Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-010		
Subject:	Incident To Services		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	January 1, 2024	**Revised Date:**	January 2024
Date Reviewed:	December 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☐	**WV**	☐	**DE**	☒	**NY** ☐
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

BACKGROUND:

Incident-To billing is a specific method of billing developed by the Center for Medicare and Medicaid Services (CMS). Services provided by employees as “incident to” are covered when they meet all the requirements for "incident to" and are medically necessary for the individual needs of the patient. In order to be covered as "incident to" the physician’s service, the service must be:

1. An integral, although incidental, part of the physician’s professional service.
2. Commonly rendered without charge or included in the physician’s bill.
3. Commonly furnished in physician’s offices or clinics Furnished by the physician or by auxiliary personnel under the physician’s direct supervision.

"Incident to" services must be performed under the direct supervision of the physician. Per CMS, “Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.” CMS further indicates, under direct supervision, “This does not mean, however, that to be considered "incident to", each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be "incident to" when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflects his/her active participation in and management of the course of treatment.” Hospital and skilled nursing facility services cannot be billed as "incident to" at any time.

DEFINITIONS:

Term or Acronym	Definition
APP	Advanced Practice Provider
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CNS	Clinical Nurse Specialist
COMM	Commercial
CRNA	Certified Registered Nurse Anesthetist
CRNP	Clinical Registered Nurse Practitioner
CRN	Clinical Registered Nurse
Credentialed	Successfully completing the process if having education, training, and professional experience verified to meet the internal requirements of the Plan for serving as an in-network provider
Enumerated	The assignment of a specific identifying number to a provider for submission on claims
LCSW	Licensed Clinical Social Workers
MA	Medicare Advantage
NM	Nurse Midwife
NP	Nurse Practitioner
NPI	National Provider Identifier
PA	Physician Assistant
PCP	Primary Care Physician
RNFA	Registered Nurse First Assistant

Modifier	Definition
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REIMBURSEMENT GUIDELINES:

Rendering or Performing Provider Enumeration

Advanced Practice Providers (APPs) defined as any of the following **must** list themselves as the rendering/performing provider on the 1500 claim:

- Physician Assistant
- Clinical Nurse Specialist
- Nurse Practitioner
- All Master's prepared behavioral health therapists, including LSCWs and LSW
- Licensed and Associate Marriage and Family Counselors
- Licensed Professional Counselors
- Certified Register Nurse Practitioner PCP (CRNP)
- Certified Registered Nurse

- Therapists and Counselors
- Pharmacist* (Applicable only to Medicare Advantage and WV Commercial plans)

Note: The above does not apply to the New York Region. All NY APPs must list as rendering providers.

Note: Incident-To services only apply to place of service (POS) 11.

Failure of the Provider to enumerate and list themselves as rendering provider when different than the billing provider will result in:

1. Potential post-payment investigation and recoupment of paid claim reimbursement for non-compliance against this policy.
2. If the rendering provider has not been enumerated in the Highmark systems the claim can be rejected. The claim may be resubmitted for reimbursement consideration once the rendering provider is credentialed / enumerated in the Plan's system.

Examples of Acceptable "Incident To" Billing (does not apply to NY Region)

1. Auxiliary personnel administer services under the supervision of a physician. If the "Incident To" requirements above are met, the services must be reported under the physician's NPI number.
2. Auxiliary personnel administer services under the supervision of an APP. If the "Incident To" requirements above are met, the services should be billed under the APP's NPI number.

Plan of Care and Scope of License

Auxiliary personnel cannot bill "Incident To" services when a **physician or APP** approved plan of care is not documented in the medical record. All new conditions / diagnoses must have an established plan of care documented in the medical record.

Note: Services of unlicensed clinicians who are training under the supervision of a licensed clinician cannot be billed.

To qualify as ancillary "Incident To," services must be part of the patient's normal course of treatment, during which a physician or APP personally performed an initial service and remains actively involved in the course of treatment. The physician does not have to be physically present in the patient's treatment room while these "Incident To" services are provided, but must provide direct or general supervision*****, that is, they must be available to render ancillary personnel assistance, if necessary.

***Note**: General supervision only applies to behavioral health services.

Direct and General Supervision

Direct supervision - an eligible professional provider must be immediately physically available to assist without delay in the care of the patient (for example in the office suite). All supervision must be in accordance with the state licensure or certification requirements of the performing licensed or certified health care practitioner. To qualify for "Incident To" billing, a physician or APP must be physically available, without delay, to assist the ancillary staff at any time.

General Supervision - the procedure or service is furnished under the physician's overall direction and control, or, that general instructions are given, and tasks are undertaken to achieve the required outcomes or objectives, but the physician's presence is not required during the performance of the procedure.

Note: General supervision only applies to behavioral health services.

Certain diagnostic tests have been identified that have extended technical components wherein the patient goes about normal daily activities while being monitored. These tests include, but are not limited to Holter monitoring, cardiac event monitoring, and sleep studies. These procedures are performed under the physician's overall management and control, but the physician is not present for the duration of the test.

The technical component of diagnostic tests may be performed by technicians who have appropriate training and proficiency, as evidenced by state licensure or state certification from the appropriate state health or education department. In the absence of a state-level licensure or certification, the technician must be certified by the appropriate national credentialing body. In these cases, payment can be made to the provider who supervises and employs the licensed or certified technician.

Employment Relationship

An employment relationship is established if all the following criteria are sufficiently documented:

- The employer has the power to hire and fire;
- The employer has the power to direct the work done by the employee and has ultimate responsibility for the manner of his/her performance;
- The employer has the duty to pay wages, fringe benefits, and establish the level of compensation;
- There is no compensation received by any facility for the services of the employee during the period of employment by the employer

APP Billing Procedure

1. Ancillary staff billing Incident-To services should use the ordering physician or APP NPI in the rendering provider field if different than the billing provider NPI.
2. Incident-To ancillary services billed under the APP NPI will be subject to standard APP reductions.
3. Ancillary services billed under a physician NPI will receive 100% of contracted fee schedule.

Note: For Commercial business, the **SA modifier** must be appended to all Incident To services when services are rendered by an APP, billing "Incident To" claims. The licenses held by these professionals may be recognized as different names for each state.

Delaware Commercial Products Reimbursement Provision

Effective January 1, 2024, due to the mandatory minimum payment provisions contained at 18 Del. Admin. Code § 1322-5.0 for Primary Care Providers, the provisions of this policy only apply to commercial market reimbursement for services rendered by contracted primary care providers in the State of Delaware. This policy is inapplicable for commercial market reimbursement for non-primary care services rendered by contracted providers in the State of Delaware.

New York Medicare Advantage Supplemental Reimbursement Guidelines

The information in this section and below pertains ***only*** to New York Medicare Advantage business and is addition to the direction in the above REIMBURSMENT GUIDELINES section.

For psychology services rendered under the "incident to" provision, the billing provider must first evaluate the patient personally and then initiate the course of treatment. The appropriately trained therapists may then render psychological services to the patient under the billing provider's direct supervision.

Only the types of practitioners listed below, when they are performing within their scope of clinical practice as authorized under state law, are qualified to perform the indicated diagnostic and/or therapeutic psychological services under the "incident to" provision.

1. Doctorate or Masters level Clinical Psychologist: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90880, 90899
2. Doctorate or Masters level Clinical Social Worker: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90899
3. Clinical Nurse Specialist (CNS): 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90899
4. Nurse Practitioner (NP): 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90899
5. Other providers of mental health services licensed or otherwise authorized by the state in which they practice for services within their scope of practice (e.g., licensed clinical professional counselors, licensed marriage and family therapists). These other providers may not bill Medicare directly for their services, but may provide mental health treatment services to Medicare beneficiaries under the "incident to" provision.

