The Health Insurance for the Aged and Disabled Act (title XVIII of the Social Security Act), known as "Medicare," is ubiquitous in the healthcare industry and has been since its inception in 1965. While the healthcare industry evolves, so too does Medicare. An area of the healthcare industry receiving particular attention is the shortage of primary care physicians and the growth of nonphysician practitioners ("NPPs"). As such, Medicare, and specifically Medicare billing policies, has evolved to address the growing involvement of NPPs and their prominence in the healthcare industry. This article gives an overview of NPPs and Medicare coverage and billing requirements affecting NPPs through a discussion of NPPs and Medicare generally, followed by a detailed discussion of qualifications, coverage criteria, billing and payment for Medicare services furnished by NPPs, “incident to” coverage under the Medicare statute, and concludes with a discussion of notable state and federal healthcare laws affecting NPPs.

I. Preliminary Considerations

Nonphysician Practitioners – Overview

The term “nonphysician practitioner” or “NPP” is fluid, often applied to many different disciplines. The Center for Medicare and Medicaid Services (“CMS”), a branch of the United States Department of Health and Human Services charged with administering Medicare, uses the term NPP to reference a wide range of disciplines. General references to NPPs include all nonphysician disciplines contemplated by CMS, however specific discussions of qualifications and billing requirements in this article are limited to the following disciplines: Physician Assistants (“PAs”), Nurse Practitioner (“NPs”), Certified Registered Nurse Anesthetists (“CRNAs”), and Certified Nurse Midwives (“CNMs”).

Please note that the practice scope of each NPP is defined by the law of the jurisdiction in which the NPP practices. This article is not state-specific and contains general descriptions of qualifications and requirements of each practice. Each general description contained herein should be confirmed for a particular jurisdiction.

Growth of NPPs. According to a study on the health profession workforce by the United States Government Accountability Office, NPPs are the fastest growing segment of the primary healthcare

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1 NPPs are sometimes referred to as “physician extenders,” “midlevel providers,” or simply, “midlevels.” We note that some disciplines oppose the use of such terminology as it could be construed as questioning the legitimacy of such NPPs as independently licensed practitioners within their scopes of practice. Such terminology is further opposed as vague and inaccurately used for a wide range of professions. Recognizing the controversy of collectively referring to various disciplines as one collective group, we use the term NPP in this article for convenience.
workforce.\textsuperscript{2} As an example, in the past decade, primary care physicians experienced an average per capita increase of 1\%, compared to a 4\% increase in PAs and a 9\% increase in NPs.\textsuperscript{3}

Furthermore, the current cost of healthcare is high and rising. NPPs can help lower the cost of healthcare, while improving access and providing quality healthcare to many. NPPs are also more likely to provide healthcare services to the traditionally underserved regions, such as rural areas, and attend to minority patients and uninsured patients.\textsuperscript{4} With an aging population, increased access to affordable healthcare is paramount, and as a result, NPPs have grown significantly. The healthcare industry will continue to evolve, and the increase in NPPs will likely continue with it.

**The Role of NPPs**

NPPs are increasingly important in America’s healthcare industry and carry a wide range of responsibilities. The following is a brief summary of the general roles occupied by each discipline.

*Physician Assistants.* Upon graduation from an accredited PA educational program and meeting other licensing requirements, PAs are licensed to practice medicine under the supervision of a physician. PAs examine patients, diagnose and treat illnesses, prescribe medicines, perform procedures, assist in surgery, and counsel patients.

*Nurse Practitioners.* NPs are Registered Nurses who have Master’s degree in nursing and meet other requirements. NPs provide primary and preventive care, prescribe medicines, and treat common minor illnesses and injuries.

*Certified Registered Nurse Anesthetists.* CRNAs are Registered Nurses who have a Master's degree in nursing and meet other requirements. CRNAs provide anesthesia while working with other healthcare professionals.

*Certified Nurse Midwives.* CNMs are Registered Nurses who have a Master's degree in nursing and meet other requirements. CNMs may practice in hospitals and medical clinics. They may also deliver babies in birthing centers and attend home births.

The specific qualifications, licensing and billing requirements for each of the above referenced NPPs is discussed in detail below.

**Medicare Billing – Overview**


\textsuperscript{3} *Id.*; Swartz, Mark, Health Care Reform and the Primary Care Workforce Bottleneck. J GEN INTERN MED April 2012 available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3304030/.

\textsuperscript{4} Grumbach, K., Who is Caring for the Underserved? A Comparison of Primary Care Physicians and Nonphysician Clinicians in California and Washington. ANNALS OF FAMILY MEDICINE, July/August 2003 available at http://annfammed.org/content/1/2/97.full.
CMS has issued manuals to assist healthcare providers with properly billing the Medicare program for services rendered. An increasingly complex set of rules and regulations, the Medicare billing policies have become an area of significant attention as the demand for NPPs has grown and continues to grow.

In 1992, Medicare introduced the Medicare Fee Schedule, a list of about 7,000 billable services. Most physician and NPP services are paid according to the Medicare Physician Fee Schedule, receiving a predetermined percentage of the value of the services. Under this payment scheme, “participating” healthcare providers take “assignment,” meaning such providers accept Medicare’s approved rate of the services as payment in full.5 In accordance with the Health Insurance Portability and Accountability Act (“HIPAA”), CMS issues a National Provider Identifier (“NPI”) to healthcare providers, including NPPs, through which Medicare billing must occur. The NPI is a unique identifier, but does not carry any information about the provider such as the state in which they practice or their medical specialty.

An NPP who requests payment from Medicare for services rendered must meet the Medicare requirements to qualify as a provider in that specialty.

