Part B Insider (Multispecialty) Coding Alert

FRAUD & ABUSE - Separate Tests Vs. Incident-To: A Stark Difference

Individual physicians could lose out under new CMS interpretation

At first glance, the new policy that the **Centers for Medicare & Medicaid Services** sneaked under the radar regarding "incident-to" diagnostic tests may appear to be a minor issue.

After all, Medicare reimburses the same amount for tests whether they're billed incident-to or under the provider number of the person who performed them. And physicians can still bill globally for both technical and professional components, even if they can't bill incident-to for tests, CMS officials told attorney **Alice Gosfield** with **Gosfield & Associates** in Philadelphia, PA.

In fact, with no money at stake for Medicare, "I don't understand what difference it makes" to CMS, notes Gosfield. "I can't get anybody to tell me the policy application of this."

But the change makes a huge difference to individual physicians billing for diagnostic tests within a group practice, notes Gosfield. That's because the Stark self-referral law forbids physicians from receiving compensation for designated health services (DHS) that they order from entities with which they or family members have a financial relationship.

The Stark law allows physicians to receive reimbursement from related entities only under certain circumstances, notes attorney **John Knapp** with **Duane Morris** in Philadelphia, PA. For example, a physician can receive an incentive or bonus compensation for services provided within a physician group, as long as the services were provided incident-to the physician's own services.

If the services weren't provided incident-to the physician's services, then "the money has to be essentially retained within the group and divided in a way that does not take into account their personal referrals or utilization of DHS," explains Knapp.

For example, let's say your practice owns an MRI. Doctor A within your practice orders four MRIs a week, while Doctor B only orders one per week. If Doctor A personally performs the MRIs, then he can be compensated for his work, but most likely a technician performs the MRIs under Doctor A's supervision.

If Doctor A can bill for those MRIs incident-to his services, then Doctor A can receive a bonus that reflects the fact that he ordered four MRIs. But if those services aren't billed incident-to, then the Stark law says that the bonus must be calculated according to other methods, such as seniority or each physician's stake in the practice. Chances are, Doctor A and Doctor B will receive the same amount, even though Doctor A ordered four times as many MRIs.

In other words, you can give each physician in the group dollar-for-dollar credit for services personally performed or billed incident-to, notes Gosfield.

Bottom line, the compensation could not track back to the doctor's actual usage of the MRI machine, explains Knapp. "It may be that CMS believes that by allowing physicians to be, in effect, personally compensated for their referrals," they're receiving an incentive to order more tests, he notes.

This change came out of nowhere, Gosfield stresses. She even has a letter from a CMS official documenting the level of supervision that a physician must have over diagnostic tests to bill "incident-to" for them. In a 2000 transmittal, CMS laid out physician supervision requirements for 750 CPT codes for diagnostic tests, and CMS officials clarified in a letter that physicians could use either "incident-to" supervision requirements or the transmittal's requirements.