The psychological services referenced in the above HCPCS codes may only be delegated to employees who qualify for one of the categories of individuals listed above. For example, a psychiatrist may hire a clinical social worker to perform services designated by the HCPCS codes listed in #2 above. Individuals who are performing services "incident to" a qualified Medicare practitioner are not required to be separately enrolled as an independent practitioner in Medicare.

It is not permissible for the billing provider to hire and supervise a professional whose scope of practice is outside the provider's own scope of practice as authorized under State law, or whose professional qualifications exceed those of the "supervising" provider. For example, a certified nurse-midwife (CNM) may not hire a psychologist and bill for that psychologist's services under the "incident to" provision, because a psychologist's services are not integral to a CNM's personal professional services and are not regularly included in the CNM's bill. Even though sections 1861(s)(2)(l) and 1861(gg) (l) of the Social Security Act authorize coverage for services furnished "incident to" a CNM's services, psychological services are not commonly furnished in CNM's offices nor within their scope of practice. Similarly, even though section 1861(s)(2)(K)(iv) authorizes coverage for services furnished "incident to" a physician assistant's services, a physician assistant would not be qualified to supervise psychological services performed by the types of individuals listed above.

Individuals who are not licensed or otherwise authorized by state law to provide psychological services may not provide psychological services under the "incident to" provision. This level of professional credentialing is necessary to furnish appropriate medically necessary services under the "incident to" provision.

Psychological services furnished to Medicare beneficiaries under the "incident to" provision by individuals other than those listed above are not covered. (Note: the standards for professional credentialing are higher for these services billed to Medicare Part B than for similar services performed by other mental health professionals not under the "incident to" provision and billed to Medicare Part A. Under the "incident to" provision, services are performed in the place of the billing provider. In order for services performed and billed under the "incident to" provision to be commensurate with the services performed by the billing provider, and therefore medically necessary, this higher standard of professional credentialing is necessary.)

The practice of "marriage and family therapy" includes the identification and treatment of cognitive, affective and behavioral conditions related to marital and family dysfunctions that involve the professional application of psychotherapeutic and systems theories and techniques in the delivery of services to individuals, couples, and families. Local laws regulating their professional practice do not authorize any licensed marriage and family therapist or marriage and family therapy associate to administer or interpret psychological tests. Please refer to applicable state laws.

Coverage of services and supplies "incident to" the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel. (CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 60.1B. This also applies to the services of certain non - physician practitioners who are being licensed by the states under various programs to assist or act in the place of the physician, including nurses, clinical psychologists, clinical social workers and other therapists. *Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services* (CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15,, Section 60.1 - Section 60.3). *Services and supplies incident to a physician's service in a physician directed clinic or group association are generally the same as those described for the office setting* (CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 60.3).

For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under section 1891(s)(2)(A) of the Act. Such services can be covered only under the hospital outpatient or inpatient benefit and payment for such services can be made to only the hospital by a Medicare Part A MAC (CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 60).

For "incident to" services to be covered when a physician's office is in an institution, the *auxiliary medical personnel must be members of the office staff rather than of the institution's staff, and the cost of supplies must represent an expense to the physician's office practice. In addition, services performed by the employees of the physician outside the "office" area must be directly supervised by the physician; his presence in the facility as a whole would not suffice to meet this requirement. (In any setting, of course, supervision of auxiliary personnel in and of itself is not considered a "physician's professional service" to which the services of the auxiliary personnel could be an incidental part, i.e., in addition to supervision, the physician must perform or have performed a personal professional service to the patient to which the services of the auxiliary personnel could be considered an incidental part). Denials for failure to meet any of these requirements would be based on §1861(s)(2)(A) of the Act.* (CMS Pub 100-03; *Medicare National Coverage Determinations (NCD) Manual,* Chapter 1, Part 1, 70.3)

If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than a hospital or SNF), their services are covered incident to a physician's service only if there is

direct supervision. The availability of the physician by telephone or the presence of the physician somewhere in the institution does not constitute direct personal supervision (CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 60.1).

RELATED POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Policy Z-27: Eligible Providers

Refer to the following Reimbursement Policies for additional information:

- RP-001: Assistant Surgery
- RP-035: Correct Coding Guidelines
- RP-041: Services Not Separately Reimbursed
- RP-044: Medication Therapy Management Services
- RP-068: Mid-Level Practitioners and Advanced Practice Providers

ADDITIONAL BILLING INFORMATION, REFERENCES AND GUIDELINES:

- Provider Billing Manual; Chapter 6, Unit 4: Reporting Mid-level Provider Services for Medicare Advantage (Pennsylvania and West Virginia Only)

REFERENCES:

- Centers for Medicare and Medicaid Services; MLN Matters SE0441, issued August 23, 2016.
- Centers for Medicare and Medicaid Services; Pub 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Sections 60-63
- Centers for Medicare and Medicaid Services; Pub 100-03; *Medicare National Coverage Determinations (NCD) Manual,* Chapter 1, Part 1, 70.3
- Centers for Medicare and Medicaid Services; Article A52825 https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52825&ver=4&bc=0
- Medicare Physicians Fee Schedule Final Rule Calendar Year (CY) 2021, 2023
- West Virginia Legislature; (2020) Senate Bill 787 http://wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB787%20SUB1%20enr.htm&yr=2020&sesstype=RS&i=787
- New York Insurance Law Section 4303 https://www.nysenate.gov/legislation/laws/ISC/4303
- Novitas Solutions: E/M services furnished by a non-physician practitioner incident to a physician's service https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00150920

POLICY UPDATE HISTORY INFORMATION:

1 / 2021	Partial Implementation BH Fee reimbursement, SA Modifier, Incident to guideline
4 / 2021	Full Policy Implementation, Enumeration reporting guidelines, removed facility information
10 / 2021	Implementation of Highmark NY RNFA and Midwife Legislative bill S1233A
11 / 2021	Added note for NY Region only applies to Medical Surgical
1 / 2022	Added modifier FR
6 / 2022	Added Provider Manual Reference Chapter 6 Unit 4
9 / 2023	Entire policy revised and Mid-level reductions were moved to RP-068
1 / 2024	Removed PA Commercial from policy application

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-010		
Subject:	Incident To Services		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	September 25, 2023	**Revised Date:**	September 2023
Date Reviewed:	June 2023		
Source:	Reimbursement Policy		

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REIMBURSEMENT GUIDELINES:

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Coverage of services and supplies "incident to" the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel. (CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 60.1B. This also applies to the services of certain non - physician practitioners who are being licensed by the states under various programs to assist or act in the place of the physician, including nurses, clinical psychologists, clinical social workers and other therapists. *Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services* (CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15,, Section 60.1 - Section 60.3). *Services and supplies incident to a physician's service in a physician directed clinic or group association are generally the same as those described for the office setting* (CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 60.3).

For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under section 1891(s)(2)(A) of the Act. Such services can be covered only under the hospital outpatient or inpatient benefit and payment for such services can be made to only the hospital by a Medicare Part A MAC (CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 60).

For "incident to" services to be covered when a physician's office is in an institution, the *auxiliary medical personnel must be members of the office staff rather than of the institution's staff, and the cost of supplies must represent an expense to the physician's office practice. In addition, services performed by the employees of the physician outside the "office" area must be directly supervised by the physician; his presence in the facility as a whole would not suffice to meet this requirement. (In any setting, of course, supervision of auxiliary personnel in and of itself is not considered a "physician's professional service" to which the services of the auxiliary personnel could be an incidental part, i.e., in addition to supervision, the physician must perform or have performed a personal professional service to the patient to which the services of the auxiliary personnel could be considered an incidental part). Denials for failure to meet any of these requirements would be based on §1861(s)(2)(A) of the Act.* (CMS Pub 100-03; *Medicare National Coverage Determinations (NCD) Manual,* Chapter 1, Part 1, 70.3)

If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than a hospital or SNF), their services are covered incident to a physician's service only if there is

direct supervision. The availability of the physician by telephone or the presence of the physician somewhere in the institution does not constitute direct personal supervision (CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 60.1).

