AULTCARE

UNDERSTANDING INCIDENTAL SERVICES AND PREVENTING RELATED CLAIM DENIALS

COMPREHENSIVE EDUCATIONAL RESOURCE

Overview of Denial Reason

Incidental services are secondary or supportive services that are integral to a primary procedure or treatment. They are not separately payable because payers bundle them into the reimbursement for the main service. Submitting claims with only incidental services and no primary code often results in denials such as "All services incidental; no primary submitted."

Definition of Incidental Service

An incidental service is a procedure, supply or charge that is considered part of the overall care package for a primary service. These services occur during the same encounter and are necessary for completing the main procedure.

What Incidental Services Are Part Of

Incidental services belong to:

- **Inpatient Care:** Bundled into room and board or surgical procedures
- **Outpatient/Professional Care:** Bundled into office visits, minor procedures or therapy sessions

Key Characteristics

- Linked to a primary CPT®/HCPCS Code (e.g., add-on codes like +33225)
- Same session or setting as the primary service
- Not separately payable because they are considered integral

Comparison Table: Inpatient vs. Outpatient Incidental Services

SETTING	EXAMPLES OF INCIDENTAL SERVICES	WHAT THEY ARE A PART OF
Inpatient	Recovery room (Rev 0710), anesthesia (Rev 0370), pharmacy (Rev 0250), lab (Rev 0300)	Surgical procedure or inpatient stay
Outpatient	Venipuncture (CPT 36415), interactive complexity (+90785), additional IV push (+96376), Doppler color flow (+93325)	Office visit, infusion therapy, psychotherapy, imaging

Common Types of Incidental Services

- Add-on CPT codes (marked with "+") that require a primary code
- Pharmacy and IV therapy (Revenue Codes 0250–0269)
- Medical/surgical supplies (Revenue Codes 0270–0279)
- Lab and radiology services when part of inpatient or outpatient care
- Recovery room and anesthesia (Revenue Codes 0370–0379, 0710–0719)

Examples of Incidental Services Not Separately Payable

- +33225 (LV lead placement) without primary pacemaker/ICD code
- +11046 (additional wound debridement) without initial debridement code
- Pharmacy charges under Rev Code 0250 when billed without a primary procedure
- Recovery room charges under Rev Code 0710 when billed alone
- Venipuncture (36415) when billed without an E/M or lab service

Compliance Best Practices

- Follow coding rules: Always check CPT/HCPCS guidelines for add-on codes.
- Include primary code: Never submit incidental services alone.
- Match revenue codes: Ensure revenue codes align with CPT/HCPCS codes.
- Document clearly: Support the primary and incidental services in the medical record.
- Avoid unbundling: Do not bill separately for services that must be bundled.

Common Denial Reasons

- All services incidental; no primary submitted
- Bundled service (payer considers part of another procedure)
- Incorrect revenue code pairing
- Missing modifiers for distinct services

Summary

Incidental services are secondary to a primary procedure and are not billed separately. They must be paired with the correct primary CPT/HCPCS code and appropriate revenue code to avoid denials. Common examples include add-on codes, anesthesia, recovery room charges and certain pharmacy or lab services. Follow coding guidelines, avoid unbundling and ensure documentation supports the primary service. Accurate pairing and compliance reduce claim denials and improve reimbursement.

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