COMMON GROUND
HEALTHCARE COOPERATIVE

REIMBURSEMENT POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Reimbursement of Advanced Practice Nonphysician Practitioners- WI MP-PY-1666	09/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies.

In addition to this policy, reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

This policy does not ensure an authorization or reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Reimbursement of Advanced Practice Nonphysician Practitioners

B. Background

Centers for Medicare and Medicaid Services (CMS) established guidelines regarding reimbursement of advanced practice providers, initially categorized under non-physician practitioners (NPP), including, but not limited to, physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), licensed social workers (LSW), mental health counselors (MHC) and marriage family therapists (MFT).

NPPs are health care providers who assess, diagnose, and treat patients but do not possess the education or certification as a physician. NPPs work in both the medical/surgical realm and within behavioral health (BH) models that deliver psychotherapy, counseling and other substance use disorder services. Billing varies according to the level of the practitioner and field of practice. The scope of practice for each type of NPP will vary by state and is defined by state laws and regulations.

Medical billing falls under 2 categories: direct billing and incident-to billing. Direct billing involves a claim that is submitted under the NPPs National Provider Identification (NPI) number with a reduced payment that is typically a percentage of the contracted fee schedule. Incident-to billing involves claims submitted under the supervising physician's NPI that are paid at a higher percentage of the physician's fee schedule.

CMS billing protocols ensure that healthcare providers deliver services efficiently while complying with regulatory standards. Understanding guidelines is crucial to navigate the billing process successfully, optimize reimbursement, and maintain compliance with regulations. This policy applies to services provided by NPPs within a medical or other healthcare practice and to both in- and out-of-network providers. Common Ground Healthcare Cooperative (CGHC) recognizes licensed NPPs as a separate provider type when working under the supervision of a participating physician or doctorate-level provider.

C. Definitions

- **Consolidated Billing** – All claims for the entire package of care received by residents or inpatient members must be billed by the facility.

D. Policy

I. General Reimbursement Guidelines

A. If a practitioner or provider has a contract with CGHC that contract supersedes this policy direction and is the governing document.

B. Providers are required and responsible for use of any applicable modifiers on claims, as necessary.

C. Patients cannot be charged more than amounts permitted under federal law. If a member pays more for a service than the assigned payment limits, the excess amount must be refunded.

D. All providers must follow applicable CMS qualifications and criteria for direct and incident to billing, service requirements, coverage and documentation guidelines, and billing guidelines.
   1. Direct billing criteria include the following:
      a. The service(s) provided is considered a physicians' service and is a covered service under the member's benefit plan.
      b. The service(s) provided is within the NPP's scope of practice for the applicable license/certification and state.
      c. Claims include assigned individual NPP NPI number.
      d. NPPs must be credentialed.
   2. Incident to services criteria include the following:
      a. Services must be an integral ("incidental") part of the member's normal treatment when the physician performed an initial service and remains actively involved in the member's care.
      b. Services are those commonly rendered without charge or included in the physician's bill.
      c. Billed services occurred in an office or clinic setting, not hospital inpatient or outpatient setting.
      d. Services must be provided under direct physician supervision (ie, supervising physician and NPP must be associated with the same practice and the supervising physician must be present in the location of service and immediately available to provide assistance and direction throughout the time the NPP is performing services).
      e. Physician involvement must be documented in the medical record.

II. Physical Health or Medical/Surgical
CGHC reimburses physical health NPPs at the following rates:
   A. Certified Registered Nurse Anesthetists (CRNAs) are exempt from mid-level reductions in payment and paid at 100% of the Physician Fee Schedule (PFS).
   B. Anesthesiologist Assistants (AAs)
      1. Services are paid at 100% under the PFS or in accordance with the level of supervision provided.
      2. Units are paid under the Anesthesia Fee Schedule and based on applicable locality adjusted anesthesia conversion factor multiplied by the sum of allowable base and time units (ie, 1 anesthesia time unit = 15 minutes anesthesia time).
   C. Physician Assistants (PAs)
      1. Incident to and incident to a PA services provided outside a hospital or SNF setting are paid at 85% of the amount a physician receives under the PFS.
      2. Assistant-at-surgery services are paid 85% of 16% of the physician rate under the PFS.
      3. When services are provided in the hospital setting (inpatient and outpatient), payment is unbundled and made directly to the PA under the PFS.
   D. Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)

1. Direct billing is paid at 80% of the lesser of the actual charge or 85% of the amount a physician receives under the PFS when furnished outside a hospital or skilled nursing facility (SNF) setting.
2. Assistant-at-surgery services are paid 85% of 16% of the amount a physician receives under the PFS.
3. Incident to services provided by auxiliary personnel outside a hospital or SNF setting are paid at 85% of the physician rate under the PFS.