RELATED POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Policy Z-27: Eligible Providers

Refer to the following Reimbursement Policies for additional information:

- RP-001: Assistant Surgery
- RP-035: Correct Coding Guidelines
- RP-041: Services Not Separately Reimbursed
- RP-044: Medication Therapy Management Services
- RP-068: Mid-Level Practitioners and Advanced Practice Providers

ADDITIONAL BILLING INFORMATION, REFERENCES AND GUIDELINES:

- Provider Billing Manual; Chapter 6, Unit 4: Reporting Mid-level Provider Services for Medicare Advantage (Pennsylvania and West Virginia Only)

REFERENCES:

- Centers for Medicare and Medicaid Services; MLN Matters SE0441, issued August 23, 2016.
- Centers for Medicare and Medicaid Services; Pub 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Sections 60-63
- Centers for Medicare and Medicaid Services; Pub 100-03; *Medicare National Coverage Determinations (NCD) Manual,* Chapter 1, Part 1, 70.3
- Centers for Medicare and Medicaid Services; Article A52825 https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52825&ver=4&bc=0
- Medicare Physicians Fee Schedule Final Rule Calendar Year (CY) 2021, 2023
- West Virginia Legislature; (2020) Senate Bill 787 http://wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB787%20SUB1%20enr.htm&yr=2020&sesstype=RS&i=787
- New York Insurance Law Section 4303 https://www.nysenate.gov/legislation/laws/ISC/4303
- Novitas Solutions: E/M services furnished by a non-physician practitioner incident to a physician's service https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00150920

POLICY UPDATE HISTORY INFORMATION:

1 / 2021	Partial Implementation BH Fee reimbursement, SA Modifier, Incident to guideline
4 / 2021	Full Policy Implementation, Enumeration reporting guidelines, removed facility information
10 / 2021	Implementation of Highmark NY RNFA and Midwife Legislative bill S1233A
11 / 2021	Added note for NY Region only applies to Medical Surgical
1 / 2022	Added modifier FR
6 / 2022	Added Provider Manual Reference Chapter 6 Unit 4
9 / 2023	Entire policy revised. Mid-level reductions moved to RP-068.

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-010		
Subject:	Incident To Billing Services and Advanced Practice Provider Reductions		
Effective Date:	February 1, 2021	**End Date:**	
Issue Date:	June 27, 2022	**Revised Date:**	June 2022
Date Reviewed:	June 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This is a dual-purpose policy that 1) outlines the Plan's Incident to position, and 2) lists payment policy guidelines for Advanced Practice Providers (APPs).

1) Incident to applies to the DE, PA and WV regions, Incident to does not apply to NY (all NY APP's MUST bill as rendering provider on every claim, without exception)
2) Advanced Practice Provider Payment Reductions apply to DE, NY and PA regions only as specified.

Incident To Description: (Applies to DE, PA, and WV, does not apply to NY Region)

This policy serves to clarify "Incident To" services billed by physicians and non-physician practitioners practicing within their scope of license and aligns with CMS billing instructions. "Incident To" services are defined as those services furnished by someone other than the supervising physician and billed under the physician's NPI. Incident To services are paid at 100% of the contracted fee schedule, when policy requirements are met.

"Incident To" services are also relevant to services performed by auxiliary personnel working within the scope of license (nurses, technicians, and therapists) and supervised by certain non-physician practitioners (advanced practice providers such as physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologists, and others). These services are subject to the same requirements as physician-supervised services.

REIMBURSEMENT GUIDELINES (Does not apply to NY Region; all NY APPs must list as rendering providers)

To qualify as "Incident To," services must be part of the patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. The physician does not have to be physically present in the patient's treatment room while these "Incident To" services are provided, but must provide general supervision, that is, they must be available to render APP assistance, if necessary.

The following requirements must be met to qualify as "Incident To" services:

- The physician personally treats, establishes the diagnosis, and develops the plan of care for the patient on the **first visit** (new patient visit) for a particular medical problem. Or the APP may render services if the supervising physician signs off on the new/updated plan of care.
- A physician in the group (need not be the same physician who originally treated the patient) is physically on site when supporting personnel provides follow-up care on a future visit.
- The physician personally treats, and diagnoses established patients who present with any **new conditions/diagnoses**.
- The physician has an active part in the ongoing care of the patient. Subsequent services by the physician must be of a frequency that reflects his/her continuing active participation in, and management of, the course of the treatment. At a minimum, the supervising physician must co-sign all new care plans and co-sign the medical record for all newly diagnosed problems.
- Both the supervising physician and the supporting personnel must be employed or contracted by the group entity billing for the service of the supporting personnel (such as "W-2" employment, a leased employee, or an independent contractor). If the physician is a sole practitioner, the physician must employ all supporting personnel.

The following services do not qualify for "Incident To" billing:

- New patient office visit (CPT 99202-99205). If there is no sign off on the plan of care.
- Any **new conditions/diagnoses** encountered during the visit not addressed in the established plan of care. In this instance, the supervising physician needs to sign off on the established plan of care for the new condition/diagnosis.
- No auxiliary services can be billed "Incident To" when a supervising physician or APP is not physically present in the office at the time the service is rendered.
- Services delivered by an APP without supervision in an institutional setting (i.e. hospital, skilled nursing facility, home etc.). If the supervising physician is *physically present* in the institutional setting and the APP is working under the physician's direct supervision, "Incident To" billing is allowed.

Examples of Non-Acceptable and Acceptable "Incident To" Billing
(Applies to DE, PA, and WV, does not apply to NY Region)

1. An APP administers services to a patient without documented supervision from the physician. The services should be billed under the APP's NPI and are not considered "Incident To."
2. In an office setting an APP performs a portion of an E/M encounter and the physician completes the E/M service. If the "Incident To" requirements above are met, the physician

reports the service under the physician's NPI number. If the "Incident To" requirements above are not met, the service must be reported using the APP's NPI number.

3. Auxiliary personnel administer services under the supervision of a physician. If the "Incident To" requirements above are met, the services must be reported under the physician's NPI number.
4. Auxiliary personnel administer services under the supervision of an APP. The services should be billed under the APP's NPI number.
5. Billing for new patient visits or visits for new problems not previously assessed by the supervising physician; to quality for "Incident To" billing the supervising physician must approve by signing off on the care plan for all new problems.

Plan of Care and Scope of License (Applies to DE, PA, and WV, does not apply to NY Region)

An APP, and/or auxiliary personnel, cannot bill "Incident To" services when no **physician** approved plan of care is documented in the medical record (co-signature is the minimum requirement). All new conditions/diagnoses must have an established plan of care documented in the medical record approved by the supervising physician's sign off prior to billing "Incident To" services. **If an APP is developing care plans for new patients or new conditions, that is not outside of their scope of license, if enumerated they MUST independently bill by submitting their own NPI as the rendering provider once their enumeration letter is received.**

If not enumerated, they may bill "Incident To" services based on the supervising physician reviewing and signing off on the patients record. Reporting the "SA" modifier and the supervising physician NPI.

APPs must act within the scope of practice of their license and/or certification, and in accordance with state law in which the license/certification is held and the APP practices.

Services of unlicensed clinicians who are training under the supervision of a licensed clinician cannot be billed.

