CMS Releases Proposed OPPS Rule

On July 3, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Outpatient Prospective Payment System (OPPS) proposed rule for calendar year 2009. Published in the July 18, 2008, *Federal Register*, the proposed rule includes several significant changes regarding payment for oncology services, including drugs, drug administration, and imaging services. The agency accepted comments until September 2.

Overall, CMS projects that total spending under OPPS is expected to increase from $26.9 billion to $28.7 billion. The proposed rule includes a 3 percent annual update to payments under the OPPS. Hospitals that fail to report quality data would receive only a 1.0 percent update. While CMS proposes several changes to reimbursement for drugs, biologicals, and radiopharmaceuticals provided in hospital outpatient departments, the agency does *not* propose to make additional payments for pharmacy services; the agency intends for the proposed rates to reflect *both* drug acquisition and pharmacy service costs.

Packaging Threshold. CMS proposes to continue to package payment for drugs whose cost per day is less than $60. (This is the same threshold that the agency established for 2008.) The agency also proposes to continue to:

- Exempt oral and injectable 5HT3 anti-emetics from packaging
- Package payment for all diagnostic radiopharmaceuticals that are not granted pass-through status
- Apply a claims processing edit that requires a radiopharmaceutical HCPCS code to appear on claims for nuclear medicine procedures.
- Package payment for all contrast agents.

Drugs, biologicals, and radiopharmaceuticals without pass-through status. CMS is proposing drug reimbursement at average sales price (ASP)+4 percent, a reduction from the current rate of ASP+5 percent. New drugs with HCPCS codes that do not have claims data would also be reimbursed at ASP+4 percent. Finally, radiopharmaceuticals would be reimbursed at ASP+4 percent if the manufacturer chooses to report an ASP. If the manufacturer does not submit ASP data, CMS will set payment rates based on the mean costs derived from claims data.

Drugs, biologicals, and radiopharmaceuticals with pass-through status. For drugs, CMS is proposing the same reimbursement rates as in physician offices: ASP+6 percent or the rate determined under the Competitive Acquisition Program (CAP). Among the drugs having pass-through status in 2009 are Temsirolimus injection (C9239), Ixabepilone injection (C9240), and Nelarabine injection (J9261). Among the drugs losing pass-through status on Dec. 31, 2008, are Decitabine injection (J0894) and Panitumumab injection (J9303).

Radiopharmaceuticals with pass-through status would be reimbursed at ASP+6 percent if the manufacturer chooses to submit ASP data. If the manufacturer does not submit ASP data, reimbursement would be based on the product's wholesale acquisition cost (WAC) *or* 95 percent of its average wholesale price (AWP) if WAC data are not available.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extends the current payment methodology for therapeutic radiopharmaceuticals, based on individual hospital's charges adjusted to cost, until January 1, 2010.

Brachytherapy sources. While CMS proposed to adopt prospective payment amounts for brachytherapy sources that would be determined using the agency's standard rate-setting methodology, using median costs derived from claims data, MIPPA extends the current payment methodology through January 1, 2010.

Intravenous immune globulin (IVIG). CMS proposes to package payment for G0332 (services for intravenous infusion of immunoglobulin prior to administration) into payment for the associated drug administration service in 2009. Currently, this code is reimbursed at $37.71.

Drug Administration Services. CMS proposes to reconfigure the drug administration APCs by consolidating the current six APCs into five APCs (see Table 1). While at first glance, it looks like the total payments for drug administra-

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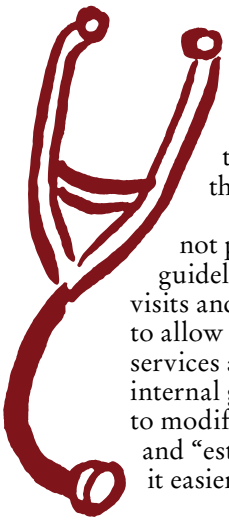
Additional Source to Help Determine Coverage for Anti-cancer Drugs

The Centers for Medicare & Medicaid Services (CMS) has added Elsevier Gold Standard's *Clinical Pharmacology* compendium to the list of Medicare anti-cancer treatment compendia. In June 2008 CMS approved two other national compendia: 1) the NCCN *Drugs & Biologics Compendium*™ and 2) Thomson Micromedex's *DrugDex*®.

tion services would have to be higher since all the new APCs have higher payment rates, the situation is more complex. Under the proposed rule, many of the codes were reassigned and a number of high-volume services have been proposed for reassignment to a lower level APC. For example, the initial hydration code (90760) is proposed to be reassigned from Level V to Level III with payments falling from $114.64 to $74.32. Table 2 summarizes the impact of the proposed rule on the 51 codes assigned to the drug administration APCs.



