Incident To

Reimbursement Policy ID: RPC.0014.5400

Recent review date: 11/2025

Next review date: 12/2027

AmeriHealth Caritas District of Columbia reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth District of Columbia may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

"Incident to" allows outpatient services that are furnished by nonphysician providers to be billed under a physician's national provider identification (NPI) number. The services must be an integral, although incidental, part of the physician's personal professional services, and they must be performed under the physician's direct supervision.

Exceptions

Behavioral Health Community Workers may bill under a Behavioral Health Provider before or until they receive their own NPI or Medicaid ID number.

“Incident To” services are not reimbursable in certain service settings. Claims with the following Place of Service (POS) codes will be denied.

- 02 – Telehealth
- 19 – Outpatient hospital
- 21 – Inpatient hospital
- 22 – On-campus outpatient hospital
- 23 – Emergency department
- 24 – Ambulatory Surgery Center
- 26 – Military Treatment Center
- 31 – Skilled Nursing Facility
- 34 – Hospice Facility
- 41 – Ambulance – Land
- 42 – Ambulance – Air
- 51 – Inpatient Psychiatric Facility
- 52 – Psychiatric Facility, Partial Hospitalization
- 53 – Community Mental Health
- 56 – Psychiatric Residential Treatment
- 61 – Comprehensive Inpatient Rehabilitation Facility

Reimbursement Guidelines

“Incident to” allows outpatient services that are furnished by auxiliary personnel to be billed under a physician’s national provider identification (NPI) number. To qualify for reimbursement as “Incident To” services, the services must be part of the patient's normal course of treatment. The physician (or advanced practice provider [APP]) must have initiated a course of treatment and remained actively involved in the course of treatment, while the service provided by the auxiliary staff was follow-up care. "Incident to" billing does not apply to a new patient or a new problem for an established patient. The physician/APP is not required 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 in the area where the care is delivered, and be available to provide assistance, if necessary. General supervision means the service is physician controlled, but physician presence is not required. This applies to all hospital outpatient therapeutic services.

In the case of post-payment review, documentation must include the name and the professional designation of staff providing the “incident to” services; co-signature of the supervising physician on documentation entries, and documentation from other dates of service, for example, the initial visit, establishing the link between the two providers. Missing or incomplete documentation may result in recoupment of payment.

Definitions

Advanced practice professional (APP)
An Advanced Practice Provider (APP) is a health care provider who is not a physician but who performs medical activities typically performed by a physician. They are most commonly a nurse practitioner or physician assistant.

Direct supervision
The physician must be immediately available to furnish assistance and direction throughout the performance of the procedure/service.

Incident to
“Incident to” a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.

General Supervision
A procedure or service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure/service. This includes all therapeutic outpatient hospital services.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. The National Correct Coding Initiative (NCCI).
V. https://www.amerihealthcaritasdc.com/search.aspx?q=incident+
VI. https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r1764b3.pdf

Attachments

N/A

Associated Policies

RPC.0021.5400 New Patient Visit
RPC.0063.5400 Place of Service

Policy History

11/2025	Reimbursement Policy Committee Approval
10/2025	Biennial Review • Added Associated Policies • New Patient Visit • Place of Service
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
06/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas District of Columbia from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section