SA modifier should be appended to all codes submitted for services rendered by any of the following:

1) Physician Assistant (PA)
2) Clinical Nurse Specialist (CNS)
3) Nurse Practitioner (NP)
4) All Master's prepared behavioral health therapists, including LSCWs and LSW
5) Licensed and Associate Marriage and Family Counselors
6) Licensed Professional Counselors
7) Certified Register Nurse Practitioner PCP (CRNP)
8) Certified Registered Nurse Psychiatric Mental Health Nurse
9) Pharmacist* (Applicable only to Medicare Advantage and WV Commercial plans)

*For more information, please review the documentation provided in the reference section of this policy.

Note: **The SA modifier must be appended to all incident to services filed for Highmark commercial business. This should always be used when services are rendered by an APP, billing "Incident To" claims.** The licenses held by these professionals may be recognized as different names for each state.

Direct Supervision (Applies to DE, PA, and WV, does not apply to NY Region)

Direct supervision means an eligible professional provider must be immediately physically available to assist without delay in the care of the patient (for example in the office suite). All supervision must be in accordance with the state licensure or certification requirements of the performing licensed or certified health care practitioner. To qualify for "Incident To" billing, a physician (not necessarily that APPs assigned supervisor) must be physically available, without delay, to assist the APP at any time.

Note: For purposes of limiting exposure for the duration of the Public Health Emergency (PHE), the plan will follow the proposed rule from the Centers for Medicaid and Medicare Services (CMS) to allow direct supervision to include virtual presence of the supervising physician using real-time, interactive audio and video technology, reporting applicable services with modifier FR when appropriate.

Certain diagnostic tests have been identified that have extended technical components wherein the patient goes about normal daily activities while being monitored. These tests include, but are not limited to Holter monitoring, cardiac event monitoring, and sleep studies. These procedures are performed under the physician's overall management and control, but the physician is not present for the duration of the test.

Note: The technical component of diagnostic tests may be performed by technicians who have appropriate training and proficiency, as evidenced by state licensure or state certification from the appropriate state health or education department. In the absence of a state-level licensure or certification, the technician must be certified by the appropriate national credentialing body. In these cases, payment can be made to the provider who supervises and employs the licensed or certified technician

Employment Relationship (Applies to DE, PA, and WV, does not apply to NY Region)

An employment relationship is established if all the following criteria are sufficiently documented:

- The employer has the power to hire and fire;
- The employer has the power to direct the work done by the employee and has ultimate responsibility for the manner of his/her performance;
- The employer has the duty to pay wages, fringe benefits, and establish the level of compensation;
- There is no compensation received by any facility for the services of the employee during the period of employment by the employer.

INCIDENT TO BILLING PROCEDURE (Applies to DE, PA, and WV, does not apply to NY Region)

1. Providers billing "Incident To" their supervising physician should submit each claim with the supervising physician's information in both the billing *and* rendering sections of the claim. INCIDENT TO billing can only be claimed if the Physician has established the initial plan of care for a specific NEW problem.
2. Each CPT/HCPCS must have the SA modifier added when APPs bill "Incident To" the supervising physician. This is the claim indicator that alerts Highmark that someone other than the supervising physician delivered services to the patient. The supervising physician is responsible for the delivery of all supervised services.

Advanced Practice Provider [APP] Reductions Applicable To PA, DE and NY. (Not Applicable to WV)

The following reimbursement reductions apply to services **rendered** by enumerated APP's unless rendering providers meet and follow "Incident To" billing requirements as outlined above.

Behavioral Health reductions (DE and PA regions only)

BEHAVIORAL HEALTH	
Practitioner	**Reimbursement (% of fee schedule)**
▪ Master Prepared Therapists ▪ Licensed Clinical Social Workers (LCSWs) ▪ Licensed Professional Counselors ▪ Licensed Marriage and Family ▪ Counselors/Associate Marriage and Family Counselors	**75%**
▪ Nurse Practitioner - Mental Health ▪ Clinical Nurse Specialist - Psychiatric Mental Health Nurse ▪ Certified Registered Nurse - Psychiatric Mental Health Nurse	**85%**
▪ Licensed Social Workers* ▪ Social Workers*	**65%**

* Licensed Social Workers apply to Commercial business only

Medical / Surgical reductions (DE, PA and NY regions only)

MEDICAL / SURGICAL	
Practitioner	**Reimbursement (% of fee schedule)**
▪ Nurse Practitioner ▪ Clinical Nurse Specialist (CRN) ▪ Clinical Registered Nurse Practitioner (CRNP) PCP ▪ Registered Nurse First Assistant (RNFA)* ▪ Nurse Midwives*	**85%**
▪ Physician Assistants (where allowed by law) ▪ Physician Assistant PCP	**85%**

* Only applicable to New York Region

Reductions listed above will apply to services rendered by an enumerated APP for codes in which care delivery is determined by the practitioner's knowledge, skills, and abilities. Examples include evaluation and management (E&M) codes, procedures performed by the mid-level, psychotherapy, etc. Commodity services such as vaccines, drugs, labs, and other diagnostic services will not be subject to the reductions when submitted on the same claim as an applicable service.

All APP's should list themselves as the rendering provider on the CMS 1500 claim form when independently diagnosing new problems and establishing a new plan of care. Remember, this policy REQUIRES APP providers practicing independently (defined within this policy as those providers seeing new patients and establishing independent plans of care) to enumerate. Please ensure enumeration within our system occurs (Informational letter received) prior to reporting your information in the rendering provider field or the claim will be rejected.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed
- RP-044: Medication Therapy Management Services (WV Region)

Highmark Provider Manual

- Chapter 6 unit 4 Reporting Mid-level Provider Services for Medicare Advantage (Pennsylvania and West Virginia Only)

ADDITIONAL BILLING INFORMATION, REFERENCES AND GUIDELINES:

- CMS MLN Matters Article SE0441 issued August 23, 2016. https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA0441.pdf
- CMS 2020 COVID-19 interim final rule (85 FR 27550 thorough 27629) https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicaid-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory
- Medicare Physicians Fee Schedule (PFS) Calendar Year (CY) 2021 https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1
- West Virginia Legislature; (2020) Senate Bill 787 http://wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB787%20SUB1%20enr.htm&yr=2020&sesstype=RS&i=787
- New York Insurance Law Section 4303 https://www.nysenate.gov/legislation/laws/ISC/4303

POLICY UPDATE HISTORY INFORMATION:

1 / 2021	Partial Implementation BH Fee Reimbursement, SA Modifier, Incident to guidelines.
4 / 2021	Full Policy Implementation, Enumeration reporting guidelines, removed facility information
10 / 2021	Implementation of Highmark NY RNFA and Midwife Legislative bill S1233A
11 / 2021	Added that HMNY Region only applies to Medical Surgical Reductions.
1 / 2022	Added modifier FR
6 / 2022	Added Provider Manual Reference Chapter 6 Unit 4

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-010		
Subject:	Incident To Billing Services and Advanced Practice Provider Reductions		
Effective Date:	February 1, 2021	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	November 2021
Date Reviewed:	November 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This is a dual-purpose policy that 1) outlines the Plan's Incident to position, and 2) lists payment policy guidelines for Advanced Practice Providers (APPs).

1) Incident to applies to the DE, PA and WV regions, Incident to does not apply to NY (all NY APP's MUST bill as rendering provider on every claim, without exception)
2) Advanced Practice Provider Payment Reductions apply to DE, NY and PA regions only as specified.

