



Incident To Services – Documentation and Correct Billing

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Agenda

- Overview
- Documentation Requirements
- Part A
- Part B
- Special Situations

Overview

General Information

- Services and supplies
 - Provided by someone other than the MD/DO or the credentialed Non-physician practitioner (NPP) e.g., ancillary staff
 - Appropriately documented and submitted under the incident to guidelines may be reimbursed at the billing MD/DO or NPP fee schedule amount
- The billing provider has set the plan of care (POC)
 - One exception (discussed later)
- When an NPP or ancillary staff provides service outside the POC, the service no longer meets the guidelines and therefore cannot be billed under the supervising physician
- Services can be provided as incident to a NPP only when that NPP is enrolled with the Medicare program
- Services and supplies having their own benefit category are not subject to incident to guidelines
 - Vaccinations/immunizations
 - Venipuncture or clinical lab services
 - Radiology services and other services requiring a certain level of supervision as stated in the Medicare Physician Fee Schedule Data Base
 - Diabetes Self-Management Training
- Different application of incident to guidelines between Part A and Part B billing

- Part B Billing (e.g., office) services must be:
 - An integral, although incidental, part of the physician's professional service
 - Commonly rendered without charge or included in the physician's bill
 - Of a type that are commonly furnished in a physician's offices or clinics
 - Furnished by the physician or ancillary personnel under the physician's direct supervision
- Part A Billing
 - Medicare Administrative Contractor (MAC) makes payment for inpatient, outpatient or partial hospitalization services
 - Billed on UB-04
 - Paid according to the billing rules for specific types of providers
- MD/DO may have services provided as incident to by either an NPP or the ancillary staff
 - NPP may have services provided as incident to by ancillary staff
 - Services provided by the NPP or ancillary staff must be within their state scope of practice
- Incident to services include not only evaluation and management (E/M) services, but can also include:
 - Minor surgeries
 - Chemotherapy administration
 - Applying and removing casts
 - Professional component of radiology services
- If the circumstances do not meet the incident to guidelines
 - Bill under the NPP or do not bill Medicare for services provided by ancillary staff

Integral

- MD/DO or NPP performed a previous evaluation and management (E/M) service and determined the patient's diagnosis and the plan of care (POC)
- MD/DO or NPP performs subsequent services of a frequency which reflects his/her active participation in and management of the course of treatment
- Determination of the frequency of subsequent visits should be medically appropriate for the patient's condition
 - Increasing with the degree of instability and uncertainty of the situation
- Medical record does not have to show that any subsequent services will be with a NPP or ancillary staff
- Services cannot be billed as incident to for a new patient or a new problem
 - This guideline is not overridden by physician set "protocols" in the office

Practitioner's Bill

- Services and any supplies commonly furnished in the practitioner's office and considered part of the physician's normal charge
- Services that represent an expense to the practitioner
- Person providing the services is a/an:
 - Employee
 - Leased employee
 - Independent contractor of the practitioner or the legal entity employing the physician

Commonly furnished in practitioner's office

- MD/DO or NPPs can be reimbursed for services provided by someone else when the services are performed in the office setting
- MD/DO or NPPs cannot bill under the incident to guidelines for services provided in a facility setting
- Drugs must represent an expense to the practitioner and must be payable
 - Self-administered drugs or drugs the patient brings it to the office, and their administration, are not payable by Medicare

Requirements of Direct Supervision

- The billing MD/DO or NPP must provide direct supervision
 - In the designated office area and immediately available to provide assistance and direction
- The supervising practitioner does not need to see the patient each time an incident to service is provided
- Practitioner has an office within an institution
 - Guidelines are the same as in a physician's office
 - "Office" must be a specific designated space, not the entire institution
 - Availability of the practitioner by telephone or the presence of the practitioner elsewhere in the institution does not meet direct supervision requirement
- Physician must be "immediately" available to furnish assistance and direction
- Not just emergency responses, but also to take over the performance of the service
- Supervision requirement is met in physician clinic situations when
 - There is a supervising physician responsible for the services performed by the NPPs and ancillary staff
 - Physician need not be the physician who determined the patient's plan of care
 - Does not have to be the same specialty as the originating physician, but do have to be members of the same group, using same tax ID number
 - Billing is under the supervising physician

