HIGHMARK.

Reimbursement Policy

Title: Incident To Services

Policy Number: RP-010

Version Number: 2026.11.01

Medicare Advantage:	PA, WV, DE, NY	Version Effective:	November 1, 2026
Commercial:	DE	Originally Effective:	January 1, 2021
Claim Type:	CMS 1500	History Versions:	Click Here → History

Disclosure: *The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan and ensure you are reimbursed based on the codes that correctly describe the health care services provided. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the members' contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations. The policy is applicable to designated markets either entirely, or partially, as indicated within the policy. Policy designation of claim type is based on how the provider is contracted with the Plan.*

Description:

Incident-to billing is a methodology established by the Centers for Medicare & Medicaid Services (CMS). Services provided by auxiliary personnel may be billed as incident-to a physician's or Advanced Practice Provider's (APP) professional services when all applicable requirements are met and the services are medically necessary for the patient.

- Services **must** be integral to the supervising physician's or APP's professional service
- Services **must** be performed in an office or clinic setting
- Services **must** be provided under direct supervision

Incident-to services may be billed under the supervising provider's National Provider Identifier (NPI) only when all applicable requirements are met and documented in the medical record.

Reimbursement Guidelines:

Rendering or Performing Provider Enumeration

Practitioners who personally perform services must be listed as the rendering or performing provider on the CMS-1500 claim, unless incident-to billing requirements are met. This applies to:

- Physician Assistant/Physician Associates
- Clinical Nurse Specialist
- Nurse Practitioner
- All Master's prepared behavioral health therapists, including LCSWs and LSW
- Licensed and Associate Marriage and Family Counselors
- Licensed Professional Counselors
- Certified Registered Nurse Practitioner PCP (CRNP)
- Certified Registered Nurse (and Nurse-Midwife where applicable)
- Clinical Psychologists, Therapists and Counselors
- Pharmacist

Requirement: APPs **must** bill as rendering provider when services are performed.
Exception: Incident-to billing permits services to be billed under the supervising provider's NPI only when all applicable requirements are met including applicable state scope-of-practice and supervision requirements.
Consequences: Claims that do not meet applicable incident-to billing requirements may be denied, rejected, or subject to recoupment.

For Highmark Delaware Commercial and Medicare Advantage claims administration purposes, modifier SA is now required to be appended to all services billed pursuant to the Incident To provisions of this policy, regardless of practitioner type.

APP Billing Procedure

- When ancillary or auxiliary personnel furnish services that meet applicable incident-to requirements, the rendering provider field must reflect the NPI of the supervising physician or APP, as applicable, when different from the billing provider NPI.
- Incident-to ancillary services reported under an APP NPI are reimbursed according to the applicable APP reimbursement methodology, including any standard APP reduction.
- Ancillary services reported under a physician NPI are reimbursed at 100% of the applicable contracted fee schedule when all incident-to requirements are met.

Coding:

Hospital and skilled nursing facility services cannot be billed as "Incident To" at any time. Modifier SA must be reported when Incident to Services are being rendered. For purposes of reimbursement under this policy, incident To Services only apply when reported with place of service (POS) 11.

Plan of Care Requirements

- A documented physician or APP approved plan of care must exist prior to billing.
- New diagnosis requires a new plan of care.
- Absence of a plan of care is non-reimbursable.

Services must be performed within the scope of license, certification, or other applicable authorization of the individual furnishing the service. Services furnished by unlicensed clinicians in training under the supervision of a licensed clinician may not be billed incident-to unless otherwise permitted by applicable law and Plan requirements.

Direct and General Supervision

Direct supervision is required unless general supervision is expressly permitted for the service, provider type, or setting. General supervision applies only to designated behavioral health services when permitted by applicable law and Plan requirements.

Certain diagnostic tests have extended technical components during which the patient continues normal daily activities while being monitored, including but not limited to Holter monitoring, cardiac event monitoring, and sleep studies. These procedures are performed under the physician's overall management and control, although the physician is not present for the duration of the test. The technical component may be performed by technicians with appropriate training and proficiency, as evidenced by state licensure, state certification, or certification by an appropriate national credentialing body when state-level licensure or certification is unavailable. Payment may be made to the provider who supervises and employs the licensed or certified technician.

For psychology services furnished "incident to," the billing provider must personally evaluate the patient and initiate treatment before delegating services. Appropriately trained therapists may furnish services under direct supervision when acting within their state-authorized scope of practice. Only the practitioner types listed below may furnish the indicated diagnostic and/or therapeutic psychological services.

1. Doctorate or Masters level Clinical Psychologist: 90785, 90832-90834, 90836-90838, 90846, 90847, 90849, 90853, 90880, 90899
2. Doctorate or Masters level Clinical Social Worker: 90785, 90832-90834, 90836-90838, 90846, 90847, 90849, 90853, 90899
3. Clinical Nurse Specialist (CNS): 90785, 90832-90834, 90836-90838, 90846, 90847, 90849, 90853, 90899
4. Nurse Practitioner (NP): 90785, 90832-90834, 90836-90838, 90846, 90847, 90849, 90853, 90899
5. Other state-licensed or authorized mental health providers (e.g., licensed clinical professional counselors, licensed marriage and family therapists) may furnish services when acting within scope and all supervision and billing requirements are met. These providers may not bill Medicare directly.

