding if services are reasonable and medically necessary, Medicare payment policy states that the carrier should consider the specialties of the physicians as well as the patient's diagnosis(es) on the assumption that concurrent care is usually (although not always) initiated because of the existence of more than one medical condition requiring diverse specialized medical or surgical services. It provides further that the patient's condition and the reasonableness and medical necessity of the particular services must also be considered. The carrier must determine from the medical record documentation if the services of additional physicians are duplicative and not medically necessary to treat the patient and if payment should be made only for the services provided by the first physician. All services provided must be medically necessary and not duplicative.

You ask if both a consultation and an E/M visit performed on the same day by physicians in the same group, even though they are in the same overall specialty but different sub-specialties would be paid. The answer is yes if the service is determined by the carrier to be medically necessary and not duplicative.

Your second question asks if two E/M services for unrelated problems performed on the same day by physicians in the same group practice, even though they are in the same overall specialty but different sub-specialties would be paid. The answer is yes if the service is determined by the carrier to be medically necessary and not duplicative.

I hope this information is helpful. Thank you for your interest in the Medicare program.

Kit Scally

Dear Ms. Gosfield:

This is in response to your letter requesting clarification on employment relationships in relation to payment policy for a split/shared evaluation and management (E/M) visit between a physician and a non-physician practitioner (NPP) or between two physicians in the same group practice. This policy was published October 25, 2002 as Transmittal 1776.
For a split/shared E/M service performed in the hospital inpatient setting, hospital outpatient setting or hospital emergency department setting the service may be billed under either the physician's or the NPP's UPIN/PIN if the physician performs any face-to-face portion of an E/M encounter (i.e., history, physician exam or medical decision making in whole or part). A social salutation alone does not constitute a face-to-face portion or “physician work” of an E/M service. Only one E/M service may be billed and the level of service is determined from the joint work for the split/shared service. The documentation from each provider (physician/NPP) must be documented and support the level of service billed.

The physician and the NPP must be in the same group practice or be employed by the same employer. A physician cannot bill for a split/shared visit or any other services provided by an NPP who is not in his/her group practice or employed by the same employer. You provided six employee scenarios/involving various employment relationships. However, the split/shared E/M service payment policy does not alter any existing Medicare employee relationship policies. When there is doubt concerning specific group practice business arrangements rather than addressing hypothetical situations we advise providers to check with their local carrier to obtain guidance. The carrier is more familiar with local business arrangements, group practices, State laws and regulations to enable the carrier to make an appropriate determination.

I hope this clarifies your employment concerns. Thank you for your interest in the Medicare program.

Sincerely,
Terrence L. Kay
Director
Division of Practitioner Services
Hospital and Ambulatory Payment Group
Center for Medicare Management
Centers for Medicare & Medicaid Services

Dear Ms. Gosfield:
I am writing in response to your letter of June 10, 2002 to Robert Ulikowski of my staff in which you were seeking clarification on CMS's policy on the diagnostic testing supervision rules as they would apply to CPT code 93015 (cardiovascular stress test with physician supervision, interpretation and report). Specifically, you request confirmation that a physician assistant (PA) or nurse practitioner (NP) may perform such a test without on-site physician presence, although the CPT description has a physician supervision component. You believe that this is consistent with the CMS reimbursement principle that a PA or NP may be reimbursed for any service which would be covered and paid for if performed by a physician, provided the service is within the PA or NP state scope of practice.

When a PA, NP or clinical nurse specialist (CNS) who meets the applicable Medicare requirements performs diagnostic tests (including CPT code 93015), these tests may be paid under their respective Part B professional service benefits, in which case the supervision requirements associated with their professional services benefits apply, rather than the physician supervision requirements outlined in, section 2070 of the Medicare Carriers Manual. Accordingly, when a PA performs a diagnostic test, the general physician supervision requirement under the PA benefit applies. When a NP or CNS furnishes a diagnostic test, the physician collaboration requirement under the NP and CNS benefits apply. These nonphysician practitioners must be authorized/licensed under their State scope of practice laws to perform the diagnostic test billed and the test must be billed under the nonphysician practitioners billing provider number (PIN).

Sincerely,
Terrence L. Kay
Director
Division of Practitioner and Ambulatory Care
Purchasing Policy Group
Center for Medicare Management
Center for Medicare and Medicaid Services

Dear Ms. Gosfield:
I am responding to your inquiry concerning the Medicare physician fee schedule global surgery policy.

The purpose of the global fee policy is to pay the surgeon one global fee that includes all the pre-, intra-, and post-operative service usually associated with the surgery. When the surgical services are provided by a group, different physicians within the group may participate in the patient care, with the group being paid the global fee (MCM 4822A.2.). Since PAs and NPs are allowed to perform any physicians' services under Medicare that are within the scope of their state license, there is no prohibition against their participating in the patient care. How the group decides to apportion the patient care usually associated with a particular surgical procedure among the group members is entirely up to the group.
There are no specific requirements as to the number of visits, their type and duration, and whether a discharge summary is needed in the global fee policy. The relative values for global surgery are based on the “typical” services provided. We recognize that variations in practices exist. These are questions of medical necessity left to the physician. We only require that if a physician intends to furnish less than the global surgical package (e.g., only the pre- and intra-operative services) that the physician indicate this on the claim by the use of a modifier (e.g., -54).