Radiation therapy services. CMS proposes modest increases in payment to several of the radiation therapy APCs (see Table 3).

Clinic visits. CMS does not propose to establish guidelines for reporting clinic visits and instead would continue to allow hospitals to report these services according to their own internal guidelines. CMS proposes to modify the definitions of "new" and "established" patients to make it easier for hospitals to determine which codes to use for clinic visits. Currently, a patient is considered to be "new" if he or she has a medical record that was established in the past 3 years.

Composite APCs for brachytherapy, imaging, and other services. In 2008 CMS created composite APCs that make a single payment for certain services that are typically performed together during a single encounter. CMS proposes to continue to use the composite APCs it created in 2008, and proposes to expand the use of composite APCs to cover three families of imaging services, ultrasound, CT and CTA, and MRI and MRA.

Packaging. In 2008 CMS significantly expanded packaging under the OPPS by designating seven

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Table 1. A Comparison of Current and Proposed APCs and Payments for Drug Administration Codes

Code	Description	2008 APC	2008 Rate	2009 APC	2009 Rate	Difference 2008-2009	Percent Change 2008-2009
90765	Therapeutic, prophylactic, or diagnostic IV infusion, initial	0440	$114.64	0439	$126.80	$12.16	10.61%
90772	Therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular	0437	$25.13	0436	$25.03	-$0.10	-0.40%
90774	Therapeutic, prophylactic, or diagnostic injection, IV push	0438	$51.22	0437	$36.66	-$14.56	-28.43%
90779	Therapeutic, prophylactic, or diagnostic injection, unlisted intra-arterial injection or infusion	0436	$16.21	0436	$25.03	$8.82	54.41%
96401	Chemotherapy injection, anti-neoplastic, subcutaneous, or intramuscular	0438	$51.22	0437	$36.66	-$14.56	-28.43%
96402	Chemotherapy injection, hormonal anti-neoplastic, subcutaneous, or intramuscular	0438	$51.22	0437	$36.66	-$14.56	-28.43%
96409	Chemotherapy injection, IV push, single or initial drug	0439	$105.38	0439	$126.80	$21.42	20.33%
96413	Chemotherapy infusion, up to 1 hour, single or initial drug	0441	$149.34	0440	$191.06	$41.72	27.94%
96415	Chemotherapy infusion, each additional hour	0438	$51.22	0437	$36.66	-$14.56	-28.43%
96417	Chemotherapy infusion, each additional sequential infusion	0438	$51.22	0438	$74.32	$23.10	45.10%
96425	Chemotherapy, intra-arterial infusion technique, initiation of prolonged infusion, requiring of portable or implantable pump	0441	$149.34	0440	$191.06	$41.72	27.94%
96542	Chemotherapy injection, sub-arachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	0438	$51.22	0439	$126.80	$126.80	147.56%

Source: Health Policy Alternatives, *www.healthpolicyalternatives.com*.

categories of ancillary services that no longer would receive separate payment: guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast agents, and observation services. CMS proposes to continue to package payment for these services because the agency believes that packaging encourages hospitals and physicians to work together to provide services more efficiently.

Conversion factor. CMS is proposing to increase the 2008 conversion factor by 3.0 percent for 2009. Hospitals that fail to report quality data are subject to a reduction of 2.0 percent.

New technology APCs. CMS proposes to reassign the following three new technology APCs to clinical APCs:

- C9725, placement of endorectal intracavitary applicator for high intensity brachytherapy from APC 1507 to APC 0164
- C9726, placement and removal (if performed) of applicator into breast for radiation therapy from APC 1508 to APC 0028
- C9727, insertion of implants into the soft palate; minimum of three implants from APC 1510 to APC 0252.

Quality measures. Beginning Jan. 1, 2009, hospitals that fail to submit quality data for outpatient services will receive a reduction in their annual payment update factor of 2.0 percentage points. The proposed rule expands the Hospital Outpatient Quality Data Reporting Program (HOP QDRP).