Incident To Description: (Applies to DE, PA, and WV, does not apply to NY Region)

This policy serves to clarify "Incident To" services billed by physicians and non-physician practitioners practicing within their scope of license and aligns with CMS billing instructions. "Incident To" services are defined as those services furnished by someone other than the supervising physician and billed under the physician's NPI. Incident To services are paid at 100% of the contracted fee schedule, when policy requirements are met.

"Incident To" services are also relevant to services performed by auxiliary personnel working within the scope of license (nurses, technicians, and therapists) and supervised by certain non-physician practitioners (advanced practice providers such as physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologists, and others). These services are subject to the same requirements as physician-supervised services.

REIMBURSEMENT GUIDELINES FOR INCIDENT TO BILLING (Does not apply to NY Region; all NY APPs must list themselves as rendering provider)

To qualify as "Incident To," services must be part of the patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. The physician does not have to be physically present in the patient's treatment room while these "Incident To" services are provided, but must provide general supervision, that is, they must be available to render APP assistance, if necessary.

The following requirements must be met to qualify as "Incident To" services:

- The physician personally treats, establishes the diagnosis, and develops the plan of care for the patient on the **first visit** (new patient visit) for a particular medical problem. Or the APP may render services if the supervising physician signs off on the new/updated plan of care.
- A physician in the group (need not be the same physician who originally treated the patient) is physically on site when supporting personnel provides follow-up care on a future visit.
- The physician personally treats, and diagnoses established patients who present with any **new conditions/diagnoses**.
- The physician has an active part in the ongoing care of the patient. Subsequent services by the physician must be of a frequency that reflects his/her continuing active participation in, and management of, the course of the treatment. At a minimum, the supervising physician must co-sign all new care plans and co-sign the medical record for all newly diagnosed problems.
- Both the supervising physician and the supporting personnel must be employed or contracted by the group entity billing for the service of the supporting personnel (such as "W-2" employment, a leased employee, or an independent contractor). If the physician is a sole practitioner, the physician must employ all supporting personnel.

The following services do not qualify for "Incident To" billing:

- New patient office visit (CPT 99202-99205). If there is no sign off on the plan of care.
- Any **new conditions/diagnoses** encountered during the visit not addressed in the established plan of care. In this instance, the supervising physician needs to sign off on the established plan of care for the new condition/diagnosis.
- No auxiliary services can be billed "Incident To" when a supervising physician or APP is not physically present in the office at the time the service is rendered.
- Services delivered by an APP without supervision in an institutional setting (i.e. hospital, skilled nursing facility, home etc.). If the supervising physician is *physically present* in the institutional setting and the APP is working under the physician's direct supervision, "Incident To" billing is allowed.

Examples of Non-Acceptable and Acceptable "Incident To" Billing (Applies to DE, PA, and WV, does not apply to NY Region)

1. An APP administers services to a patient without documented supervision from the physician. The services should be billed under the APP's NPI and are not considered "Incident To."
2. In an office setting an APP performs a portion of an E/M encounter and the physician completes the E/M service. If the "Incident To" requirements above are met, the physician reports the service under the physician's NPI number. If the "Incident To" requirements above are not met, the service must be reported using the APP's NPI number.
3. Auxiliary personnel administer services under the supervision of a physician. If the "Incident To" requirements above are met, the services must be reported under the physician's NPI number.
4. Auxiliary personnel administer services under the supervision of an APP. The services should be billed under the APP's NPI number.
5. Billing for new patient visits or visits for new problems not previously assessed by the supervising physician; to quality for "Incident To" billing the supervising physician must approve by signing off on the care plan for all new problems.

Plan of Care and Scope of License (Applies to DE, PA, and WV, does not apply to NY Region)

An APP, and/or auxiliary personnel, cannot bill "Incident To" services when no **physician** approved plan of care is documented in the medical record (co-signature is the minimum requirement). All new conditions/diagnoses must have an established plan of care documented in the medical record approved by the supervising physician's sign off prior to billing "Incident To" services. **If an APP is developing care plans for new patients or new conditions, that is not outside of their scope of license, if enumerated they MUST independently bill by submitting their own NPI as the rendering provider once their enumeration letter is received.**

If not enumerated, they may bill "Incident To" services based on the supervising physician reviewing and signing off on the patients record. Reporting the "SA" modifier and the supervising physician NPI.

APPs must act within the scope of practice of their license and/or certification, and in accordance with state law in which the license/certification is held and the APP practices.

Services of unlicensed clinicians who are training under the supervision of a licensed clinician cannot be billed.

An SA modifier should be appended to all codes submitted for services rendered by any of the following

1) Physician Assistant (PA)
2) Clinical Nurse Specialist (CNS)
3) Nurse Practitioner (NP)
4) All Master's prepared behavioral health therapists, including LSCWs and LSW
5) Licensed and Associate Marriage and Family Counselors
6) Licensed Professional Counselors

7) Certified Register Nurse Practitioner PCP (CRNP)
8) Certified Registered Nurse Psychiatric Mental Health Nurse
9) Pharmacist* (Applicable only to Medicare Advantage and WV Commercial plans)

*For more information, please review the documentation provided in the reference section of this policy.

Note: **The SA modifier must be appended to all incident to services filed for Highmark commercial business. This should always be used when services are rendered by an APP, billing "Incident To" claims.** The licenses held by these professionals may be recognized as different names for each state.

Direct Supervision (Applies to DE, PA, and WV, does not apply to NY Region)

Direct supervision means an eligible professional provider must be immediately physically available to assist without delay in the care of the patient (for example in the office suite). All supervision must be in accordance with the state licensure or certification requirements of the performing licensed or certified health care practitioner. To qualify for "Incident To" billing, a physician (not necessarily that APPs assigned supervisor) must be physically available, without delay, to assist the APP at any time.

Note: For purposes of limiting exposure for the duration of the Public Health Emergency (PHE), the plan will follow the proposed rule from the Centers for Medicaid and Medicare Services (CMS) to allow direct supervision to include virtual presence of the supervising physician using real-time, interactive audio and video technology, reporting applicable services with modifier FR when appropriate.

Certain diagnostic tests have been identified that have extended technical components wherein the patient goes about normal daily activities while being monitored. These tests include, but are not limited to Holter monitoring, cardiac event monitoring, and sleep studies. These procedures are performed under the physician's overall management and control, but the physician is not present for the duration of the test.

Note: The technical component of diagnostic tests may be performed by technicians who have appropriate training and proficiency, as evidenced by state licensure or state certification from the appropriate state health or education department. In the absence of a state-level licensure or certification, the technician must be certified by the appropriate national credentialing body. In these cases, payment can be made to the provider who supervises and employs the licensed or certified technician

Employment Relationship (Applies to DE, PA, and WV, does not apply to NY Region)

An employment relationship is established if all the following criteria are sufficiently documented:

- The employer has the power to hire and fire;
- The employer has the power to direct the work done by the employee and has ultimate responsibility for the manner of his/her performance;
- The employer has the duty to pay wages, fringe benefits, and establish the level of compensation;

- There is no compensation received by any facility for the services of the employee during the period of employment by the employer.

INCIDENT TO BILLING PROCEDURE (Applies to DE, PA, and WV, does not apply to NY Region)

1. Providers billing "Incident To" their supervising physician should submit each claim with the supervising physician's information in both the billing *and* rendering sections of the claim. INCIDENT TO billing can only be claimed if the Physician has established the initial plan of care for a specific NEW problem.
2. Each CPT/HCPCS must have the SA modifier added when APPs bill "Incident To" the supervising physician. This is the claim indicator that alerts Highmark that someone other than the supervising physician delivered services to the patient. The supervising physician is responsible for the delivery of all supervised services.