Sincerely,

Terrence L. Kay
Director
Division of Practitioner and Ambulatory Care
Plan and Provider Purchasing Group
Center for Medicare Management
Centers for Medicare and Medicaid Services
(Formerly the Health Care Financing Administration)

Dear Ms. Gosfield:

This is in response to your inquiry to address further the issue of “scribing” a note in the medical record. At this point, there is little more we can add to our previous letter. As stated in the Evaluation and Management (E/M) documentation guidelines, the history (review of systems and/or past, family, and social history) may be recorded by ancillary staff or completed by a patient. The physician, who is performing the E/M service must review this information and include a note in the medical record supplementing or confirming the information recorded by other staff. The physician, who performs the physical examination (PE) and furnishes the medical decision making (MDM), is responsible for documenting the PB and MDM in the medical record. I hope this clarifies your concerns.

Sincerely,

Terrence L. Kay
Director
Division of Practitioner and Ambulatory Care
Plan and Provider Purchasing Policy Group
Center for Health Plans and Providers

Dear Ms. Buppert:

This is to respond to your letter regarding the use of office visit Current Procedural Terminology (CPT) codes by nurse practitioners (NPs) to bill Medicare.

As you correctly noted, the Health Care Financing Administration (HCFA) has neither proposed a rule nor distributed a program memorandum or transmittal concerning the use of the high-level evaluation and management (E/M) codes by nurse practitioners. However, HCFA is certainly concerned about the proper use of E/M codes by all physician specialties and non-physician practitioners. All E/M services billed must be medically necessary. As you may know, HCFA has been involved in the development of improved E/M documentation guidelines for a number of years. Therefore, I invite you to submit to HCFA specific examples and other information concerning the use of high-level E/M codes by NPs that you believe would be helpful in further developing E/M guidelines.

I do not believe that either you or Ms. Alice Gosfield has advised your respective clients incorrectly regarding Medicare billing. It appears that the differences in the advice may merely constitute differences in style of legal practice and not differences in interpretation of the rules and policies. Nevertheless, with no existing pertinent rule or policy in the meantime, I believe Ms. Gosfield presents a practical approach in her recent letter discussing these issues. I hope that this addresses your concerns.

Sincerely,

Terrence L. Kay
Director
Division of Practitioner and Ambulatory Care
Plan and Provider Purchasing Policy Group
Center for Health Plans and Providers

Dear Ms. Gosfield:

This is in response to your letter asking for policy clarification on the correct use of documentation guidelines by staff employed in a physician practice (e.g., nurse practitioner and other ancillary personnel).

It is important to state that the teaching physician policy and the incident to policy are two distinct payment policies and do not substitute for each other. The Medicare teaching physician policy has always been restricted to the physician and a resident in the care of his/her patient. Residents do not serve solely as “scribes” although there is no prohibition. We are not opposed to the use of any personnel as “scribes” if the meaning of the term is “one who enters information in the
You are correct that the documentation guidelines do permit ancillary staff and/or the patient to complete a history and review of systems questionnaire.

Staff employed by the physician who provide “incident to” services outside of the hospital setting and who do not meet the criteria as a nurse practitioner, physician assistant, clinical nurse specialist or nurse midwife may act as a scribe. In this instance the physician must write a note supplementing or confirming the information recorded in this manner.

Other staff employed by a physician who meet the criteria as a nurse practitioner, physician assistant, clinical nurse specialist or nurse midwife who provide services incident to the physician (assuming the rules for “incident to” are met) can also act as a scribe and may, of course, perform physician services that fall within the scope of professional license in the State in which they practice. In this “incident to” situation it is the physician who bills the appropriate level of CPT code for the evaluation and management service provided by the staff member. The physician assumes the responsibility for what his employee has performed. It is not a requirement that the physician review what they perform at that time, repeat the key components of the encounter nor write a confirmatory statement.

As stated earlier, the teaching physician rules govern the resident/physician situation only.

Sincerely,
Terrence L. Kay
Director
Division of Practitioner and Ambulatory Care
Plan and Provider Purchasing Group
Center for Health Plans and Providers

Dear Ms. Gosfield:
This is in response to your letters and faxed requests about coding for diagnostic services. The issue you have raised is under discussion among HCFA Staff.

For diagnostic services requiring a physician interpretation, the physician submitting the bill should report the diagnosis code which most accurately describes the condition found as a result of the test. This is easiest when the condition found as a result of the radiologic exam or the pulmonary function test or the pathology involving the physician interpretive or consultative service is one for which there is a definitive diagnosis code. The second diagnosis code listed should be the one submitted by the requesting physician. In the absence of a definitive diagnosis code, it would be appropriate to code the reason provided by the referring physician for requesting/ordering the test.