II. Qualifications, Coverage Criteria, Billing, and Payment for Medicare Services Furnished by NPPs

Physician Assistants

As described by the American Academy of Physician Assistants, a PA is a state-licensed medical professional who is authorized to practice medicine under the direction and supervision of a physician.6 Although PAs do not possess authority to practice medicine independently from a physician-delegation agreement or beyond the auspices of a supervising physician, PAs are highly trained and qualified to make clinical decisions and provide a range of diagnostic, therapeutic, preventative, and health maintenance services.7 PA services are most commonly delivered within a primary care setting; however, a PA’s clinical role can be within either a primary or specialty care setting and may include both medical and surgical care services.8 This section provides a summary of: (1) the general qualifications for becoming a PA; (2) the Medicare coverage criteria for services provided by PAs; (3) the process for billing Medicare for services performed by a PA; and (4) Medicare’s payment methodology for covered PA services.

Qualifications. In order for a PA’s services to be covered under Medicare, a PA must first satisfy each of the following conditions (1) have graduated from a physician assistant educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs; or (2) have passed the national certification examination that is administered by the National Commission on

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8 Id.
Certification of Physician Assistants; and (3) be licensed by the State to practice as a physician assistant. 9

Coverage Criteria. The scope of a PA’s authorized services is principally a function of the law of the state in which a PA is licensed to deliver healthcare services. It was not until January 1, 1998 that a PA’s medically reasonable and necessary professional services first became eligible for coverage under the Medicare Program, subject to the following conditions:

(1) The services are of a type that classify as “physician’s services” if such services were furnished by a doctor of medicine or osteopathy;

(2) The services are performed by a person who meets all of the PA educational, certification and licensure qualifications described within 42 C.F.R. § 410.74(c);

(3) The services are performed under the general supervision of a physician - although a supervising physician must be immediately available to the PA for consultation, unless otherwise required by State law, a supervising physician need not be physically present when a PA performs services;

(4) The PA is legally authorized to perform the services in the State in which such services are performed; and

(5) The services are not otherwise precluded from Medicare coverage pursuant to any statutory exclusion. 10

Similar to the coverage of other NPPs, Medicare also covers certain services and supplies that are delivered “incident to” the services of a PA, so long as the requirements of 42 C.F.R. § 410.26 are satisfied. 11 A detailed description of “incident to” services is provided within Section III herein.

Billing. Although a PA must have his or her own NPI, a PA is not permitted to collect directly from Medicare for his or her services, which is distinguished from the authorized billing practices of other NPPs. A PA’s services may only be billed by a PA’s employer or contractor, provided that such employer or contractor uses the PA’s NPI for identification purposes when billing for a PA’s services. 12 Because payment for a PA’s services may only be made to an actual qualified employer of a PA or to a provider/supplier for whom a PA furnishes services as an independent contractor, an employment and/or

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9 42 C.F.R. § 410.74(c).
11 78 Fed. Reg. 74,230, 74,811 (Dec. 10, 2013) (effective January 27, 2014, 42 C.F.R. § 410.74(b) is amended to read as follows: “(b) Services and supplies furnished incident to a physician assistant’s services. Medicare Part B covers services and supplies incident to the services of a physician assistant if the requirements of §410.26 are met”).
independent contractor arrangement should be carefully structured to comply with all applicable state and federal laws, including Internal Revenue Service requirements.\textsuperscript{13}

Under Medicare guidelines, the employer or contractor of a PA can be either an individual or an organizational entity.\textsuperscript{14} In the case of an organizational employer or contractor, if such organization is properly formed as a legal entity (e.g., professional corporation or limited liability company) within a State that permits PAs to hold ownership interests in such an entity (e.g., as a stockholder or member), the entity is permitted to bill for PA services even if the PA is an owner or officer of the entity, provided that the entity is eligible to enroll as a provider or supplier in the Medicare program.\textsuperscript{15} Importantly, PAs “may not otherwise organize or incorporate and bill for their services directly to the Medicare program, including as, but not limited to sole proprietorships or general partnerships.”\textsuperscript{16} As such, a “qualified” employer or contractor would not include a group of PAs who desire to incorporate and bill for their services, nor would a leasing agency or staffing company qualify as a “provider” or “supplier” of services within the Medicare program.\textsuperscript{17}

\textit{Payment.} Similar to other Medicare-participating providers, claims and payment for a PA’s services may only be made on an assignment basis.\textsuperscript{18} As described above, payment for covered PA services may only be made to either the PA’s (a) qualified W-2 employer, or (b) 1099 independent contractor, assuming that such employer or contractor is eligible to enroll as a provider or supplier of services within the Medicare program.\textsuperscript{19} Under current Medicare guidelines, PA services are paid at eighty percent (80%) of the lesser of the actual charge, or eighty-five percent (85%) of what a physician is paid under the Medicare physician fee schedule.\textsuperscript{20}

Under federal law, a special and separate payment policy exists for services that a PA furnishes as an assistant-at-surgery.\textsuperscript{21} When a PA actively assists a physician in performing a surgical procedure and the PA delivers more than ancillary services, the PA’s services are eligible for payment as “assistant-at-surgery services.”\textsuperscript{22} While Medicare still pays for PA assistant-at-surgery services at the standard PA payment rate (80% of actual or 85% of Medicare physician fee schedule), because Medicare reimburses physicians who perform assistant-at-surgery services at 16% of the surgical payment amount under the Medicare physician fee schedule, the actual payment amount for assistant-at-surgery services performed by a PA is equal to 13.6% of the amount paid to a physician (\textit{i.e.}, 85% of the 16% payment amount).\textsuperscript{23}

\textbf{Nurse Practitioners}

\textsuperscript{13} See 42 C.F.R. § 410.150(b)(15).
\textsuperscript{14} Benefit Policy Manual, \textit{supra} note 10, at § 190.D.
\textsuperscript{15} \textit{Id}.
\textsuperscript{16} \textit{Id}.
\textsuperscript{17} \textit{Id}.
\textsuperscript{18} 42 C.F.R. § 410.74(d)(2).
\textsuperscript{19} See 42 C.F.R. § 410.150(b)(15).
\textsuperscript{21} \textit{Id}.
\textsuperscript{22} \textit{Id}.
\textsuperscript{23} \textit{Id}.
Since 1998, any NP participating under the Medicare program may have his or her services covered if he or she meets certain qualifications and is legally authorized to furnish NP services in the State where the services are performed. This section provides a summary of: (1) the general qualifications for becoming a NP; (2) the Medicare coverage criteria for services provided by NPs; (3) the process for billing Medicare for services performed by a NP; and (4) Medicare’s payment methodology for covered NP services.

