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.

HISTORY

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.

HISTORY

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.

HISTORY

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.

HCTC

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:

- CMS MLN Matters Article SE0441 issued August 23, 2016. https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA0441.pdf
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- 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

HISTORY

POLICY UPDATE HISTORY INFORMATION:

01 / 2021	Partial Implementation BH Fee Reimbursement, SA Modifier, Incident to guidelines.
04 / 2021	Full Policy Implementation, Enumeration reporting guidelines, removed facility information
10 / 2021	Implementation of HM NY RNFA and Midwife Legislative bill S1233A

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** ☒		

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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:

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- 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.

HISTORY

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.

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- Certified Register Nurse Practitioner PCP (CRNP)
- Certified Registered Nurse Psychiatric Mental Health Nurse
- 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.

HISTORY

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.

HISTORY

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.

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.

HISTO

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

POLICY UPDATE HISTORY INFORMATION:

01 / 2021	Partial Implementation BH Fee Reimbursement, SA Modifier, Incident to guidelines.
04 / 2021	Full Policy Implementation, Enumeration reporting guidelines, removed facility information

HISTORY

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** ☒		
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.

HISTORY

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 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.

- 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 by the group entity billing for the service (such as a "W-2", 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 visits (CPT 99202-99205).
- Any **new conditions/diagnoses** encountered during the visit not addressed in the established plan of care. In this instance, the supervising physician needs to see the patient and establish a 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.

HISTORY

Plan of Care and Scope of License

An APP, and/or auxiliary personnel, cannot bill "Incident To" services when no **physician** generated 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 by the supervising physician prior to billing "Incident To" services. If an APP is developing care plans for new patients or new conditions, they **MUST** independently bill by submitting their own NPI as both the billing and rendering provider.

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.

A 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 Anesthetist (CRNA)

- Certified Registered Nurse Psychiatric Mental Health Nurse
- 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:

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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.

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HISTORY

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

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

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- 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.

HISTORY

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.

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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.

HISTORY