E. Certified Nurse Midwives (CNMs)
1. Direct billing is paid at 80% of the lesser of the actual charge or 100% of the amount a physician receives under the PFS. When billing directly for services in a hospital setting (inpatient and outpatient), payments are unbundled and paid under the PFS.
2. Covered drugs and biologicals provided incident to CNM services are paid according to Part B drug and biological payment methodology.
3. Incident to services provided outside a hospital or SNF setting are paid at 100% of the physician rate under the PFS.
4. Covered clinical diagnostic laboratory services are paid according to the Clinical Laboratory Fee Schedule.
5. When most of a global service is provided and a physician is called in to provide a portion of care or when the physician provides most of the service and calls in a CNM, payment will be based on the portion of the global fee that would be paid to the billing practitioner. Service modifiers would be used to report that not all covered global allowance services were provided.

F. Other NPPs of physical health services
NPPs not listed above will be paid at 85% of the physician rate under the PFS.

III. Behavioral Health
CGHC reimburses NPPs (eg, marriage and family therapists, mental health counselors, licensed social workers, substance abuse counselors) at 75% of the clinical psychologist rate under the PFS. Clinical psychologists are paid 100% of the rate paid to physicians under the PFS.

A. MFT and MHC services furnished to skilled nursing facility residents on or after January 1, 2024 are excluded from consolidated billing.
B. There may be other billing exclusions related to BH billing by certain groups of NPPs (eg, MFT/MHC services to inpatient of Medicare-participating hospitals, MFT/MHC services to client under partial hospitalization or intensive outpatient programs by hospital outpatient departments or community mental health centers). Providers are responsible for submitting claims appropriately.

IV. Commodity Services
These services will not be subject to reductions when submitted on the same claim as an applicable service and will be reimbursed at 100% of the fee schedule allowance if covered under the member's benefit plan, but not limited to,

A. laboratory services
B. after-hours services

C. supplies
D. injected or infused drugs
E. diagnostic tests

E. Conditions of Coverage

I. Proper documentation is crucial to demonstrate compliance with supervision requirements, including maintaining clear records of services provided, the nature of the supervisory relationship, and any collaboration with the supervising physician or BH professional. CGHC reserves the right to request supervision documents or medical records that establish the validity of billed services.

II. Additional criteria may exist for billing some services (eg, assistant-at-surgery) that include the use of modifiers or other guidelines. Providers are responsible for billing these services according to federal and/or state guidelines.

III. Paid claims submitted in violation of state and/or federal guidelines or filed incorrectly by providers, including a lack of modifier use, may be subject to recoupment.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	06/04/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	09/01/2025	
Date Archived		

H. References

1. Advanced practice nonphysician practitioners. Centers for Medicare and Medicaid Services. Updated December 5, 2024. Accessed June 3, 2025. www.cms.gov
2. Consolidated Appropriations Act, Sections 4113 and 4121(FF) (2023).
3. Incident to services and supplies. Centers for Medicare and Medicaid Services. Updated April 9, 2025. Accessed June 3, 2025. www.cms.gov
4. Marriage and family therapists. Centers for Medicare and Medicaid Services. Updated April 11, 2025. Accessed June 3, 2025. www.cms.gov
5. Marriage and Family Therapist Services, 42 C.F.R. § 410.53 (2023).
6. Medicare and Medicaid Programs. 42 CFR Parts 401, 405, 410, 411, 414, 423-425, 427, 428, and 491 (2024).
7. Medicare and Mental Health Coverage. Centers for Medicare and Medicaid Services; 2024. MLN1986542. Accessed May 3, 2025. www.cms.gov
8. Mental Health Counselor Services, 42 C.F.R. § 410.54 (2023).
9. Payment for Physician's Services, 42 U.S.C. 1395, section 1848(g)(4)(A) (2018).