**Qualifications.** An NP must be a registered professional nurse authorized to practice and perform NP services in accordance with State law in which the services are furnished. Additionally, an NP must satisfy one of the following: (1) for NPs that obtained Medicare billing privileges for the first time on or after January 1, 2003, be certified as an NP by a recognized national certifying body with established standards for NPs, and have a Master’s degree in nursing or a Doctor of Nursing Practice doctoral degree; (2) for NPs that obtained Medicare billing privileges for the first time before January 1, 2003, be certified as an NP by a recognized national certifying body with established standards for NPs; or (3) obtained Medicare billing privileges for the first time before January 1, 2001.

**Coverage Criteria.** For NP services to be covered by Medicare, the following criteria must be met. The services or supplies must be medically reasonable and necessary. Medically necessary services and supplies are proper and required for the diagnosis or treatment of the beneficiary’s medical condition. Additionally, medically necessary services must be furnished for the diagnosis, direct care, and treatment of the medical condition, meet the standards of good medical practice, and are not primarily for the convenience of the beneficiary, healthcare provider, or supplier.

To be covered by Medicare, NP services must be performed in collaboration with a physician. Collaboration occurs when an NP works with one or more physicians to deliver healthcare services within the scope of their professional expertise and direction and appropriate supervision is provided by the physician as required by the law of the State in which the services are furnished. Notably, the physician is generally not required to be present when the services are furnished or to independently evaluate the patients.

Additionally, an NP may provide assistant-at-surgery services and be selected as a hospice beneficiary’s attending physician, but an NP may not, in his or her capacity as a hospice beneficiary’s attending physician certify or recertify a terminal illness with a prognosis of six months or less. Furthermore, services and supplies may be furnished incident to the services and supplies of an NP. A detailed discussion of “incident to” services is below.

**Billing.** An NP may either bill the Medicare program directly for services using his or her NPI or have an employer or contractor bill using the NP’s NPI for reassignment payment. For services furnished incident to the professional services of a supervising physician, the supervising physician must bill

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25 MLN, supra note 12, at 6.
26 Id.
27 Id.
28 Id.
29 Id.
under his or her NPI for such “incident to” services. But an NP must bill under his or her NPI for services that are furnished incident to their own professional services.30

Payment. Payment of NP services billed to the Medicare program is made only on assignment basis. As mentioned earlier, “assignment” means that the provider or supplier will be paid the Medicare allowed amount as payment in full for his or her services and may not bill or collect from the beneficiary any amount other than unmet copayments, deductibles, and/or coinsurance.31 Payment may be made directly to an NP for their professional services when furnished in collaboration with a physician.32 Generally, NPs are paid for covered services at 80 percent of the lesser of the actual charge for the services or 85 percent of what a physician is paid under the Medicare Physician Fee Schedule.33 When services furnished to hospital inpatients and outpatients are billed directly by the NP, payment is unbundled and made to the NP.34

There is a separate payment policy for NPs furnishing assistant-at-surgery services. When an NP actively assists a physician in performing a surgical procedure and furnishes more than ancillary services, the NP’s services are eligible for payment at the NP assistant-at-surgery rate. Such assistant-at-surgery services are paid at 85 percent of 16 percent of what a physician is paid under the Medicare Physician Fee Schedule.35 Since physicians are paid at 16 percent of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that NPs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians.36

The outpatient mental health treatment limitation used to apply to payment for NP services. As of January 1, 2014, Medicare reimburses outpatient mental health treatment at parity with other Medicare Part B Services.37

Certified Registered Nurse Anesthetists

CRNAs may bill Medicare directly for their services or have payment made to an employer or an entity under which they have a contract.38 This section provides a summary of: (1) the general qualifications for becoming a CRNA; (2) the Medicare coverage criteria for services provided by CRNAs; (3) the process for billing Medicare for services performed by a CRNA; and (4) Medicare’s payment methodology for covered CRNA services.

Qualifications. A CRNA is a registered nurse who meets the licensure requirements imposed by the State in which the CRNA practices with respect to non-physician anesthetists. Generally, a CRNA is licensed by the State in which he or she practices and is currently certified by the Council on Certification of Nurse Anesthetists or has graduated within the past 18 months from a nurse anesthesia program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational

30 Id.
31 Id.
33 Id.
34 MLN, supra note 12, at 7.
35 Id.
37 MLN, supra note 12, at 7.
38 Claims Processing Manual, supra note 20.
Programs, or another accreditation organization designated by the Secretary of the Department of Health and Human Services, and is awaiting initial certification.39

Coverage Criteria. For CRNA services to be covered by Medicare, the following criteria must be met. The services or supplies must be medically reasonable and necessary. Medically necessary services and supplies are proper and required for the diagnosis or treatment of the beneficiary’s medical condition. Additionally, medically necessary services must be furnished for the diagnosis, direct care, and treatment of the medical condition, meet the standards of good medical practice, and are not primarily for the convenience of the beneficiary, healthcare provider, or supplier.40

To be covered by Medicare, CRNAs must be legally authorized and qualified to furnish the services in the State in which such services are performed.41

When general, regional, and monitored anesthesia is administered by a CRNA, it must be supervised by the operating practitioner performing the procedure or by an anesthesiologist who is immediately available if needed, unless the CRNA is located in a State that has opted out of the supervision requirements. An “immediately available” anesthesiologist is physically located within the same area as the CRNA and is not otherwise occupied in a way that prevents immediate hands-on intervention.42

Billing. A CRNA may bill the Medicare program either directly for services using his or her own NPI or under an employer’s or contractor’s NPI. For purposes of billing, anesthesia time means the time during which the CRNA is present with the patient. It begins when the CRNA begins to prepare the patient for anesthesia services and ends when the CRNA is no longer furnishing anesthesia services to the patient.43 Blocks of time may be added around an interruption in anesthesia time as long as continuous anesthesia care is furnished within the time periods around the interruption.44 Claim forms must include a certification that the CRNA services were medically directed or the CRNA services were not medically directed.45

If a physician furnishes concurrent medical services for a procedure involving CRNAs and the medical direction service is unassigned, the physician should bill on an assigned basis on a separate claim for the CRNA service. If the physician is participating or takes assignment, both the physician and CRNA services should be billed on one claim but as separate line items.46

Payment. Payment is made only on assignment basis according the fee schedule for CRNAs. Anesthesia services furnished by a CRNA are paid at the lesser of the actual charge, the Medicare Physician Fee Schedule or the CRNA Fee Schedule. The amount is further qualified by the statutorily determined conversion factors which are not discussed herein.47 Furthermore, payment procedures for anesthesia services performed by a teaching CRNA are not addressed herein.

