



March 30, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH)

Dear Administrator Oz,

The American Academy of Physician Associates (AAPA), on behalf of the over 190,000 PAs (physician associates/physician assistants) throughout the United States, would like to provide comments to the CRUSH RFI. In the RFI, CMS requests ideas from stakeholders regarding regulatory and programmatic changes it can make to reduce fraud and protect taxpayer dollars. Specifically, in one section of the RFI, CMS asks:

“Are there existing requirements or policies, including those issued through regulations, memoranda, administrative orders, subregulatory guidance documents, or policy statements that could be altered to increase CMS’ ability to promote payment accuracy and efficiency to protect the integrity of Medicare, Medicaid, CHIP, and the Health Insurance Marketplace?”

AAPA approves of CMS’s efforts to protect the integrity of the Medicare program and commends its attention to payment accuracy. We have long emphasized that one opportunity to reduce the likelihood of fraud is to increase data transparency, particularly claims information regarding which health professionals provide and bill for which services.

In the RFI, CMS notes several potential actions the agency may take when fraud is suspected, including suspension of payments to health professionals. Such payment suspensions, as well as subsequent investigations and audits, while important in verifying instances of fraud, can nevertheless encumber workflows and care provision. This

highlights the importance of ensuring that CMS is identifying the proper perpetrators of fraud and that the agency minimizes the likelihood of false accusations.

CMS notes in the RFI that it uses data analytics of claims to identify suspected fraud. However, data analytic determinations are only as good as the quality of the data used. While AAPA is supportive of these methods, we caution that programmatic policies that perpetuate a lack of transparency on claims regarding which health professionals are providing services may complicate data-driven identification efforts and lead to false identifications of fraud, while drawing resources from legitimate enforcement efforts elsewhere.

Nearly all medical services performed by PAs are reimbursed by public and private payers. However, a substantial percentage of medical services delivered by PAs to Medicare, Medicaid, and commercial payer beneficiaries are currently “hidden” in healthcare claims data. This is due to certain payer billing provisions and/or the fact that some payers do not enroll/credential PAs, which make it difficult, if not impossible, to appropriately measure the volume of services and the quality of care delivered by PAs. Instead, where these policies exist and are utilized, services provided by PAs are attributed to physicians with whom they work.

Policies that allow one health professional to receive credit and payment for the care provided by another health professional, particularly when a physician takes credit and is paid at a higher rate than a PA, open the door to possible fraudulent claim submissions to acquire a greater volume of services or increased reimbursement. For example, a bad actor may submit claims for services under “incident to” or split (or shared) billing when the requirements to use those billing mechanisms have not been met. For example, “incident to” could erroneously be used for new patient encounters or split (or shared) billing could be used when the identified billing professional did not perform a substantive part of the service. Further, a practitioner could submit claims for services not rendered and the ability to detect an outlier number of claims beyond the degree of services one professional may reasonably be able to provide may not be detected due allowances for a volume of claims to be submitted “incident to” or as a split (or shared) service. The environment to commit these types of fraud is founded in claims submission policies that allow inaccurate attribution of services.

Medicare’s “Incident To” Billing and Claim Transparency

“Incident to” is a Medicare billing provision that allows medical services performed by one health professional in the office or clinic setting to be submitted to the Medicare program and reimbursed under the name of another health professional. Of particular interest to AAPA is “incident to” billing for services performed by PAs and nurse practitioners (NPs) that are attributed to physicians.

Due to how services billed “incident to” are reported through Medicare’s claims process, with the claims being indistinguishable as being performed by the actual rendering provider, a substantial percentage of medical services performed by PAs and NPs may be attributed to physicians with whom they work. When this occurs, it is nearly impossible to accurately identify the type, volume, or quality of medical services provided by PAs and NPs. Accurate data collection and appropriate analysis of workforce utilization are lost.

The transparency concerns regarding “incident to” billing are well-documented. The Medicare Payment Advisory Commission, in its report released on June 14, 2019, noted the increasing role of PAs and NPs in providing care to Medicare beneficiaries and estimated that a significant share of services provided by PAs and NPs were billed “incident to,” and identified many of the adverse consequences of “incident to” billing stemming from compromised data quality.¹ This lack of transparency under “incident to” and the resulting threat to data accuracy has a negative impact on patients, health policy researchers, PAs and NPs, and the Medicare program.

