PUBLICATION

'Incident To' Personnel and Credentials: CMS's New Teeth to Address an Old Problem [Ober|Kaler]

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Medicare's "incident to" provision found at 42 U.S.C. § 1395x(s)(2)(A) addresses coverage of services and supplies furnished "incident to a physician's professional service," principally in a physician's office or clinic. Similarly, 42 U.S.C. § 1395x(s)(2)(B) addresses hospital outpatient services – mainly services of a therapeutic nature – that are furnished "incident to a physicians' services." Implementing these provisions, the Medicare regulations at 42 C.F.R. §§ 410.26 and 410.27 authorize payment for services furnished by auxiliary personnel under the supervision of physicians in the office, clinic and hospital outpatient settings.

Although the Medicare rules authorize payment for "incident to" services, those rules have not always been specific about the credentials that auxiliary "incident to" personnel must hold. Rather, CMS has generally deferred to the states and to the individual facilities themselves to make this determination. This has left open the question of what happens if the auxiliary personnel fail to comply with state law because, for example, the person in question lacks the education, experience or other credentials necessary under state law to perform certain types of services or because state law requires the individual be licensed and that license has lapsed. Certainly, such a failure could lead to state sanctions, but from the perspective of Medicare, the failure to comply with state credentialing and licensing requirements has been, at most, a violation of the Medicare conditions of participation. As a condition violation, such a failure required corrective action going forward, but had no overpayment ramifications.

In 2009, the Office of the Inspector General at HHS issued a report addressing instances in which Medicare "incident to" services were furnished by auxiliary personnel who lacked the requisite licenses or certifications. The OIG recommended to CMS that it revise its "incident to" rules to address the shortcoming. Now, in the December 10, 2013 Federal Register, CMS has taken this step, in both the physician fee schedule rule, 78 Fed. Reg. 74,230, 74,410-74,411, and the hospital outpatient rule, 78 Fed. Reg. 74,826, 75,058-75,061.

In both rules, CMS clarified that effective January 1, 2014, Medicare's payment for "incident to" services is conditioned on the services being furnished in accordance with state law. CMS's action thus transforms what had been, at most, a condition of participation into a payment condition.

The impact of this payment condition is potentially far reaching. As its Federal Register statements show, CMS has been concerned about situations in which services are provided by auxiliary personnel who are out of compliance with state law when providing the service or even "part" or an "aspect" of that service. *See* 78 Fed. Reg. at 74,411, col. 1 (Physician Fee Schedule Rule); 78 Fed. Reg. at 75,058, col. 3 (Hospital Outpatient Rule). Given this concern and CMS's response, it seems possible that payment for a "full" service might be denied even when the "incident to" personnel who is out of compliance with state law is furnishing only a small part of that service. This could be particularly problematic in the context of hospital outpatient PPS, which is employing increased use of packaging to bring more services and supplies within individual APCs.

So, for example, one could have, in an extreme case, a registered nurse who prior to an outpatient surgery takes a patient's vital signs and assists the patient in preparing for that surgery. That nurse may have allowed her license to lapse the week before. Does this mean that the whole APC payment for the outpatient surgery is

subject to being denied? If one reads the preamble to the regulation, this seems to be a definite possibility. One might argue under these circumstances that the scope of the penalty greatly exceeds the nature of the alleged infraction and that, at most, only a portion of the payment should be denied. But given the lack of clarity in the rules regarding the scope of a payment disallowance, it will be incumbent upon providers and their counsel in these extreme cases to work with the Medicare contractors to seek a result that is more equitable than a “full service disallowance.”

Ober|Kaler's Comments

Plainly, oversight by physicians, clinics and hospitals of the credentials and licenses of auxiliary personnel has always been important. Medicare, however, has now raised the stakes, making it a condition of payment that auxiliary personnel be fully licensed and credentialed if they deliver or assist in delivering the service being billed. Physicians, clinics, and hospitals would be well advised to take extra steps now to ensure that all auxiliary personnel are acting within the scope of state law and that their credentials are up to date. Even a single infraction, as discussed above, could have significant financial consequences.