Documentation Requirements

E/M Services

- The billing MD/DO or NPP determines the POC
 - NPP or ancillary staff continue the treatment determined by the billing provider
- Changes in the plan including changing a drug or the dosage of the same drug constitute a new POC
 - No longer meet the requirements for incident to
 - Services are billed under the NPP provider number

Other services

- Injections
 - When billing for a diagnostic or therapeutic injection, the requirements for incident to must be met
 - POC must show the correct drug, correct dosage, correct route and correct frequency
 - Same incident to rules apply when billing for chemotherapy
 - Medical record documentation for the specific date of service must show
 - ❖ Dosage given
 - ❖ Time involved
 - ❖ Name and signature of the person giving the drug
 - ❖ POC documentation showing the correct drug, correct dose, correct route and correct frequency as ordered
 - Injections as part of a diagnostic test can be submitted as incident to when all requirements are met
 - Document supervising practitioner's physical presence in the office setting

Signature Requirements

- For Medicare purposes, the MD/DO or NPP billing the service is not required to sign documentation prepared by the NPP or ancillary personnel
 - Signature of the person performing the service is required
 - Co-signing a note does not qualify the service as incident to; all requirements must be met
 - Incident to requirements for Medicare billing are separate and distinct from any facility or group rule requiring all services must be signed by the physician

Part A

Hospital Billing

- Inpatient Prospective Payment System (IPPS)
 - Services bundled into one Medicare Severity Diagnosis Related Group (MS DRG) payment
 - All services provided by facility or under arrangement

➤ **Outpatient Prospective Payment System (OPPS)**

- In an inpatient Part B or outpatient setting, the hospital may bill for services provided by ancillary staff under the required supervision of a physician or NPP
 - Physician ordered
 - Integral, though incidental part of treatment
 - Must be furnished in the facility, or department for which the facility submits charges
 - Billed on UB-04
- Part B Inpatient stay
 - Patient has no Part A benefits available, no Part A entitlement, or services don't meet Part A coverage criteria
 - Integral, though incidental part of treatment
 - Billed on UB-04
- Vaccines provided to inpatients of a hospital under the vaccine benefit.
 - Hospital bills on bill type 12X using the discharge date of the hospital stay or the date benefits are exhausted
- Services provided by physician ancillary staff employees are part of the hospital charges to Medicare – not part of the physician's charge
- Services must be an integral part of the physician's treatment; the physician cannot simply write an order
- Therapeutic services must be furnished under the order of the treating MD/DO
- In a hospital setting, some services may require general rather than direct supervision
 - See the Centers for Medicare & Medicare Services (CMS) Internet-Only Manual (IOM) Publication100-02, Chapter 6, Section 10 and 20 for a listing of these services

Comprehensive Outpatient Rehabilitation Facility (CORF)

- Services provided in a CORF are considered as incident to the physician
- Services provided in a CORF by a Physical Therapist Assistant (PTA) or Occupational Therapist Assistant (OTA) can be considered incident to when:
- The Physical Therapist (PT) or Occupational Therapist (OT) sets the plan of care
 - The PT or OT are
 - On the premises
 - In direction telecommunication with the PTA or OTA
 - Must be at least one qualified professional on the premises during the facility's operating hours
- Does not apply to nursing services, Speech Language Pathology (SLP), or social/psychological services

Critical Access Hospital (CAH)

- The determination of whether incident to provisions are applicable is based on the payment Method chosen by CAH
 - Method 1 – the physician bills Medicare Part B directly
 - The place of service (POS) code is inpatient or outpatient hospital
 - The nursing staff are part of the hospital employees and therefore incident to does not apply
 - Method 2 – The facility bills Medicare Part B of A directly
 - The POS is inpatient or outpatient hospital

End Stage Renal Disease (ESRD) Facility

- Test routinely covered under Composite Rate
 - Hematocrit, hemoglobin, and clotting time tests furnished incident to dialysis treatments
- Drug and Biologicals covered that meet requirements in CMS IOM Publication 100-2, Chapter 11, Section 30.4
 - EPO/Aranesp covered when furnished incident to a to a physician's service
 - No payment made if administered in renal facility or self administration by a home dialysis patient