The Potential for Fraud in the Medicare Program

Under “incident to” billing, claims data collected and used by the Medicare program are fundamentally flawed due to the erroneous attribution of medical care to the wrong health professional. This has financial implications, as “incident to” billing allows for the services of PAs and NPs, typically reimbursed at 85%, to be reimbursed at the physician rate of 100%. The financial incentive to receive a higher reimbursement if services are billed “incident to” may lead to improper billing practices to bolster revenue, and practitioners claiming an increased rate without all required conditions being met. Improper payments and the association of services to a different health professional have downstream financial consequences to the Medicare program as well, biasing programmatic assessments of quality of care and resulting value incentives.

The possibility of fraudulent claims being submitted only compounds other threats of “incident to” to the Medicare program, including hindering the ability of CMS to make the most accurate policy decisions or conduct an appropriate analysis of provider workforce utilization, provider network adequacy, and resource use allocation. As example, in CMS’s 2019 Physician Fee Schedule final rule, the agency acknowledged limitations in data usage and burden reduction estimations due to the ability to report services using “incident to” billing.²

¹ Medicare Payment Advisory Commission. June 2019 Report to the Congress: Medicare and the Health Care Delivery System. 2019. <https://www.medpac.gov/document-type/report/>

² The Department of Health and Human Services. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program--Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the

The Effect of Suspected Fraud on Medicare Beneficiaries

In addition to the direct negative financial effects “incident to” may have on the Medicare program, the possibility of fraud also affects patients. One of the key elements in ensuring that healthcare is consumer-centric is to provide patients with relevant and accurate information about their health status, the care they receive, and the health professionals delivering that care. Each patient receives a Medicare Summary Notice (MSN) or an Explanation of Benefits (EOB) after receiving care. The MSN/EOB identifies the service the patient received and who delivered the care, among other details of the visit. “Incident to” billing often leads to patient confusion because the name of the health professional who provided their care does not appear on the MSN/EOB notice. When PA or NP services are billed “incident to,” the MSN/EOB lists the service as having been performed by a physician who did not see the patient, which can cause patients to question who provided their care and whether they need to correct what appears to be erroneous information regarding their visit.

CMS notes in another section of the RFI that beneficiaries are often subjects of outreach by unscrupulous individuals seeking to obtain their personally identifiable information. This fact is likely to make beneficiaries question MSNs/EOBs that state they received care from a health professional they do not recall seeing. Simultaneously, CMS is seeking to make it easier for beneficiaries to identify and report potentially suspicious claims. While noble in intent, the perpetuation of “incident to” has the potential to lead to an increased reporting by beneficiaries of legitimate claims as fraudulent. Increased time and resources to determine legitimate claims that were billed “incident to” may undermine the effectiveness of increased beneficiary reporting and decrease the likelihood of detecting legitimate fraud.

Possible Interventions to Mitigate the Negative Effects of “Incident To” Billing

One way to significantly reduce the threat of bad actors from using “incident to” for either for claims that do not meet the billing requirements or for nonexistent services would be to repeal “incident to” billing. However, this would require an act of Congress as the billing provision is rooted in the US Code. One way to eliminate inappropriate billing to capture a higher reimbursement rate would be to remove the incentive by reimbursing PAs and NPs at the same rate as physicians for equivalent services. However, this too would require an act of Congress. AAPA encourages CMS to support these efforts to help reduce fraud in the Medicare system.

Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.
<https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>

While AAPA is aware CMS cannot eliminate the statutorily established “incident to” billing, we believe there are policies the agency can modify to minimize its use and/or the effect of insufficient transparency brought on by “incident to” billing. First, CMS should require that the name and NPI of the health professional who rendered patient care be included on all claims, including those billed “incident to.” This could be accomplished by requiring claims to list an additional provider (e.g., a “performing” provider) to the “billing” or “rendering” provider. At a minimum, a modifier code should be used to identify a claim as “incident to”. This additional detail, alerting Medicare for the first time to the volume of services that are billed “incident to,” may indicate potential overuse or improper usage. This new identification as to who is using “incident to” billing may deter bad actors from submitting fraudulent claims in the first place, while also helping Medicare target its audit efforts toward heavy users of “incident to” to ensure proper compliance with requirements of the billing provision. The identification of PAs and NPs on claims for all services they provide will simultaneously allow for proper attribution when Medicare makes subsequent determinations of provider quality and resource utilization that lead to financial adjustments, as well as provider ratings patients rely on for care selection.