Advanced Practice Provider [APP] Reductions Applicable To PA, DE and NY. (Not Applicable to WV)

The following reimbursement reductions apply to services **rendered** by enumerated APP's unless rendering providers meet and follow "Incident To" billing requirements as outlined above.

Behavioral Health reductions (DE and PA regions only)

BEHAVIORAL HEALTH	
Practitioner	**Reimbursement** (% of fee schedule)
▪ Master Prepared Therapists ▪ Licensed Clinical Social Workers (LCSWs) ▪ Licensed Professional Counselors ▪ Licensed Marriage and Family ▪ Counselors/Associate Marriage and Family Counselors	**75%**
▪ Nurse Practitioner - Mental Health ▪ Clinical Nurse Specialist - Psychiatric Mental Health Nurse ▪ Certified Registered Nurse - Psychiatric Mental Health Nurse	**85%**
▪ Licensed Social Workers* ▪ Social Workers*	**65%**

* Licensed Social Workers apply to Commercial business only.

Medical / Surgical reductions (DE, PA and NY regions only)

MEDICAL / SURGICAL	
Practitioner	**Reimbursement (% of fee schedule)**
▪ Nurse Practitioner ▪ Clinical Nurse Specialist (CRN) ▪ Clinical Registered Nurse Practitioner (CRNP) PCP ▪ Registered Nurse First Assistant (RNFA)* ▪ Nurse Midwives*	**85%**
▪ Physician Assistants (where allowed by law) ▪ Physician Assistant PCP	**85%**

* Only applicable to New York Region

Reductions listed above will apply to services rendered by an enumerated APP for codes in which care delivery is determined by the practitioner's knowledge, skills, and abilities. Examples include evaluation and management (E&M) codes, procedures performed by the mid-level, psychotherapy, etc. Commodity services such as vaccines, drugs, labs, and other diagnostic services will not be subject to the reductions when submitted on the same claim as an applicable service.

All APP's should list themselves as the rendering provider on the CMS 1500 claim form when independently diagnosing new problems and establishing a new plan of care. Remember, this policy REQUIRES APP providers practicing independently (defined within this policy as those providers seeing new patients and establishing independent plans of care) to enumerate. Please ensure enumeration within our system occurs (Informational letter received) prior to reporting your information in the rendering provider field or the claim will be rejected.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed
- RP-044: Medication Therapy Management Services (WV Region)

ADDITIONAL BILLING INFORMATION, REFERENCES AND GUIDELINES:

- CMS MLN Matters Article SE0441 issued August 23, 2016. https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA0441.pdf
- CMS 2020 COVID-19 interim final rule (85 FR 27550 thorough 27629)

https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicaid-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory

- Medicare Physicians Fee Schedule (PFS) Calendar Year (CY) 2021 https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1
- West Virginia Legislature; (2020) Senate Bill 787 http://wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB787%20SUB1%20enr.htm&yr=2020&sesstype=RS&i=787
- New York Insurance Law Section 4303 https://www.nysenate.gov/legislation/laws/ISC/4303

POLICY UPDATE HISTORY INFORMATION:

1 / 2021	Partial Implementation BH Fee Reimbursement, SA Modifier, Incident to guidelines.
4 / 2021	Full Policy Implementation, Enumeration reporting guidelines, removed facility information
10 / 2021	Implementation of Highmark NY RNFA and Midwife Legislative bill S1233A
11 / 2021	Added that HMNY Region only applies to Medical Surgical Reductions.
1 / 2022	Added modifier FR

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP- 010		
Subject:	Incident To Billing		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	October 1, 2021	**Revised Date:**	June 2021
Date Reviewed:	June 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒			**NY** ☒
Applicable Claim Type	**UB**	☒	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy serves to clarify "Incident To" services billed by physicians and non-physician practitioners practicing within their scope of license and aligns with CMS billing instructions. "Incident To" services are defined as those services furnished by someone other than the supervising physician and billed under the physician's NPI.

"Incident To" services are also relevant to services performed by auxiliary personnel working within the scope of license (nurses, technicians, and therapists) and supervised by certain non-physician practitioners (advanced practice providers [APPs]) such as physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologists, and others. These services are subject to the same requirements as physician-supervised services.

REIMBURSEMENT GUIDELINES:

To qualify as "Incident To," services must be part of the patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. The physician does not have to be physically present in the patient's treatment room while these "Incident To" services are provided, but must provide direct supervision, that is, they must be present in the office suite to render assistance, if necessary.

The following requirements must be met to qualify as "Incident To" services:

- The physician personally treats, establishes the diagnosis, and develops the plan of care for the patient on the **first visit** (new patient visit or consultation) for a particular medical problem. Or the APP may render services if the supervising physician signs off on the plan of care.
- A physician in the group (need not be the same physician who originally treated the patient) is physically on site when supporting personnel provides follow-up care on a future visit.
- The physician personally treats and diagnoses established patients who present with any **new conditions/diagnoses**.
- The physician has an active part in the ongoing care of the patient. Subsequent services by the physician must be of a frequency that reflects his/her continuing active participation in, and management of, the course of the treatment.
- Both the supervising physician and the supporting personnel must be employed or contracted by the group entity billing for the service of the supporting personnel (such as "W-2" employment, a leased employee, or an independent contractor). If the physician is a sole practitioner, the physician must employ the supporting personnel.

The following services do not qualify for "Incident To" billing:

- New patient office visit (CPT 99202-99205). If there is no sign off on the plan of care.

- Any **new conditions/diagnoses** encountered during the visit not addressed in the established plan of care. In this instance, the supervising physician needs to sign off on the established plan of care for the new condition/diagnosis.
- No auxiliary services can be billed "Incident To" when a supervising physician or APP is not physically present in the office at the time the service is rendered.
- Services delivered by an APP without supervision in an institutional setting (i.e. hospital, skilled nursing facility, Home etc.). If the supervising physician is physically present in the institutional setting and the APP is working under the physician's direct supervision, "Incident To" billing is allowed.

Plan of Care and Scope of License

An APP, and/or auxiliary personnel, cannot bill "Incident To" services when no **physician** approved plan of care is documented in the medical record. All new conditions/diagnoses must have an established plan of care documented in the medical record approved by the supervising physician's sign off prior to billing "Incident To" services. **If an APP is developing care plans for new patients or new conditions, that is not outside of their scope of license, if enumerated they MUST independently bill by submitting their own NPI as the rendering provider once their enumeration letter is received.**

If not enumerated they may bill "Incident To" services based on the supervising physician reviewing and signing off on the patients record. Reporting the "SA" modifier and the supervising physician NPI.

APPs must act within the scope of practice of their license and/or certification, and in accordance with state law in which the license/certification is held and the APP practices.

Services of unlicensed clinicians who are training under the supervision of a licensed clinician cannot be billed.

An SA modifier should be appended to all codes submitted for services rendered by any of the following

- Physician Assistant (PA)
- Clinical Nurse Specialist (CNS)
- Nurse Practitioner (NP)
- All Master's prepared behavioral health therapists, including LSCWs and LSW
- Licensed and Associate Marriage and Family Counselors
- Licensed Professional Counselors
- Certified Register Nurse Practitioner PCP (CRNP)
- Certified Registered Nurse Psychiatric Mental Health Nurse
- Registered Nurse First Assistant (RNFA)*
- * Only applicable to New York Region
- Nurse Mid Wives*
  * Only applicable to New York Region
- Pharmacist* (Applicable only to Medicare Advantage and WV Commercial plans)
  *For more information please review the documentation provided in the reference section of this policy.

Note: **The SA modifier must be appended to all incident to services filed for Highmark commercial business. This should always be used when services are rendered by an APP, billing "Incident To" claims.** The licenses held by these professionals may be recognized as different names for each state.