40 MLN, supra note 12, at 4.
41 Id.
42 Id.
44 MLN, supra note 12, at 5.
45 Id.
46 Claims Processing Manual, supra note 20.
47 Id.
**Certified Nurse Midwives**

As of 1988, the services provided by a CNM or incident to the CNM’s services are covered by Medicare. In general, CNMs are registered nurses who have graduated from a nurse-midwifery education program that has been accredited by the Accreditation Commission for Midwifery Education (“ACME”) (formerly the American College of Nurse-Midwives Division of Accreditation) and have passed a national certification examination to receive the professional designation of certified nurse-midwife.48 Because CNMs are educated within the disciplines of both nursing and midwifery, the scope of practice for CNMs is broad, ranging from care before and during childbirth and throughout the postpartum period, to gynecological and family planning services, and even, under certain circumstances, extends to the care of newborns during the first 28 days of a child’s life.49 This section provides a summary of: (1) the general qualifications for becoming a CNM; (2) Medicare coverage criteria for services provided by CNMs; (3) the process for billing Medicare for services delivered by a CNM; and (4) Medicare’s payment methodology for authorized CNM services.

**Qualifications.** Medicare requires CNMs to meet specific qualifications prior to a CNM being eligible for reimbursement of services under the Medicare program. Specifically, pursuant to regulations promulgated by the Centers for Medicare and Medicaid Services (CMS), CNMs are required to demonstrate each of the following qualifications: (1) be a registered nurse who is legally authorized to practice as a nurse-midwife in the State where services are performed; (2) have successfully completed a program of study and clinical experience for nurse-midwives that is accredited by an accrediting body approved by the U.S. Department of Education; and (3) be certified as a nurse-midwife by the American College of Nurse-Midwives or the American College of Nurse-Midwives Certification Council.50

**Coverage Criteria.** As a general rule, only medically reasonable and necessary healthcare items and services are reimbursed by Medicare. In addition to this generally applied standard for Medicare-covered services, CMS has established particular guidelines governing the provision of services by specific provider types. On July 1, 1988, Medicare first determined that the services provided by a CNM or those services “incident to” a CNM’s services would be covered under the Medicare program.51 While the scope of covered services has changed over time, there are two primary coverage criteria for services rendered by a CNM. First, the services must be personally performed by a CNM and must be within the CNM’s scope of practice as authorized by the law of the state in which such services are furnished.52 Second, the services provided by a CNM, including both obstetrical and gynecological services, must qualify as “physician services” under Medicare guidelines if such services had been provided by a doctor of medicine or osteopathy.53 Medicare will also cover certain services and supplies

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50 42 C.F.R. § 410.77(a).
52 42 C.F.R. § 410.77(b)(1).
53 Id.; see also Benefit Policy Manual, supra note 10, at Chapt. 15, § 180.C.1.
that are delivered “incident to” the services of a CNM if the requirements of 42 C.F.R. § 410.26 are satisfied.54 A detailed description of “incident to” services is provided within Section III herein.

Unless otherwise required by state law, Medicare does not mandate that a CNM deliver healthcare services to patients under a physician’s supervision, oversight or collaboration.55 While the majority of states recognize licensed CNMs as “independent practitioners”, it is important for practitioners to review the specific supervision and collaboration requirements of each jurisdiction in which a CNM wishes to practice.

Finally, Medicare does not impose any limitations or restrictions related to the locations and types of facilities where CNM services may be performed. As such, a CNM’s services are covered regardless of the setting where such services are delivered, including, but not limited to, the CNM’s office, in the patient’s home, a healthcare clinic, birthing center, or in a hospital or other facility owned or operated by a CNM.56

Billing. Similar to other advanced practice nurses, a CNM is permitted to bill for the services he or she renders by either (a) billing the Medicare Program directly using the CNM’s National Provider Identifier (NPI), or (b) authorizing the CNM’s qualified employer or contractor to bill the Medicare Program for services using the CNM’s NPI to identify the CNM’s services and to demonstrate reassignment of payment.57 If a CNM authorizes an employer or contractor to bill for the services delivered by the CNM, such authorization should be memorialized under a valid and duly executed employment agreement or independent contractor arrangement.

Payment. As required for other Medicare-participating healthcare providers, a CNM and/or the CNM’s employer or contractor may only receive payment for Medicare covered services on an assignment basis.58 Payment for covered services may be made directly by Medicare to the CNM for the CNM’s professional services, and for services furnished incident to a CNM’s professional services.59 Although Medicare’s payment methodology for CNMs has been amended from time to time, as of January 1, 2011, payment for CNM services is currently made at eighty percent (80%) of the lesser of the actual charge, or one hundred percent (100%) of the physician fee schedule amount.60 Special payment considerations, which deviate from the physician fee schedule payment methodology, include:

(a) Covered drugs and biologicals furnished incident to CNM services are paid according to the Part B drug/biological payment methodology; and