Second, CMS should remove regulatory policies that perpetuate and potentially proliferate the use of “incident to” billing. One example is the agency’s recently finalized policy to allow for direct supervision by electronic means for PAs and NPs. This policy stands to exacerbate already existing transparency problems surrounding accurate attribution of services to the appropriate health professional by making it easier to provide direct supervision, a requirement for “incident to” billing. Instead, AAPA recommends that CMS revise this policy to allow for direct supervision by audio/visual communication only for the supervision of health professionals who are not authorized to bill Medicare for their services. AAPA is concerned that CMS’s policy to broadly redefine direct supervision to include audio/visual communication for all health professionals in nearly all circumstances under §410.26 will continue to make it easier for practices to use “incident to” billing when it comes to services provided by PAs and NPs. With increased use of “incident to” comes the increased potential for fraudulent claims to go undetected. Contrary to registered nurses, medical assistants, and technicians, PAs and NPs can provide and bill for services under their own names instead of a physician’s name, and at a lower cost of care (reimbursement rate) to the Medicare program.

A second example is ambiguous policy language communicated by Medicare Administrative Contractors (MACs) surrounding requirements for the level of physician involvement when an established patient presents with a new problem. Policy guidelines on MAC websites may be read as allowing “incident to” to be used for new problems and involving minimal involvement by a physician (a face-to-face encounter and the initiation of a course of treatment) that is contrary to Federal guidelines regarding “incident to” billing. Like with CMS’s policy regarding direct supervision by electronic means, this language, interpreted as a policy flexibility, may result in increased usage of the “incident to” billing mechanism due to a perception of decreased burden. As such, by addressing

these two policies, CMS has the ability to place constraints on the use and ease of use of “incident to,” to make potential fraudulent billing practices less frequent.

Other Payer Enrollment Policies and Claim Transparency

Some private payers, such as those who work with CMS through Medicare Advantage plans, Medicaid Managed Care plans, and plans on the Federally Facilitated Exchange, have policies that do not allow for the enrollment of PAs under a plan. When this occurs, PAs, who are authorized to provide services under the plan, have their services submitted by and attributed to a physician with whom they work. This results in a similar effect as Medicare’s “incident to” billing in that it does not allow for the attribution of services to the health professionals who provided them. It also typically results in reimbursement at the physician rate.

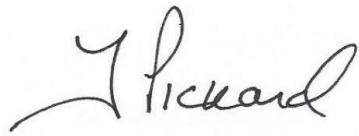
These flawed enrollment practices can result in negative financial implications in several ways. First, when health professionals can bill for the services of other health professionals who are able to bill themselves, there is a decreased likelihood of identifying fraudulent claims, as the elevated volume of services a health professional provides is instead assumed to be capturing the services of multiple health professionals. Second, obscuring the health professional who provided care biases data based on such services. As payers increasingly use data to make decisions on network adequacy and provider value, payers who do not separately identify PAs within their systems will have inaccurate information with which to perform these analyses. Several of the determinations that stem from these analyses are financial in nature. Medicare, having a financial relationship with these payers, has a vested interest in reducing costs that result from inaccurate data.

AAPA requests that, to improve transparency regarding which health professionals are providing what services, CMS require all private payers with whom it contracts under the Federally Facilitated Exchanges, Medicare Advantage, and Medicaid Managed Care, to enroll PAs as rendering providers and to be appropriately identified on a claim.

The identification of professional work is important for clinical quality assessment, practice improvement, productivity measurement, care contribution, and population health management. Accurate recognition of PAs will not change state or federal laws regarding the range of services PAs are authorized to perform and will not increase the amount of reimbursement paid. In fact, it is likely to reduce overall expenditure and help ensure Medicare program integrity. For improved accuracy and accountability, as well as a diminished opportunity for fraud, AAPA advocates for claims to be submitted under the name of the health care professional who performed the service.

Thank you for the opportunity to provide comments regarding the CRUSH request for information. AAPA welcomes further discussion with CMS regarding these important issues. For any questions you may have please do not hesitate to contact Sondra DePalma, AAPA Vice President of Reimbursement & Professional Practice, at sdepalma@aapa.org.

Sincerely,

A handwritten signature in black ink that reads "T Pickard". The signature is written in a cursive style with a large, stylized initial "T".

Todd Pickard, DMSc, PA-C, DFAAPA, FASCO
President & Chair of the Board
American Academy of Physician Associates