For the 2010 annual payment update, CMS proposes to require the seven quality measures used for the 2009 payment update (five emergency department and two perioperative care measures) and to add four new imaging measures: 1) MRI lumbar spine for low back pain, 2) mammography follow-up rates, 3) abdomen CT, use of contrast material, and 4) and thorax CT, use of contrast material.

For 2011 CMS proposes to choose from a list of 18 measures, including the following oncology measures: 1) radiation therapy is administered within 1 year of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer; 2) adjuvant chemotherapy is considered or administered within 4 months of surgery to patients under age 80 with AJCC III colon cancer; 3) adjuvant hormonal therapy for patients with breast cancer; and 4) needle biopsy to establish diagnosis of cancer precedes surgical excision/resection.

Table 2. Total 2008 Administration Payments Compared to Proposed 2009 Payments*

Drug Administration Category	Total Frequency	2008 Total Payments (calculated)	2009 Proposed Total Payments (calculated)	Change in in Total Payments (calculated)	% Change in Total Payments (calculated)
All drug administration codes, including chemotherapy administration codes	11,750,234	$703,912,664	$673,171,558	-$30,741,105	-4.4%
Chemotherapy administration Codes (CPT 96401-96549)	1,302,862	$138,435,814	$163,749,340	$25,313,526	18.3%

*The impact was calculated by multiplying the "total frequency" in the median cost file that CMS posted on its website by the current and proposed payments.
Source: Health Policy Alternatives, *www.healthpolicyalternatives.com*.

Table 3. Proposed APCs and Payments for Select Radiation Therapy Services

APC	Description	2008 Rate	Proposed 2009 Rate	Change from 2008-2009
0300	Level I Radiation Therapy	$90.63	$91.71	1.19%
0301	Level II Radiation Therapy	$141.19	$146.60	3.83%
0303	Treatment Device Construction	$183.94	$192.63	4.72%
0304	Level I Therapeutic Radiation Treatment Preparation	$99.21	$102.59	3.41%
0305	Level II Therapeutic Radiation Treatment Preparation	$250.16	$261.89	4.69%
0310	Level III Therapeutic Radiation Treatment Preparation	$863.82	$900.50	4.25%
0312	Radioelement Applications	$542.29	$522.14	-3.72%

Source: Health Policy Alternatives, *www.healthpolicyalternatives.com*.

PQRI Pays More than $36 Million in Physician Bonuses

In July CMS announced that more than 56,700 healthcare professionals who satisfactorily reported quality information to Medicare under the 2007 Physician Quality Reporting Initiative (PQRI) were awarded more than $36 million in bonus payments. Payments should have been received no later than August 2008 by physicians, physician group practices, and other PQRI eligible professionals. The average incentive amount for individual professionals was more than $600; the average incentive payment for a physician group practice was more than $4,700.

The 2008 PQRI had 119 quality measures, compared to 74 in 2007. Under a proposed rule issued by CMS June 30, 56 more measures may be added to the 2008 list. More information about the PQRI program is available on the Web at *http://www.cms.hhs.gov/PQRI.*

PHOTOGRAPH/BIGSTOCKPHOTO

ACCC Submits Comments on 2009 Proposed Physician Fee Schedule

On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted, making changes to the Medicare program. The legislation contains provisions that place a freeze on the scheduled Medicare reimbursement cut of 10.6 percent through December 31, 2009. It also provides a 1.1 percent increase to physician reimbursement that takes effect on January 1, 2009.

On June 30, 2008, CMS released the Medicare Physician Fee Schedule proposed rule for calendar year 2009. For radiation oncologists, the overall impact of the 2009 proposed physician fee is expected to be about a 1 percent reduction for payment of services. Medical oncologists and hematologists are expected to see little to no change in payment rates from 2008 to 2009. In brief, here's what the agency has proposed for 2009.

Physician Quality Reporting Initiative. PQRI, which allows eligible professionals to report quality measures relating to their clinical practice, has new proposed measures for 2009 including:

- Myelodysplastic syndrome (MDS) and acute leukemias: baseline cytogenetic testing performed on bone marrow
- MDS: documentation of iron stores in patients receiving erythropoietin therapy
- Multiple myeloma: treatment with bisphosphonates
- Chronic lymphocytic leukemia (CLL): baseline flow cytometry
- Breast cancer: hormonal therapy for Stage IC-III ER/PR positive breast cancer
- Colon cancer: chemotherapy for Stage III colon cancer patients
- Cancer: plan for chemotherapy documented
- Breast cancer resection pathology reporting: pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
- Colorectal cancer resection pathology reporting: pT category and pN category with histologic grade
- Prostate cancer: appropriate initial evaluation
- Prostate cancer: avoidance of overuse of bone scan for staging low-risk prostate cancer patients
- Prostate cancer: adjuvant hormonal therapy for high-risk prostate cancer patients
- Prostate cancer: 3D radiotherapy
- Preventive care and screening: screening mammography
- Preventive care and screening: colorectal cancer screening.