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54 78 Fed. Reg. 74,230, 74,811 (Dec. 10, 2013) (effective January 27, 2014, 42 C.F.R. § 410.77(c) is amended to read as follows: “(c) Incident to services: Basic rule. Medicare Part B covers services and supplies incident to the services of a certified nurse-midwife if the requirements of §410.26 are met”).
55 42 C.F.R. § 410.77(b)(2).
56 Benefit Policy Manual, supra note 10, at Chapt. 15, § 180.F.
57 MLN, supra note 12, at 7.
58 42 C.F.R. § 410.77(d)(2). Assignment means that the CNM (a) will be paid the Medicare allowed amount as payment in full for his or her services; and (b) may not bill or collect from the beneficiary any amount other than unmet copayments, deductibles, and/or coinsurance. MLN, supra note 12, at 7.
59 Claims Processing Manual, supra note 20, at §130.1.
60 Id. Prior to 2011, CNM services were paid at eighty percent (80%) of the actual charge or sixty-five percent (65%) of the amount that a physician would be paid under the Medicare physician fee schedule. MLN, supra note 12, at 7.
(b) Covered clinical diagnostic lab services furnished by CNMs are paid according to the clinical diagnostic lab fee schedule.61

There is also a special payment calculation for services delivered by a CNM under an established global fee allowance (e.g., total obstetrical care).62 When a CNM provides most of the care that is part of a global service and a physician provides a portion of care for the same global service, the fee paid to the CNM for his or her care is calculated based on the portion of the global fee that would have been paid to the physician for the care provided by the CNM.63

III. “Incident To” Services and Billing

In addition to covering professional services of NPPs under the requirements set forth above, Medicare covers services and supplies when furnished “incident to” a physician’s or NPP’s services.64

Overview of “Incident To” Services

Medicare covers certain medical and other health services of physicians and NPPs when furnished “incident to” a physician’s or NPP’s services. The concept of “incident to physicians’ services” includes constantly-evolving criteria that are part of an increasingly complicated regulatory scheme.65 There is a dual regulatory scheme covering “incident to” services, with each such scheme being determined by the environment in which the services are rendered. Incident to services in a noninstitutional setting (i.e., in a physician’s office or clinic) are governed by 42 U.S.C. 1395x(s)(2)(A), while incident to services in a hospital outpatient settings are under 42 U.S.C. 1395x(s)(2)(B).

Noninstitutional “Incident To” Services. For purposes of “incident to” services, a “noninstitutional” setting is one other than a hospital or skilled nursing facility.66 Incident to services furnished in such noninstitutional settings are covered by Section 1395x(s)(2)(A), and services in a hospital inpatient or outpatient settings are not covered under this section and may not be billed as such. In order for services to be billed as “incident to” services under Section 1395x(s)(2)(A), the services must, in addition to occurring in a noninstitutional setting, be integral although incidental, involve the ongoing active participation and management of the treating physician or NPP (as the case may be), be of the type of services commonly furnished in a physician’s offices, be included in the physician’s bill, be an expense to the practice, and be under the direct supervision of the physician or NPP.67 Each of the criteria is discussed below:

61 Claims Processing Manual, supra note 20, at §130.1. Until recently, outpatient treatment services for mental illnesses furnished by a CNM were also subject to a variable outpatient mental health treatment limitation (e.g., in 2013, a reduction of 81.25% was applied to the Medicare physician fee schedule amount for outpatient mental health services). See 42 C.F.R. § 410.155(a) and MLN, supra note 12, at 7. However, on January 1, 2014, the outpatient mental health treatment limitation was eliminated, meaning that Medicare will now pay outpatient mental health services at the same rate as other Part B services. Id.
62 See Claims Processing Manual, supra note 20, at §130.2.
63 Id. An example calculating the global allowance payment for CNMs is provided within the Claims Processing Manual. See id.
64 42 U.S.C. §§ 1395k, 1395x(s)(2)(A), (B).
66 Benefit Policy Manual, supra note 10, at § 60.
• Noninstitutional setting: To be covered under Section 1395x(s)(2)(A), “incident to” services must be furnished in a noninstitutional setting. As discussed above, a noninstitutional setting is one other than a hospital or skilled nursing facility.

• Integral, although incidental: The services or supplies must be furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment.\(^68\) To satisfy this requirement, the services need not be furnished on the same day as the professional service by the physician or NPP, but rather can occur or continue on other dates for an extended period of time after the professional service.\(^69\)

• Ongoing active participation and management: The physician or NPP who furnished the professional service to which “incident to” services relate must be actively involved in the course of treatment, furnishing additional professional services with sufficient frequency.\(^70\) There are often questions regarding the frequency of professional services to satisfy this requirement. CMS has not provided any generally applicable guidelines regarding frequency, and such medical professionals generally default to seeing the patient at frequencies “consistent with appropriate medical practice in the management of the particular condition.”\(^71\)

• Commonly furnished in a physician’s office: According to CMS, Section 1395x(s)(2)(A) does not cover items or services “clearly of a type a physician is not expected to have on hand in his/her office or…of a type not considered medically appropriate to provide in the office setting.”\(^72\) Ultimately, whether this requirement is satisfied depends on a variety of factors including, among others, the specialty of the physician, the availability of the services elsewhere in a particular community, the complexity of the service, and medical risks associated with the service. As the healthcare industry evolves, so too will these factors continue to evolve. This requirement is limited, however, by CMS’s guidelines stating that “services having their own statutory benefit category are covered under that category rather than as incident to services.”\(^73\)

• Included in physician’s bill: Section 1395x(s)(2)(A) services must be billed by the physician, NPP, or the entity that bills for the professional service of such physician or NPP.\(^74\)

• Expense to the practice: Section 1395x(s)(2)(A) services must represent an expense to the physician or NPP’s practice or the entity billing for the physician or NPP services.\(^75\)

• Direct supervision: Direct supervision in an office setting means that the physician or NPP must be present in the office suite and immediately available to assist and direct through the procedure. However, the physician or NPP need not be in the room while the procedure is performed.\(^76\)

**Hospital Outpatient “Incident To” Services.** Section 1395x(s)(2)(B) of the Medicare statute provides coverage for particular types of services that can be furnished to hospital outpatients as “incident to” services. The following requirements must be satisfied for coverage as “incident to” services under Section 1395x(s)(2)(B):