Examples of Non Acceptable and Acceptable "Incident To" Billing:

1. An APP administers services to a patient without documented supervision from the physician. The services should be billed under the APP's NPI and are not considered "Incident To."
2. In an office setting an APP performs a portion of an E/M encounter and the physician completes the E/M service. If the "Incident To" requirements above are met, the physician reports the service under the physician's NPI number. If the "Incident To" requirements above are not met, the service must be reported using the APP's NPI number.
3. Auxiliary personnel administer services under the supervision of a physician. If the "Incident To" requirements above are met, the services must be reported under the physician's NPI number.
4. Auxiliary personnel administer services under the supervision of an APP. The services should be billed under the APP's NPI number.
5. Billing for new patient visits or visits for new problems not previously assessed by the supervising physician; to quality for "Incident To" billing the supervising physician must approve by signing off on the care plan for all new problems.

Direct Supervision

Direct supervision means an eligible professional provider must be immediately physically available to assist without delay in the care of the patient (for example in the office suite). All supervision must be in accordance with the state licensure or certification requirements of the performing licensed or certified health care practitioner. To qualify for "Incident To" billing, a physician (not necessarily that APPs assigned supervisor) must be physically available, without delay, to assist the APP at any time.

Note: For purposes of limiting exposure related to the 2019 novel coronavirus, the plan will follow the proposed rule from the Centers for Medicaid and Medicare Services (CMS) to allow direct

supervision to include virtual presence of the supervising physician using real-time, interactive audio and video technology. For the duration of the Public Health Emergency (PHE).

Certain diagnostic tests have been identified that have extended technical components wherein the patient goes about normal daily activities while being monitored. These tests include, but are not limited to Holter monitoring, cardiac event monitoring, and sleep studies. These procedures are performed under the physician's overall management and control, but the physician is not present for the duration of the test.

Note: The technical component of diagnostic tests may be performed by technicians who have appropriate training and proficiency, as evidenced by state licensure or state certification from the appropriate state health or education department. In the absence of a state-level licensure or certification, the technician must be certified by the appropriate national credentialing body. In these cases, payment can be made to the provider who supervises and employs the licensed or certified technician

Employment Relationship

An employment relationship is established if all of the following criteria are sufficiently documented:

- The employer has the power to hire and fire;
- The employer has the power to direct the work done by the employee and has ultimate responsibility for the manner of his/her performance;
- The employer has the duty to pay wages, fringe benefits, and establish the level of compensation;
- There is no compensation received by any facility for the services of the employee during the period of employment by the employer.

Advanced Practice Provider [APP] Reductions for PA and DE (not applicable to WV)

The following reimbursement reductions apply to services **rendered** by enumerated Advanced Practice Providers unless rendering providers meet and follow "Incident To" billing requirements as outlined below.
Note: Behavioral Health reductions listed below do not apply to the New York region.

BEHAVIORAL HEALTH	
Practitioner	**Reimbursement** (% of fee schedule)
▪ Master Prepared Therapists ▪ Licensed Clinical Social Workers (LCSWs) ▪ Licensed Professional Counselors ▪ Licensed Marriage and Family ▪ Counselors/Associate Marriage and Family Counselors	**75%**
▪ Nurse Practitioner - Mental Health ▪ Clinical Nurse Specialist - Psychiatric Mental Health Nurse ▪ Certified Registered Nurse - Psychiatric Mental Health Nurse	**85%**
▪ Licensed Social Workers* ▪ Social Workers*	**65%**

* Licensed Social Workers apply to Commercial business only.

MEDICAL / SURGICAL	
Practitioner	**Reimbursement** (% of fee schedule)
▪ Nurse Practitioner ▪ Clinical Nurse Specialist (CRN) ▪ Clinical Registered Nurse Practitioner (CRNP) PCP ▪ Registered Nurse First Assistant (RNFA)* ▪ Nurse Midwives*	**85%**
▪ Physician Assistants (where allowed by law) ▪ Physician Assistant PCP	**85%**

* Only applicable to New York Region

Reductions listed above will apply to services rendered by an enumerated mid-level for codes in which care delivery is determined by the practitioner's knowledge, skills, and abilities. Examples would include: E & M Codes, procedures performed by the mid-level, psychotherapy, etc. Commodity services such as vaccines, drugs, labs, and other diagnostic services will not be subject to the reductions when submitted on the same claim as an applicable service.

All APP's should list themselves as the rendering provider on the CMS 1500 claim form when independently diagnosing new problems and establishing a new plan of care. Remember, this new policy REQUIRES mid-level providers that practice independently (defined within this policy as those providers seeing new patients and establishing independent plans of care) to enumerate. Please ensure enumeration within our system occurs (Informational letter received) prior to reporting your information in the rendering provider field or the claim will be rejected.

INCIDENT TO BILLING PROCEDURE

1. Providers billing "Incident To" their supervising physician should submit each claim with the supervising physician's information in both the billing *and* rendering sections of the claim. INCIDENT TO billing can only be claimed if the Physician has established the initial plan of care for a specific NEW problem.
2. Each line CPT/HCPCS must have the SA modifier added when APPs bill "Incident To" the supervising physician. This is the claim indicator that alerts Highmark that someone other than the supervising physician delivered services to the patient. The supervising physician is responsible for the delivery of all supervised services.

All applicable APPs independently billing Highmark for services must be separately enumerated in our provider systems. Failure to enumerate with Highmark may result in potential claim denial.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed
- RP-044: Medication Therapy Management Services (WV Region)

ADDITIONAL BILLING INFORMATION, REFERENCES AND GUIDELINES:

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- West Virginia Legislature; (2020) Senate Bill 787 http://wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB787%20SUB1%20enr.htm&yr=2020&sesstype=RS&i=787
- New York Insurance Law Section 4303 https://www.nysenate.gov/legislation/laws/ISC/4303

POLICY UPDATE HISTORY INFORMATION:

01 / 2021	Partial Implementation BH Fee Reimbursement, SA Modifier, Incident to guidelines.
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Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-010		
Subject:	Incident To Billing		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	April 5, 2021	**Revised Date:**	April 2021
Date Reviewed:	March 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy serves to clarify "Incident To" services billed by physicians and non-physician practitioners practicing within their scope of license and aligns with CMS billing instructions. "Incident To" services are defined as those services furnished by someone other than the supervising physician and billed under the physician's NPI.

"Incident To" services are also relevant to services performed by auxiliary personnel working within the scope of license (nurses, technicians, and therapists) and supervised by certain non-physician practitioners (advanced practice providers [APPs]) such as physician assistants, nurse practitioners, clinical nurse specialists, clinical psychologists, and others. These services are subject to the same requirements as physician-supervised services.

REIMBURSEMENT GUIDELINES:

To qualify as "Incident To," services must be part of the patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. The physician does not have to be physically present in the patient's treatment room while these "Incident To" services are provided, but must provide direct supervision, that is, they must be present in the office suite to render assistance, if necessary.

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- Pharmacist* (Applicable only to Medicare Advantage and WV Commercial plans)

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Practitioner	**Reimbursement** **(% of fee schedule)**
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▪ Nurse Practitioner - Mental Health ▪ Clinical Nurse Specialist - Psychiatric Mental Health Nurse ▪ Certified Registered Nurse - Psychiatric Mental Health Nurse	**85%**
▪ Licensed Social Workers* ▪ Social Workers*	**65%**

* Licensed Social Workers apply to Commercial business only.

