Massachusetts | Commercial

Commercial Reimbursement Policy

Subject: **"Incident to" Services - Professional**	
Policy Number: **C-11002**	Policy Section: **Administration**
Last Approval Date: **06/02/2022**	Effective Date: **06/02/2022**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a Wellpoint member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Wellpoint may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

"Incident to" services, rendered by qualified auxiliary office personnel and performed under direct supervision by a physician or other qualified health care provider are eligible for separate reimbursement when separately reported by the supervising provider.

These separately reportable services are considered “Incident to” when performed by qualified auxiliary office personnel. “Incident to” services rendered and reported under the supervising provider’s identification number must meet the Health Plan’s definition of medically necessary and be otherwise covered services.

I. Wellpoint requires that “Incident to” services meet the following criteria:
   - The supervising provider must be physically present in the office suite and/or immediately available when necessary via interactive communication to provide assistance and direction throughout the evaluation and management (E/M) visit or other rendered service
   - The supervising provider must stay involved and have an active part in the ongoing care of the patient, which includes reviewing the documentation for each visit for each patient whose care the auxiliary personnel was involved with
   - For a group practice, any provider within the group and recognized by the Health Plan as eligible to submit claims directly to the Health Plan may qualify as a supervising provider

II. Wellpoint does not follow CMS “Incident to” reimbursement rules for any physician or non-physician provider (NPP) who has been assigned or is waiting for their own NPI. Therefore:
   - If a physician or NPP has an NPI and is recognized by the Health Plan as eligible to submit claims directly to the Health Plan, the provider is required to report their services under their own NPI.
   - Separately reportable “Incident to” services are only eligible for reimbursement under the supervising provider’s NPI if the specific type of NPP or qualified auxiliary office personnel who rendered the services is *ineligible* to submit claims directly to the Health Plan; this rule will apply even when a provider is in the process of applying for their own NPI number.

III. The following services are <u>not</u> eligible for reimbursement as “Incident to” services:
   - Incidental services that are not separately reportable
   - Services performed for patients in a facility setting
   - Services provided by ambulance or Emergency Medical Technicians (EMT) performed under the telephonic supervision of a physician or other qualified health care provider
   - Services rendered by any provider who is eligible to directly submit claims to the Health Plan for reimbursement
   - When the provider is a type who is eligible to receive an NPI and is a provider type recognized by the Health Plan to submit claims directly to the Health Plan; while the provider is waiting to receive their NPI and/or Health Plan eligibility, their services are not eligible for reimbursement as “Incident to” services
   - Services performed by other non-licensed health care providers who do not qualify as auxiliary personnel to the extent licensure is required by the Health Plan and/or the state in which the Health Plan operates

IV. When covered “Incident to” services are rendered in accordance with this policy, the “Incident to” services are eligible for reimbursement based on the maximum allowance of the applicable supervising provider’s fee schedule. Wellpoint requires that all documentation and reporting requirements, as indicated in our reimbursement policies, must be followed.

V. Providers known as non-physician practitioners (NPPs) are qualified to assist a physician or another qualified health care provider or act in the place of such individuals without direct supervision. NPPs 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 NPP practices.

In accordance with this policy, NPPs who are eligible to receive their own National Provider Identification (NPI) and who are recognized by the Health Plan must submit their claims directly to the Health Plan under their own NPI.

Related Coding
Standard correct coding applies

Policy History

06/02/2022	Biennial review approved; minor language changes
04/22/2020	Biennial review approved; minor administrative changes
06/01/2019	Policy template updated; description section removed
01/03/2017	Annual Review; policy language updated to include “Medicare Advantage Employer Group” follows this policy
01/05/2016	Revision: Policy Language updated to include the description of a supervising provider; added language to include a supervising provider must review auxiliary documentation for each visit
07/07/2015	Annual Review: Policy Language updated to include that a provider must be immediately available and adding “via interactive communication”. Also added incident criteria to section B.
07/01/2014	Annual Review: Policy Language updated with minor changes to paragraph 4
07/02/2013	Annual Review: Policy language updated to include ‘other qualified health care professional’
07/10/2012	Annual Review; no updates
06/07/2011	Adopted by Enterprise Professional Reimbursement Committee

References and Research Materials

This policy has been developed through consideration of the following:

- Centers for Medicare and Medicaid Services (CMS)
- American Academy of Family Physicians (AAPP)

Definitions

Auxiliary personnel	Personnel who, as determined by the Health Plan, are not eligible to directly submit claims to the Health Plan and, therefore, not eligible to receive direct reimbursement

“Incident to” Services	Certain services that are integral to the care of a patient and are performed by auxiliary personnel under direct physician or other qualified health care professional supervision
General Reimbursement Policy Definitions	

Related Policies and Materials

Code and Clinical Editing - Professional
Documentation and Reporting Guidelines for Evaluation and Management Services - Professional
Scope of License - Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.