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\(^{68}\) Benefit Policy Manual, *supra* note 10, at § 60.1.  
\(^{69}\) *Id.*  
\(^{70}\) *Id.*  
\(^{71}\) *Id.*  
\(^{72}\) *Blanchard supra* note 65.  
\(^{73}\) Benefit Policy Manual, *supra* note 10, at § 60.1.A.  
\(^{75}\) 42 U.S.C. § 1395x(s)(2)(A).  
\(^{76}\) 42 U.S.C. § 1395x(s)(2)(A).  
\(^{77}\) 42 C.F.R. § 410.26(b)(3)(ii).
• Direct supervision: Direct supervision in a hospital outpatient setting means that physician or NPP must be immediately available to furnish assistance and direction during the procedure. Direct supervision under Section 1395x(s)(2)(B) does not apply to “nonsurgical extended duration therapeutic services” for which a new, more flexible, regulatory scheme applies.77

• Integral, although incidental: The services or supplies must be furnished as an integral, although incidental, part of the physician’s or NPP’s services. While hospitals generally have rules for hospital department furnishing Section 1395x(s)(2)(B) services to assure all patients have an attending physician, problems are likely to arise in emergency departments when a patient leaves the hospital following triage but before seeing a physician. If a physician or NPP has not met face-to-face with the patient, there have not been any professional services to which the triage services could be incident.

Hospitals should note that CMS appears to be changing its interpretation regarding the coverage rules under Section 1395x(s)(2)(B), intending to subject all non-diagnostic services to the requirements of “incident to” services as applied in hospital outpatient settings.78

“Incident To” Services Furnished by NPPs. With a growth in the number of NPPs, and the evolution of practice by NPPs to an almost independent professional practice, it is important to distinguish services rendered by NPPs as part of their independent professional services versus those furnished “incident to” the professional services of a physician. Noninstitutional “incident to” services are paid at the full Medicare Physician Fee Schedule as opposed to the 85 percent rate payable for NPP professional services.79 While it may be financially beneficial for a practice to bill an NPP’s services under the higher “incident to” pay rate, because an NPP could, in most cases, have furnished the services independently, the requirements for “incident to” services become harder to satisfy.

Particularly problematic to billing an NPP’s services as “incident to” a physician’s professional services is the requirement that the services be integral, although incidental to the physician’s professional service. This requirement is only satisfied if the physician personally furnished a professional service during which the physician establishes a course of treatment that is to be carried out by an NPP on an “incident to” basis.80 Therefore, new patient visits cannot be performed by an NPP as “incident to” services.81 Furthermore, a physician must maintain responsibility for the management of the patient’s medical condition and furnish sufficient professional services to demonstrate continued participation in the case.82

Issues also arise in billing an NPP’s services as “incident to” a physician’s professional services when a patient raises a new issue with an NPP during the course of treatment. Assuming the NPP satisfied all other “incident to” requirements during the course of treatment, the patient’s act of raising a new chief complaint cannot be treated by the NPP as part of the course of treatment previously established by the physician. Because the physician has not seen the patient with regard to the new condition, all services in connection with such condition are categorically excluded from “incident to” services.83 The services furnished by the NPP will be covered by Medicare, assuming all applicable requirements and

77 The flexible rules applying to such exception are not discussed in this article.
78 See Blanchard, supra note 65.
79 See 42 C.F.R. §§ 405.520, 414.52, 414.56.
80 Benefit Policy Manual, supra note 10, at § 60.2. Id.
81 Id.
82 Id.
83 Id.
qualifications are met, but they will be covered as independent NPP services payable at the 85 percent fee rate, as opposed to “incident to” services payable according the full amount listed in the Medicare Physician Fee Schedule.\(^8^4\)

In the event of a shared or split visit between a physician and an NPP in a noninstitutional setting involving Evaluation and Management services (“\textit{E&M Services}”), an NPP may assist a physician and bill his or her services as “incident to” the physician’s services. In these instances, the NPP can perform part of the visit before the patient’s face-to-face encounter with the physician, and still bill the services as “incident to.” However, if any of the “incident to” requirements are not satisfied, the NPP will have to bill his or her services under his or her own NPI, and will be paid accordingly at the 85 percent rate. When a shared or split visit occurs in a hospital setting, the services are covered by Medicare, but are not considered “incident to” under the statute. In such hospital settings, the Medicare instructions allow the physician to bill for the complete service associated with the E&M Services even though the service is not covered as an “incident to” service.\(^8^5\)

\textit{Billing Generally.} As discussed above, assuming all “incident to” requirements are satisfied, an NPP’s services can be billed as “incident to” services at 100 percent of the Medicare Physician Fee Schedule. However, if an NPP cannot establish all requirements for “incident to” services, the NPP’s services will be considered independent and payable at 85 percent of the Medicare Physician Fee Schedule.

\section*{IV. Other Considerations}

The information included within this Section IV is intended to provide a general overview of certain notable state and federal healthcare laws and regulations that require special consideration relating non-physician practitioners (NPPs). Specifically, this Section IV introduces and briefly discusses the following areas of law: (A) Interstate Practice Issues; (B) Antitrust law; (C) the federal Stark Law and Anti-Kickback Statute; and (D) the federal False Claims Act.

\textbf{Interstate Practice}

In general, the scope of practice for all NPPs is governed by the laws of the state in which an NPP performs healthcare services. As such, prior to delivering patient care services within a particular state, an NPP must ensure that he or she satisfies the specific licensing requirements established by the jurisdiction in which the NPP’s services will be performed. However, as advancements in medical technology are made (\textit{e.g.}, telemedicine) and healthcare services become increasingly available to patients across state lines, state licensing boards continue to explore collaborative strategies for simplifying the process by which medical professionals can provide services within multiple jurisdictions.

In 1998, the National Council of State Boards of Nursing introduced model legislation for a “Nurse Licensure Compact” which would permit a nurse who is licensed within one compact/member state to practice nursing within any other compact/member state without the nurse being required to endure the

\footnotesize{\(^8^4\) Claims Processing Manual, supra note 20, at § 30.6.1. \(^8^5\) \textit{Id.}}
extensive licensure application processes for multiple states. Although, at present, there are 24 member states, unfortunately for NPPs trained within the field of nursing the Nurse Licensure Compact expressly excludes advance practice registered nurses (e.g., CRNAs, NPs, and CNMs) from the full benefits of such multi-state licensure.