CMS also offers two new reporting periods (January 1, 2009 to December 31, 2009, or July 1, 2009 to December 31, 2009) to provide eligible professions with additional options for reporting PQRI data. In addition, CMS will accept PQRI data via clinical registries and electronic health records systems.

Diagnostic testing. CMS proposes to improve the quality of diagnostic testing performed by physicians and non-physician practitioners (NPPs) in their offices by requiring them to enroll as suppliers of these services and to meet certain quality and performance standards, including applicable federal and state licensure and health and safety requirements that currently apply to independent diagnostic testing facilities.

IVIG. CMS now believes that the market for accessing and providing IVIG has improved to the point that it no longer needs to provide a pre-administration payment. Therefore, the agency proposes to discontinue separate payment for IVIG pre-administration-related services furnished on or after January 1, 2009.

CMS accepted comments on the proposed rule until August 29, 2008, and will respond to those comments in a final rule to be issued by November 1, 2008. In brief, ACCC recommended that the agency make the following changes to the physician fee schedule for CY 2009:

- Continue to work with Congress, MedPAC, and other parties to stabilize or replace the SGR formula so physicians do not face major cuts to reimbursement each year.
- Reinstate the add-on payment for pre-administration-related services for IVIG.
- Continue and expand the PQRI program in a manner that promotes the best quality of care possible. CMS should also work with specialty groups to ensure that the measures currently in place accurately reflect quality of care in each specialty.
- Address shortcomings in some PQRI measures in order to ensure all therapies, both oral and injectable, can be reported.
- Make public the number of providers participating in the PQRI program.
- Work with Congress to ensure

the successful implementation of the new ASP methodology implemented by the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).
- Work with the AMA RUC and other specialty societies to determine "potentially mis-valued services."
- Exercise caution in implementing the payment limits for imaging procedures to protect patient access to these services.
- Encourage the RUC to review the codes that have not been reviewed in nearly 20 years.
- Defer to recent Congressional action in the area of accreditation for imaging procedures, instead of implementing the Independent Diagnostic Testing Facilities (IDTFs) requirement.
- Implement the proposed changes to the Competitive Acquisition Program (CAP).

FDA Announces Label Revisions for ESAs

On July 30 the Food and Drug Administration (FDA) announced the following changes to the approved labeling for the use of erythropoietin stimulating agents (ESAs):
- ESAs are approved for use only after a patient's hemoglobin level falls under 10 grams per deciliter (g/dl)
- Label references to an upper limit of 12 g/dl have been eliminated
- ESAs are not indicated if the intent of chemotherapy is to cure a patient.

The current final policy does *not* include restrictions for ESA treatment for MDS patients. Despite the recommendations of the Oncologic Drug Advisory Committee, ESA use in breast and head/neck cancers are not further restricted in the new label. For background on the issue and ACCC's position, visit *www.acccancer.org.*

| Billing and Coding |

"Incident to": The Good, the Bad, and the Ugly

by Cindy C. Parman, CPC, CPC-H, RCC

"Incident to" services are those that are performed by ancillary personnel under the supervision of a qualified Medicare provider. A number of myths surround charges billed in the name of the physician but performed by his or her staff, and the Centers for Medicare & Medicaid Services (CMS) recently published and then rescinded a Transmittal relating to "incident to" criteria. Incidental procedures such as injections, blood draws, and other ancillary services may be performed "incident to" the physician's professional service and billed in the name of the physician. However, specific criteria must be addressed when a mid-level provider or non-physician practitioner performs services that are billed in the name of the supervising physician.

Billing for Non-Physician Practitioners

Non-physician practitioners are professionals licensed by a State under various health programs to assist the physician or act in place of the physician. As with all service providers, Medicare states that any service or procedure rendered by a non-physician practitioner must be: 1) medically necessary and 2) within the scope of practice in the State in which the individual is treating patients. Medicare reimburses non-physician practitioners directly at 85 percent of the physician fee schedule allowance for covered procedures.