These services may be delegated only to auxiliary personnel who meet the qualifications in this section, such as a clinical social worker furnishing the HCPCS codes listed for clinical social workers. Individuals furnishing services "incident to" a qualified Medicare practitioner are not required to enroll separately in Medicare as independent practitioners. The supervising provider must be qualified to perform and oversee the services, consistent with scope of practice and the services typically provided in the practice setting.

Individuals not licensed or otherwise authorized under state law to provide psychological services may not furnish such services "incident to"; appropriate credentialing is required. Services that do not meet these requirements may be denied or reviewed, and providers may submit corrected claims or supporting documentation to demonstrate compliance.

Coverage of services and supplies furnished "incident to" a physician's professional services in private practice is limited to services under direct physician supervision. Direct supervision requires the supervising provider to be immediately available to assist and direct throughout the service either through physical presence or through real-time audio/video technology when permitted by CMS and applicable law. The supervising provider is not required to be present in the same room. This requirement also applies to certain state-licensed non-physician practitioners, including nurses, clinical psychologists, clinical social workers, and other therapists. Services and supplies furnished incident to a physician's service in a physician-directed clinic or group association are generally subject to the same office-setting requirements. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 60.1–60.3).

For hospital patients and SNF patients in a Medicare-covered stay, Medicare Part B does not cover physician-employed auxiliary personnel services as incident to physicians' services under section 1891(s)(2)(A) of the Act. Such services may be covered only under the hospital outpatient or inpatient benefit, and payment may be made only to the hospital by a Medicare Part A MAC. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 60).

When a physician's office is located in an institution, "incident to" coverage requires auxiliary medical personnel to be office staff, not institution staff, and supplies must be an expense of the physician's office practice. If auxiliary personnel perform services outside the office setting, such as in a patient's home or in an institution other than a hospital or SNF, coverage applies only when direct supervision requirements are met. Physician availability by telephone, or presence elsewhere in the institution, does not constitute direct personal supervision. Supervision alone is not a physician professional service; the physician must also perform, or have performed, a personal professional service to which the auxiliary personnel's service is incidental. Denials for failure to meet these requirements are 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).

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 employee's work 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.

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.

Definitions:

Term or Acronym	Definition
Incident-to Requirements	Applicable CMS and Plan requirements that must be met for services furnished by auxiliary personnel or an Advanced Practice Provider (APP) to be billed under the supervising provider's National Provider Identifier (NPI). These requirements include, but are not limited to, documentation of an established plan of care, the supervising provider's initial service and ongoing involvement in the patient's treatment, the service being furnished as an integral part of the patient's normal course of treatment, and the applicable level of supervision required for the service and setting.
Direct Supervision	The supervising provider is immediately available to provide assistance and direction throughout the performance of the service, either through physical presence or through real-time audio/video technology when permitted by CMS and applicable law. The supervising provider is not required to be present in the same room.
General Supervision	The service is furnished under the supervising provider's overall direction and control, but the supervising provider's physical presence is not required during performance of the service. General supervision applies only where permitted under this policy and applicable law, including designated behavioral health services when applicable.
Plan of Care	A documented course of treatment established after the supervising provider personally performed the initial service. The supervising provider must remain actively involved in the patient's treatment at a frequency consistent with the patient's condition and treatment plan.
Ancillary/Auxiliary Staff	Non-billing staff
APP	Advanced Practice Provider = Licensed, Billable Practitioner
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CNS	Clinical Nurse Specialist
COMM	Commercial
CRNA	Certified Registered Nurse Anesthetist
CRNP	Certified Registered Nurse Practitioner
CRN	Certified Registered Nurse
Credentialed	Successfully completing the process of 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**
SA	Highmark claims-reporting indicator for services billed under the Incident To provisions, regardless of practitioner type.
FR	The supervising practitioner was present through two-way, audio/video communication technology

References:

- Centers for Medicare and Medicaid Services (CMS); MLN Matters SE0441, issued August 23, 2016.
- CMS; Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 60-63
- CMS; Pub 100-03; Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 1, 70.3
- CMS; Article A52825
- Medicare Physicians Fee Schedule Final Rule Calendar Year (CY) 2021, 2023
- West Virginia Legislature; (2020) Senate Bill 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

Related Plan Policies:

Refer to the following Commercial Medical Policies for additional information:

- Z-27: Eligible Providers

Refer to the following Reimbursement Policies for additional information:

- RP-001: Assistant Surgery
- RP-020: Preventive Medicine and Office or Outpatient Evaluation and Management Services
- RP-035: Correct Coding Guidelines
- RP-041: Services Not Separately Reimbursed
- RP-057: Evaluation and Management Services
- RP-068: Mid-Level Practitioners and Advanced Practice Providers

Policy Update History:

1 / 2024	Removed PA Commercial from policy application
11 / 2026	Added modifier SA direction applicable to Medicare Advantage and DE Commercial

Highmark Reimbursement Policy Bulletin

HIGHMARK.

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.

HISTORY

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
SA	Nurse practitioner rendering service in collaboration with a physician
FR	The supervising practitioner was present through two-way, audio/video communication technology

HISTORY

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.

HISTORY

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.

HISTORY

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.

HISTORY

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

HISTORY

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

HISTORY

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

HISTORY