Recently, similar to the Nursing Licensure Compact described above, the Federation of State Medical Boards has made significant progress toward the development of an “Interstate Medical Licensure Compact” intended to simplify a physician’s multi-state licensing experience. Specifically, under the Interstate Medical Licensure Company, participating state medical boards would “retain their licensing and disciplinary authority but would agree to share information and processes essential to the licensing and regulation of physicians who practice across state borders.” Despite the fact that the Interstate Medical Licensure Compact would not directly impact the licensure and practice of NPPs, if state medical boards were to authorize a streamlined multi-state licensure procedure, such process would set an influential precedent for establishing greater efficiencies related to multi-state licensure and the interstate practice of all NPPs.

Antitrust

Federal and state antitrust laws principally seek to promote and protect competition by prohibiting, among other things, agreements that unreasonably restrain trade. While antitrust laws broadly apply to most, if not all, industries, United States case law has specifically invoked antitrust principles relating to unreasonable restraints of trade against NPPs, including alleged unlawful boycotts and the exclusion of NPPs from certain patient care activities and opportunities.

Perhaps the most notable case at the intersection of antitrust law as applied to the practice of NPPs is the 1990 Seventh Circuit Court of Appeals case of Wilk v. American Med. Ass’n. In Wilk, the court found that the American Medical Association (AMA) had engaged in an unlawful national boycott of chiropractors when the AMA discouraged its physician members from dealing with chiropractors based upon its claim that chiropractic services were “unscientific” and harmful patients. The court ruled against the AMA primarily because the AMA failed to demonstrate that its blanket refusal to deal with chiropractors was “objectively reasonable”, particularly in light of evidence that showed chiropractic care was an effective form of healthcare treatment for certain patients and ailments. Further, the court noted that the AMA’s position was likely influenced somewhat by the economic interests of AMA physician-members related to the exclusion of chiropractors from patient care.

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87 Id. The list of member states and implementation dates for each member state can be found at: https://www.ncsbn.org/Implementation_dates_list.pdf.
90 Id.
92 See id.
93 Id.
In the more recent Eighth Circuit Court of Appeals case of Minnesota Ass’n of Nurse Anesthetists v. Unity Hosp., a group of nurse anesthetists challenged an exclusive contract arrangement entered into by and between a hospital and anesthesiology physician groups, whereby nurse anesthetists were no longer permitted to contract directly with the hospital to provide healthcare services. In this case, although the exclusive contract did restrain trade by excluding nurse anesthetists from direct contract opportunities with the hospital, the court ultimately ruled in favor of the hospital and the exclusive contract arrangement because the nurse anesthetists failed to demonstrate that the parties to the exclusive contract possessed sufficient market power to indicate that such restraint on trade was unreasonable or that the exclusive contract had actual detrimental effects on competition in the relevant market. The Unity Hospital case demonstrates that not all restraints on trade, even those which restrict practice opportunities for NPPs, are prohibited by law.

Stark Law and Anti-Kickback Statute

The Stark Law. The federal physician self-referral law (the “Stark Law”) expressly prohibits a physician from referring a Medicare or Medicaid beneficiary to an entity for the provision of designated health services if the physician (or an immediate family member) has a financial relationship with such entity, unless an exception applies. The Stark Law is directed at and applies exclusively to a “physician”, which is defined to include a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. In light of this definition, the Stark Law’s scope does not directly include NPPs.

Although the Stark Law is not generally implicated by an NPP’s independently billed services or referrals independently made by an NPP, CMS has stated that if a physician directs or controls the referral activity of an NPP, such referrals, though actually made by an NPP, may be attributed to the directing physician, which would implicate the Stark Law. If an NPP referral is made in violation of the Stark Law, not only would the NPP be subject to non-payment for his or her services pursuant to such referral, but the NPP could also face potential penalties under other federal or state healthcare laws, including, but not limited to the federal False Claims Act, for claims submitted to a federal healthcare program relating to services provided pursuant to a prohibited referral.

The Anti-Kickback Statute. Unlike the Stark Law, which specifically applies to physician referrals of designated health services, the federal Anti-Kickback Statute broadly applies to all persons, including physicians and NPPs. In particular, the Anti-Kickback Statute is a criminal statute that prohibits any person from knowingly and willfully offering, paying, soliciting, or receiving any remuneration (e.g., anything of value), directly or indirectly, in an effort to induce or reward the referral of items or services payable by any federal health care program. Each party to an arrangement that violates the Anti-Kickback Statute is subject to significant civil monetary penalties, possible exclusion from the Medicare

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94 See Minnesota Ass’n of Nurse Anesthetists v. Unity Hosp., 208 F.3d 655 (8th Cir. 2000).
95 See id.
96 42 U.S.C. § 1395nn(a).
97 42 U.S.C. § 1395x(r).
98 69 Fed. Reg. 16,054, 16,063-64 (Mar. 26, 2004) (Specifically, CMS stated its concern “that physicians could attempt to circumvent section 1877 of the Act by funneling referrals through nonphysician practitioners . . . the relevant inquiry is whether the physician has controlled or influenced the nonphysician’s referral such that the referral should properly be considered the physician’s referral”).
99 42 U.S.C. § 1320a-7b(b).
program, and potential criminal sanctions.\textsuperscript{100} Because the Anti-Kickback Statute directly applies to NPPs, any remuneration offered to, made or received by an NPP must be carefully examined to ensure that such payments do not violate federal or state anti-kickback provisions.