This coding advice is the one currently operative in HCFA. This should by no means be considered to be the ‘final’ position, however. As I mentioned above, this matter is still very much under discussion.

Sincerely,
Terrence L. Kay
Director
Division of Practitioner and Ambulatory Care
Plan and Provider Purchasing Policy Group
Center for Health Plans and Providers

Dear Ms. Gosfield:
I am responding to your letter of July 1, 1998, which set forth several questions related to the coverage of consultations and diagnostic tests furnished by physician assistants (PAs). With regard to consultations, PAs may perform them, if medically necessary, under the general supervision of a physician as a practitioner service or under the direct supervision of a physician employer as an “incident to” service.

Under the policy adopted in the physician fee schedule final rule of October 31, 1997, diagnostic tests payable under the physician fee schedule, with certain exceptions listed in the regulation, have to be performed under the supervision of an individual meeting the definition of a “physician” in section 1861(r) of the Social Security Act in order to be considered reasonable and necessary and, therefore, covered under Medicare. During the comment period of the proposal to modify 42 CFR 410.32, Congress passed the BBA. Section 4511 of the BBA removed the restrictions on the areas and settings in which physician services furnished by PAs may be paid under the physician fee schedule, but HCFA made no changes in the final rule on physician supervision of diagnostic tests to take these legislative changes into account. We have now reviewed all aspects of this matter and determined that both the physician supervision regulation and the regulation on independent diagnostic testing facilities (IDTFs) (42 CFR 405.33) need to be modified to take into account the BBA changes. We are considering to propose these changes for public comment in the physician fee schedule proposed rule which will be published in the spring of 1999 to indicate that only general physician supervision is required for diagnostic tests performed by PAs when they are authorized by the State to perform such tests.
Dear Ms. Gosfield:

This is in response to your inquiries pertaining to nurse practitioners and physician assistants employed by a physician practice. Specifically you ask:

1. Can a physician be reimbursed for both instances when either a nurse practitioner (NP) or a physician assistant (PA) employed by the physician makes rounds to a patient in the hospital and the physician visits the same patient on the same day in the hospital? If the patient develops an additional problem during the day and the physician returns to see the patient, after the NP or PA has seen the patient, can both these visits be paid?

   As stated in the Medicare Carrier's Manual (MCM), Section 15505 (B), the inpatient hospital visit descriptors contain the phrase “per day” which means that the code and the payment established for the code represent all services provided on that date. Physicians may not report two hospital visits on the same day to the same patient. Likewise, as stated in MCM Section 15505 (C), if the patient is seen by one physician at some point in the day and a second physician who is covering for that physician visits the patient at another time in that day, Medicare will not pay for the second physician visit. This also applies to the NP/PA practitioner since if the services they are providing are considered physician services they can theoretically perform them if it is consistent with and within their scope of practice as determined by the individual State licensure agencies.

   However, “incident to” services must still be provided by employees of the physician under the physician's direct supervision. Those services continue to be paid for under the physician fee schedule as though physicians personally performed them. Services provided “incident to” physicians’ services to hospital patients continue to be payable only to the hospital through the hospital benefit. No separate Medicare carrier payment is made to physicians for those services.

2. You state that when two physicians practice in this manner the group practice may for example upgrade the total charge to a level 3 visit after a level 2 visit has been provided. You question if this may apply to the NP and PA scenario?

   As stated in the MCM Section 15505 (B) the physician should select a code that reflects all services provided during the date of the service. Given that the Balanced Budget Act of 1997 increases the payment for PAs, NPs and CNSs to 85 percent of the physician fee schedule amount your proposal to permit a NP or PA encounter to be paid at the same amount of a physician encounter during the same day implies essentially allowing “incident to” in the hospital setting. This is contrary to current Medicare policy.

I hope this clarifies the issues you have raised.

Sincerely,
Terrence L. Kay
Director
Division of Practitioner and Ambulatory Care
Plan and Provider Purchasing Policy Group
Center for Health Plans and Providers

Dear Ms. Gosfield:

This is in response to your inquiry regarding counseling services. You ask that when more than 50 percent of the evaluation and management (E&M) service is counseling or coordination of care, can a licensed practitioner who provides these services, incident to the physician services, bill for that level of E&M code (which allows that amount of counseling time)?

As stated in the Medicare Carrier's Manual, §15501.C, the time spent counseling a patient is used in determining the level of E&M code. However, this face-to-face time refers to the time between the physician and patient. Counseling as an incident to a physician's service is not considered part of the face-to-face physician/patient encounter. Time spent by a limited licensed practitioner is not considered when selecting the appropriate E&M code. The code selected depends on the physician service provided. Of course, nonphysician time would be used for selecting the appropriate E&M code if the nonphysician were direct billing under his/her own benefit (e.g., physician assistants in certain situations).

I hope this clarifies the issue for you. Thank you for your interest in the Medicare program.

Sincerely,
Terrence L. Kay
Director