In certain circumstances, a non-physician practitioner may perform services that are billed in the name of the supervising physician under Medicare's "incident to" provision. In order for these services to be reimbursed as "incident to" services, seven criteria must be met.

1. Determine the Payer and Coverage.
Cancer centers must first look at the patient's insurance coverage. While Medicare includes an "incident to" policy in its guidelines, many managed care and traditional indemnity plans do not recognize the "incident to" reporting convention. For those payers who do not accept "incident to" billing, ensure that your mid-level providers are fully credentialed with that payer and that all services provided are reported using the name and national provider identifier (NPI) of the non-physician practitioner.

2. Know the Site of Service.
"Incident to" services must be of a type commonly furnished in a physician's office or clinic. While non-physician practitioners can provide professional services in a hospital, these services would be reported under the non-physician practitioner's name and NPI, or considered to be part of the hospital's service (see Medicare exception for shared visits below). In the physician office, caregivers that provide "incident to" services must 1) be qualified to provide the service, 2) be directly supervised by the physician, and 3) represent a direct financial expense to the physician or professional practice (such as a W2 employee, leased employee, or an independent contractor).

3. Document Non-Physician Practitioner Qualifications.
The Office of Inspector General (OIG) published a report dated June 2001, titled "Medicare Coverage of Non-Physician Practitioner Services." In this document the OIG states: "…when a service is not addressed in a scope, it cannot be assumed that a non-physician practitioner cannot provide that service. Scopes, as well as Medicare, call for collaboration with a physician. This may have the effect of either limiting or expanding the services that are allowed."

A collaboration agreement is a written contract that provides specific guidelines for the services to be per-

formed by the non-physician practitioner, both independently and under the direct supervision of a physician. CMS previously stated that it would expect a non-physician practitioner performing a service to have all the qualifications needed to successfully complete, supervise, or interpret the procedure, therapy, or diagnostic test. Therefore, the practice should maintain information on the mid-level provider's education, training, and experience to support the independent provision of services.

4. Ensure the Service is an Established Medical Condition.
Under "incident to" billing, the physician must perform the initial patient evaluation and management (E&M) service to initiate the course of treatment. As a result, new patient visits and consultations are *never* "incident to" and cannot be reported as "shared visits" for Medicare patients. After the physician's initial patient encounter, a written treatment plan is developed that provides orders and direction for the non-physician practitioner and other practice employees to provide services "incident to" the physician's initial evaluation.

If the non-physician practitioner is providing follow-up care for an established medical condition (initially evaluated by the physician), and the patient reports *any* new medical problem, the physician must participate in the evaluation of the new problem in order for the service to be reported in the name of the physician. Generally, this participation must include physician documentation in the medical record, since treatment of a new medical condition does not meet the "incident to" definition. If the non-physician practitioner provides evaluation and treatment of a new medical condition (i.e., a condition not previously evaluated by the physician) then the services *must* be reported using the name and NPI of the non-physician practitioner.

5. Document Active Physician Involvement.
According to CMS, the treating physician must not only perform the initial patient visit service, but also provide subsequent services at a frequency which reflects his or her continued active participation in and management of the course of treatment. When the physician is involved with a particular service, his or her contribution to the care must be documented in the patient record. The extent of physician involvement should reflect the patient's condition, increasing with instability and uncertainty of the situation. While CMS has not issued national guidelines regarding the frequency of these subsequent services the physician must perform, some local Medicare contractors have published policies that detail the frequency of subsequent services that must be provided by the treating physician.

PHOTOGRAPH/FOTOLIO

…specific criteria must be addressed when a mid-level provider or non-physician practitioner performs services that are billed in the name of the supervising physician.

6. Know the Direct Supervision Requirements.
The billing physician must provide direct supervision for all "incident to" services. Direct supervision means the physician is present in the office suite and immediately available to provide assistance or direction to the non-physician practitioner. The supervising physician must be within the same entity to be considered immediately available. For example, if the patient is being seen in the clinic and the supervising physician is located in the adjoining hospital, the physician is not considered to be in the "entity" or office suite.

The physician who performed the initial evaluation and ordered the service that is subsequently performed by the non-physician practitioner may not be the same physician group member who is supervising the "incident to" service. In these situations, the supervising physician must be identified on both the paper and electronic claim forms. In other words, report the physician supervising the service on the claim form, even if this physician is not the 'provider of record' for the patient.