MEDICAL / SURGICAL	
Practitioner	**Reimbursement (% of fee schedule)**
▪ Nurse Practitioner ▪ Clinical Nurse Specialist (CRN) ▪ Clinical Registered Nurse Practitioner (CRNP) PCP	**85%**
▪ Physician Assistants (where allowed by law) ▪ Physician Assistant PCP	**85%**

Reductions listed above will apply to services rendered by an enumerated mid-level for codes in which care delivery is determined by the practitioner's knowledge, skills, and abilities. Examples would include: E & M Codes, procedures performed by the mid-level, psychotherapy, etc. Commodity services such as vaccines, drugs, labs, and other diagnostic services will not be subject to the reductions when submitted on the same claim as an applicable service.

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- West Virginia Legislature; (2020) Senate Bill 787 http://wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB787%20SUB1%20enr.htm&yr=2020&sesstype=RS&i=787

POLICY UPDATE HISTORY INFORMATION:

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04 / 2021	Full Policy Implementation, Enumeration reporting guidelines, removed facility information

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-010		
Subject:	Incident To Billing		
Effective Date:	January 1, 2021	**End Date:**	
Issue Date:	February 22, 2021	**Revised Date:**	January 2021
Date Reviewed:	January 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
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- Pharmacist* (Applicable only to Medicare Advantage and WV Commercial plans)

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Examples of Non Acceptable and Acceptable "Incident To" Billing:

1. An APP administers services to a patient without supervision from the physician. The services should be billed under the APP's NPI and are not considered "Incident To."
2. In an office setting an APP performs a portion of an E/M encounter and the physician completes the E/M service. If the "Incident To" requirements above are met, the physician reports the service under the physician's NPI number. If the "Incident To" requirements above are not met, the service must be reported using the APP's NPI number.
3. Auxiliary personnel administer services under the supervision of a physician. If the "Incident To" requirements above are met, the services must be reported under the physician's NPI number.
4. Auxiliary personnel administer services under the supervision of an APP. The services should be billed under the APP's NPI number.
5. Billing for new patient visits or visits for new problems not previously assessed by the supervising physician; to quality for "Incident To" billing the supervising physician must establish the care plan for all new problems.

Direct Supervision

Direct supervision means an eligible professional provider must be immediately physically available to assist without delay in the care of the patient (for example in the office suite). All supervision must be in accordance with the state licensure or certification requirements of the performing licensed or certified health care practitioner. To qualify for "Incident To" billing, a physician (not necessarily that APPs assigned supervisor) must be physically available, without delay, to assist the APP at any time.

Note: For purposes of limiting exposure related to the 2019 novel coronavirus, the plan will follow the proposed rule from the Centers for Medicaid and Medicare Services (CMS) to allow direct supervision to include virtual presence of the supervising physician using real-time, interactive audio and video technology. For the duration of the Public Health Emergency (PHE).

Certain diagnostic tests have been identified that have extended technical components wherein the patient goes about normal daily activities while being monitored. These tests include, but are not limited to Holter monitoring, cardiac event monitoring, and sleep studies. These procedures are performed under the physician's overall management and control, but the physician is not present for the duration of the test.

Note: The technical component of diagnostic tests may be performed by technicians who have appropriate training and proficiency, as evidenced by state licensure or state certification from the appropriate state health or education department. In the absence of a state-level licensure or certification, the technician must be certified by the appropriate national credentialing body. In

these cases, payment can be made to the provider who supervises and employs the licensed or certified technician

Employment Relationship

An employment relationship is established if all of the following criteria are sufficiently documented:

- The employer has the power to hire and fire;
- The employer has the power to direct the work done by the employee and has ultimate responsibility for the manner of his/her performance;
- The employer has the duty to pay wages, fringe benefits, and establish the level of compensation;
- There is no compensation received by any facility for the services of the employee during the period of employment by the employer.

Advanced Practice Provider [APP] Reductions for PA and DE (not applicable to WV)

The following reimbursement reductions apply to services **rendered** by enumerated Advanced Practice Providers unless rendering providers meet and follow "Incident To" billing requirements as outlined below.

BEHAVIORAL HEALTH	
Practitioner	**Reimbursement (% of fee schedule)**
▪ Master Prepared Therapists ▪ Licensed Clinical Social Workers (LCSWs) ▪ Licensed Professional Counselors ▪ Licensed Marriage and Family ▪ Counselors/Associate Marriage and Family Counselors	**75%**
▪ Nurse Practitioner - Mental Health ▪ Clinical Nurse Specialist - Psychiatric Mental Health Nurse ▪ Certified Registered Nurse - Psychiatric Mental Health Nurse	**85%**
▪ Licensed Social Workers* ▪ Social Workers*	**65%**

* Licensed Social Workers apply to Commercial business only.

MEDICAL / SURGICAL	
Practitioner	**Reimbursement (% of fee schedule)**
▪ Nurse Practitioner ▪ Clinical Nurse Specialist (CRN) ▪ Clinical Registered Nurse Practitioner (CRNP) PCP	**85%**
▪ Physician Assistants (where allowed by law) ▪ Physician Assistant PCP	**85%**
▪ Certified Registered Nurse Anesthetist (CRNA) **	**65%**

** Regional Fee Schedule variations may apply a 65% reduction consistent with current processing guidelines.

All APP's should list themselves as the rendering provider on the CMS 1500 claim form. Remember, this new policy REQUIRES mid-level providers that practice independently (defined within this policy as those providers seeing new patients and establishing independent plans of care) to enumerate. Please ensure enumeration within our system occurs prior to reporting your information in the rendering provider field or the claim will be rejected.

INCIDENT TO BILLING PROCEDURE

1. Providers billing "Incident To" their supervising physician should submit each claim with the supervising physician's information in both the billing *and* rendering sections of the claim. INCIDENT TO billing can only be claimed if the Physician has established the initial plan of care for a specific NEW problem.
2. Each line CPT/HCPCS must have the SA modifier added when APPs bill "Incident To" the supervising physician. This is the claim indicator that alerts Highmark that someone other than the supervising physician delivered services to the patient. The supervising physician is responsible for the delivery of all supervised services.

Facility (UB Claims) Only

The following information pertains to Facility (UB) Outpatient Behavioral Health Services, the appropriate modifier must be reported to receive the proper reimbursement rate for each provider level.

Modifier	Provider Level	Reimbursement (% of fee schedule)
AJ	Master Level Therapist and LCSWs	**75%**
AH	Psychologist	**100%**
AM / HA	Psychiatrist or other Physician	**100%**
GF	CRNP	**85%**

Note: **This does not include Intensive Outpatient (IOP) and Partial Hospitalization (PHP).**

All applicable APPs independently billing Highmark for services must be separately enumerated in our provider systems. Failure to enumerate with Highmark may result in potential claim denial.

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Medical Policy Z-27: Eligible Providers

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed
- RP-044: Medication Therapy Management Services (WV Region)

ADDITIONAL BILLING INFORMATION, REFERENCES AND GUIDELINES:

- CMS MLN Matters Article SE0441 issued August 23, 2016. https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA0441.pdf
- CMS 2020 COVID-19 interim final rule (85 FR 27550 thorough 27629) https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicaid-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory
- Medicare Physicians Fee Schedule (PFS) Calendar Year (CY) 2021 https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1
- West Virginia Legislature; (2020) Senate Bill 787 http://wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB787%20SUB1%20enr.htm&yr=2020&sesstype=RS&i=787

POLICY UPDATE HISTORY INFORMATION:

01 / 2021	Implementation
01 / 2021	Removed Preventive Visit and lab, flu shots. EKG, certain radiology services, supplies verbiage under “The following Services do not qualify for Incident To billing”
02 / 2021	Added Note under Direct Supervision guideline changes for COVID-19 PHE. Pharmacist eligible for Incident To (Med Adv and WV commercial) Plans only. Note added to Modifier “SA” section. Additional references added to policy.