**False Claims Act**

The federal False Claims Act prohibits any individual or business from knowingly submitting, or causing another person or entity to submit, a false or fraudulent claim for payment to any government program, including Medicare.\textsuperscript{101} Although a violation of the False Claims Act requires that a person act “knowingly,” actual knowledge of the falsity of a claim is not required; rather, a violation may be found if a person simply acts “in reckless disregard” or “in deliberate ignorance” of the truth or falsity of the information submitted within the claim for payment.\textsuperscript{102} A breach of the False Claims Act can result in civil monetary penalties of up to $11,000 for each false claim submitted and up to three times the actual damages suffered by the government as a result of the submission of false claims.\textsuperscript{103}

In a healthcare context, false claims actions are commonly associated with violations of other healthcare statutes and regulations, including, but not limited to violations of the Stark Law or the Anti-Kickback Statute. Pursuant to an amendment adopted by the Patient Accountability and Affordable Care Act, a claim submitted to a federally funded healthcare program services for items or services that were provided in violation of the Anti-Kickback Statute now “constitutes a false or fraudulent claim” under the federal False Claims Act.\textsuperscript{104} As such, an NPP and his or her employer or contractor will automatically be subject to multiple penalties under both the Anti-Kickback Statute and the False Claims Act for the submission of a single claim, which relates to services provided in violation of the Anti-Kickback Statute.

The False Claims Act also includes a provision that allows private individuals to bring false claims actions on behalf of the United States.\textsuperscript{105} Such private individuals, referred to as “qui tam relators”, who are often organizational whistleblowers, are eligible to share in a percentage of any proceeds resulting from a false claims action or settlement.\textsuperscript{106} In addition to the tie-in provision that directly connects the Anti-Kickback Statute and False Claims Act, the availability of qui tam actions and the financial incentives offered to qui tam relators for pursuing such actions, demonstrates the seriousness in which the government intends to monitor and prevent the submission of false or fraudulent claims, particularly within the healthcare industry.

**Conclusion**

NPPs occupy an important role in today’s healthcare industry. While a variety of factors have contributed to the growth of NPPs, a shortage of primary care healthcare providers coupled with an aging population has been a primary catalyst in the growth of NPPs – a trend that will continue for the

\textsuperscript{100} See generally id. §§ 1320a-7(a) and 1320a-7b.
\textsuperscript{101} See generally 31 U.S.C. § 3729.
\textsuperscript{102} Id. § 3729(b).
\textsuperscript{103} Id. § 3729(a).
\textsuperscript{104} 42 U.S.C. § 1320a-7b(g).
\textsuperscript{105} 31 U.S.C. § 3730(b).
\textsuperscript{106} Id. § 3730(d).
foreseeable future. As NPPs continue to advance in the healthcare industry, occupying increasingly diverse and important roles in providing effective and affordable healthcare services, careful consideration should be given to the compliance issues discussed in this article. As healthcare regulations at both the federal and state levels become increasingly complex, NPPs must be given particular attention, not only to ensure compliance, but also to realize the full benefit NPPs offer to society in providing effective and affordable primary healthcare services.

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OVERVIEW
Marissa Arreola is a member of the firm's Corporate & Securities Practice group. With a focus on the healthcare sector, Marissa's corporate practice represents large hospital networks, individual hospitals and physicians in a wide variety of transactions and regulatory matters. Prior to joining the firm, Marissa served as Director of Legal Services for The Methodist Hospital System, a five hospital network and academic medical center headquartered in Houston's Texas Medical Center.

EDUCATION
- University of Houston Law Center, J.D., 1998
- Order of the Barristers
- Houston Journal of International Law, Managing Editor
- Rice University B.A., 1995, cum laude

EXPERIENCE
- Developed, drafted and negotiated salary, productivity, and non-compete models for physician employment agreements.
- Formed and provided regulatory advice to compounding pharmacies.
- Served as lead counsel for a multi-specialty practice group of 300+ physicians.
- Served as lead counsel for hospitals in a multi-hospital network.
- Served as primary governance counsel for a hospital network and academic medical center with 13+ for profit and not for profit entities.
- Obtained group exemption status from the IRS for large non-profit company with numerous subsidiary entities and managed IRS Form 990s for same.
- Served as primary counsel in various private offerings.
- Successfully lobbied for changes to the Texas Occupations Code and Texas Medical Board Rules.
- Drafted and negotiated medical office leases, medical equipment leases, and time-share agreements.
Advised clients regarding Stark, Anti-Kickback, Federal False Claims Act, and various other healthcare fraud and abuse laws.

Advised clients regarding Medical Board and Board of Nursing rules.

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Tami Horton is General Counsel and Chief Privacy and Compliance Officer at Illinois Bone & Joint Institute (IBJI). In this role, Horton provides both strategic and tactical oversight to legal, compliance, risk management and related issues for IBJI’s 90+ orthopedic surgeons, rheumatologists and podiatrists, 800+ employees, 15 sites and multiple lines of business, including physical and occupational therapy and imaging, all of which are located in the Chicagoland metropolitan area.

As the first in-house employee in each of her roles, Horton is involved in legal issues related to healthcare law, corporate law, employment law, corporate compliance and oversight of professional liability defense. She manages corporate relationships and interactions with insurers, professional liability defense counsel and over 15 federal, state, county and local government entities. Horton established multiple training programs for physicians and staff and is currently helping build IBJI’s program as an awardee in the CMS Bundled Payment for Care Initiative Program. She also led the creation of a comprehensive corporate compliance program. The compliance manual and process that she developed and deployed across the IBJI organization became the basis for AHLA’s Compliance Program for Physician Practices Toolkit. Horton also regularly provides and manages training to IBJI’s entire staff of physicians and employees on compliance, HIPAA and other risk management topics.

Horton is the founder and chair of the AHLA’s Physician In-House Counsel Affinity Group, identifying and addressing the needs of a growing niche of healthcare law. This group regularly draws over 100 people to its bimonthly educational calls. She is also an active participant in the Health Care Compliance Association, the Women’s Healthcare Executive Network, the First Chair Host Committee, and a past participant in the Quarterly Lecture Committee of the Illinois Association of Healthcare Attorneys. Horton also serves on the advisory committee to a Chicago adoption organization.

Horton earned her JD with Honors from The Law School at the University of Chicago and a Bachelor’s Degree magna cum laude and with Honors from the University of Michigan. She is a member of Phi Beta Kappa.