7. Identify Significant Services.
While services incidental to the physician service may be performed by ancillary personnel and reported as "incident to," if the service or procedure performed is a significant or substantive service, the service must be reported in the name of the individual who personally performed the service. Remember Medicare defines "incident to" services as "…commonly either rendered without charge or included in the bill of the physician or non-physician practitioner, and for which payment is not made under a separate benefit category…" As a result, if the mid-level provider supervises chemotherapy while the physician is not in the office, the chemotherapy administration service would be charged under the name and NPI of the non-physician practitioner. In another example, if the non-physician practitioner performs a bone marrow aspiration and/or biopsy, the service is reported using that individual's name and NPI— regardless of whether or not the physician is in the office suite.

With respect to radiation therapy, if the mid-level provider performs the weekly treatment management service for the patient, and the physician does not provide a face-to-face encounter during the same 5-fraction week of therapy, the treatment management service is reported under the

non-physician practitioner.

Drug administration, radiation treatment management, and surgical procedures, including biopsy and aspiration, are considered to be significant, separate services that are reported in the name of the performing or supervising practitioner.

Shared Visits

When a Medicare patient visit service is a "shared" or "split" encounter between a physician and a qualified non-physician practitioner, the service is considered to have been performed "incident to" if all the above requirements are met *and* the patient is an established patient. If "incident to" requirements are not met for the shared or split visit, services must be billed using the name and NPI of the non-physician practitioner.

When a hospital inpatient, hospital outpatient, or emergency room department visit is shared between a physician and a non-physician practitioner from the same group practice, and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician or the non-physician practitioner's name and NPI. Conversely, without a face-to-face encounter between the patient and the physician (e.g., if the physician only participated in the service by reviewing the patient's medical record) then the service may only be billed using the non-physician practitioner's name and NPI.

Note: when a shared visit occurs, each practitioner must separately document the services he or she provided. For example, the physician would document the extent of history, examination, and medical decision making performed; the non-physician practitioner would separately document the elements of the patient encounter he or she performed. Both dictations may be combined to calculate the visit level for a Medicare patient, but the reviewer must be able to clearly determine what portion of the service was performed by the physician and what portion of the service was performed by the non-physician practitioner.

2008 OIG Work Plan

Based on the Work Plan for 2008, the OIG will conduct a review of Medicare claims for services furnished "incident to" the professional services of selected physicians. According to this document: "Federal regulations at 42 CFR § 410.26(b) specify criteria for 'incident to' services. We will examine the Medicare services that selected physicians bill 'incident to' their professional services and the qualifications and appropriateness of the staff who perform them. This study will review medical necessity, documentation, and quality of care for 'incident to' services."

When billing "incident to" remember that Medicare and commercial payer credentialing and payment guidelines for non-physician practitioners can be quite different. According to one managed care insurer, the purpose of a non-physician practitioner credentials review is to ensure that the individual possesses the practice experience, licenses, certifications, liability coverage, education, and professional qualifications necessary to provide a level of care consistent with professionally recognized standards.

Based on information from CMS and the OIG, these agencies plan on reviewing services performed by non-physician practitioners that are billed in the name of the physician. To ensure that *your* cancer program is correctly billing "incident to" services 1) obtain and comply with national CMS guidelines and local Medicare contractor policies and 2) verify third-party coverage of services provided by your non-physicians practitioners.

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Resources

- *Medicare Claims Processing Manual.* Chapter 12: Physicians/ Nonphysician Practitioners. Available online at: *http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf*. Last accessed July 21, 2008.
- *Medicare Benefit Policy Manual* Chapter 15: Covered Medical and Other Health Services. Available online at: *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf*. Last accessed July 21, 2008.
- *Medicare Claims Processing Manual.* Chapter 26: Completing and Processing Form CMS-1500 Data Set. Available online at: *http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf*. Last accessed July 21, 2008.
- *Office of Inspector General Work Plan Fiscal Year 2008.* Available online at: *http://www.oig.hhs.gov/publications/docs/workplan/2008/Work_Plan_FY_2008.pdf*. Last accessed July 21, 2008.
- *MLN Matters* # SE0441. Incident to Services. Available online at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0441.pdf*. Last accessed July 21, 2008.
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