Billing and Coding Guidelines
PSYCH-013 - Psychological Services under the "Incident to" Provision

Contractor Name
Wisconsin Physicians Service (WPS)

Contractor Type
Carrier B
MAC B

CMS Regulations:
Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

§1861 (s) of the Social Security Act.
42CFR410.26
Fed Reg., November 1, 2001
*****60.1 - Incident to Physician's Professional Services *(Rev. 17, 06-18-04)*
*60.3 - Incident to Physician's Service in Clinic *(Rev. 17, 06-18-04)*
*10.4 - Items 14-33 - Provider of Service or Supplier Information *(Rev. 148, 04-23-04)*
MCM Transmittal No. 1463, 1794, Section 2050.2, 2050.3, 2050.4; MCM 2050, 2050.1(updated August,2002); 2070, 2390; 3060
IL CIC7, 11/04/96;

National Policy
National Coverage defines coverage of services rendered under the 'incident' to a physician's service provision.

Under the incident to provision, *"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."*

"Incident to" services are defined as services commonly furnished in a physician's office which are "incident to" the professional services of a physician (MD or DO) and are limited to situations in which there is direct physician personal supervision.

Per Medicare Program Memorandum Transmittal AB-03-037 (March 28, 2003) *Certain nonphysician practitioners such as clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants may have services furnished incident to their professional services. To the extent that they are licensed or authorized by the State to furnish mental health services, these practitioners could have others provide some services as an incident to overall mental health services.*

However, the services that are referred to in the above statement are usually diagnostic services such as psychological and neuropsychological tests - NOT psychotherapy.

Clinical psychologists, nurse practitioners, clinical nurse specialists, physician assistants, clinical social workers may not bill for Psychiatric Therapeutic Procedures (CPT codes 90801-90899), under the incident to provision, provided by other non-physician practitioners.

CMS National Coverage Policy:

1. *Medicare Benefit Policy Manual CMS Pub 100-2, 15, §50*
   For purposes of this section, physician means physician or other practitioner (physician assistant §190 (previously §2156); nurse practitioner, §700 (previously §2158); clinical nurse specialist, §210 (previously §2160); nurse midwife, §180(previously §2154); and clinical psychologist, §160 (previously §2150) authorized by the Act to receive payment for services incident to his or her own services.
2. *Medicare Benefit Policy Manual CMS Pub 100-2,15, §50*
   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
3. *Medicare Benefit Policy Manual CMS Pub 100-2, 15, §60.4.1*
   Services and supplies commonly furnished in physicians' offices are covered under the incident to provision. Where supplies are clearly of a type a physician is not expected to have on hand in his/her office or where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the incident to provision. (§2050-1 A)
4. *Medicare Benefit Policy Manual CMS Pub 100-2, 15, §60.1B*
   Direct supervision in the office setting means the physician must be present in the office suite and immediately available and able to provide assistance and direction throughout the time the service is performed. Direct supervision does not mean that the physician must be present in the same room with his or her aide.
5. *Medicare Benefit Policy Manual CMS Pub 100-2, 15, §60.1B*
   Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.
6. *Medicare Benefit Policy Manual CMS Pub 100-2, **60.1 -***
   In some cases the physician or nonphysician practitioner who performed an initial service and ordered the service that is subsequently performed by auxiliary personnel is not the same person who is supervising the service. Then the supervising physician must be identified on both the paper and electronic claim forms. When the paper Form CMS 1500 is used, follow the instructions for completing the form, found in Pub 100-04, chapter 26, §10.4. When filing electronic claims with incident to services, supply the ordering physician information for each line of service in the 2420E loop and supply the supervising physician information in loop 2310E. If the supervising physician information differs for a specific detail line, then supply that detail line supervising physician information in loop 2420D.

Coding Guidelines

1. Any claim for a physician's service must be submitted with an ICD-9-CM diagnosis.
2. An ICD-9-CM code V82.9 (special screening of other conditions, unspecified condition) should be used to indicate screening services performed in the absence of a specific sign, symptom, or complaint. Use of V82.9 will result in the denial of claims as non-covered screening services. When billing V82.9 use the **GY modifier** to ensure an appropriate denial.

3. All ICD-9-CM diagnosis codes must be coded to their highest level of specificity (i.e. fourth or fifth digit).

Reasons for Denial

1. Services that do not comply with the definition of 'incident to a physicians services found in Medicare Benefit Policy Manual CMS Pub 100-2, 15, §50.3, §60.1, §60.2, §60.2, §60.3, and §60.4.
2. Services performed by person lacking formal training and/or performance of psychotherapy services outside the scope of practice authorized under state law.
3. Screening tests, in the absence of associated signs, symptoms or complaints are denied under Section 1862(a)(7).
5. Submitting a claim for a service submitted with an ICD-9-CM diagnosis code listed in " ICD-9 Codes that DO NOT Support Medical Necessity" will be denied as not medically necessary under Section 1862(a)(1)(A).
6. Lack of documentation in the patient record of medical justification for establishing the diagnosis on the claim. Subsequent determination that the medical record is lacking such justification will result in a retroactive denial under Section 1862(a)(1)(A).
7. Services performed by clinical social workers that do not follow the regulations in the Medicare Benefit Manual 100-2, Chapter 15, 170 - Clinical Social Worker (CSW) Services and 160 - Clinical Psychologist Services

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Original Effective Date
09/16/2010

Revision History Number/Explanation

Publication Date
08/01/2010

Notes
* - An asterisk indicates a revision to that section of the policy.