Skilled Nursing Facility (SNF)

- Part A SNF stays paid on a PPS system, according to a Resource Utilization Group (RUG) assigned to the claim
- SNF responsible for all services rendered to a beneficiary in a Part A stay under consolidated billing
 - Except for certain exceptions
- SNF consolidated billing excludes some professional services
- These same professional services are not excluded when provided under the incident to provision
- Vaccines provided to inpatients of a SNF under the vaccine benefit
 - SNF submits type of bill 22X for its Part A inpatients

Rural Health Clinic (RHC) and Federally Qualified Health Centers (FQHC)

- RHC/FQHC incident to services are:
 - Commonly rendered without charge or included in the RHC or FQHC bill
 - Commonly furnished in a physician office or clinic
 - Furnished under the physician's direct supervision
 - Furnished by a member of the RHC or FQHC staff

- Direct supervision of ancillary staff by a NPP would be based on the supervision requirements governed by the written policies of the RHC or FQHC
- RHC/FQHC incident to services include:
 - Drugs, biologicals that are not usually self-administered
 - Drugs that must be billed to the Durable Medical Equipment (DME) MAC or to Part D are not considered incident to
 - Physician prepared antigen that is forwarded to another qualified provider for administration, are not included considered incident to
 - Medicare covered preventive injectable drugs
 - Bandages, gauze, oxygen, and other supplies
 - Assisting nurses, medical assistant, others staff acting under the supervision of a physician
 - PT/OT services provided by a RHC or FQHC employee PT or OT under the direct supervision of a physician. Include the charges for PT/OT in with the charges for an otherwise covered service
 - Diabetes Self Management Training/Medical Nutrition Training (DSMT/MNT) can be provided incident to by a registered dietician or nutritional professional
 - Reported on RHC cost report
- Provision of incident to services and supplies by RHC and FQHC
 - Must result from a patient's encounter with an RHC or FQHC physician
 - Physician must be in the RHC and available for assistance at the time the incident to service is provided
 - Furnished in a medically appropriate timeframe
 - More than one can be provided in one single physician visit
 - Can be furnished by auxiliary personnel
 - Must be directly employed or contracted by the RHC or FQHC
- Incident to Services furnished in a patient's home or location other than the RHC or FQHC
 - Visit by an RHC or FQHC physician required
 - Auxiliary personnel must have direct personal supervision of a physician
 - If auxiliary personnel makes visit alone, incident to services cannot be billed
- Payment for RHC and FQHC incident to services
 - Cost of providing incident to services may be included on cost report
 - Must represent an expense incurred by the RHC or FQHC
 - Person providing the incident to service must be an employee of the RHC or FQHC or directly contracted with the RHC or FQHC
 - Provision of incident to services does not generate a billable visit
 - May be included in the charges of a different visit if within a medically appropriate timeframe

- ❖ CMS has clarified that medically appropriate timeframe is 30 days or less
- Telephone communication is included with a separately payable service and does not constitute a separately payable service

Part B

Services to Homebound

- Require direct personal supervision; billing provider must be present
- Services provided in medically underserved area need to follow the general rather than direct physician supervision and meet the following requirements:
 - The patient must be homebound
 - The physician has determined the diagnosis and course of treatment
 - The physician/clinic bills for the service
 - The services are reasonable and necessary
 - There is no Home Health Agency (HHA) serving the area
 - Instructions provide the list of services the NPP or ancillary staff may perform under the incident to guidelines

Physician Services within an Institution

- Practitioner cannot bill for services provided by members of his/her ancillary staff to
 - Hospital inpatients
 - Hospital outpatients
 - Skilled nursing facility inpatients
 - The facility includes those charges on their claim to Medicare
- **Physician's office within a facility**
 - The physician space must be a specifically designated area
 - **NPP and ancillary staff must be members of the physician office staff; not facility staff**
 - **If facility staff, the physician cannot submit charges for services provided**

Split/Shared Visit

- A visit during which both the MD/DO and the NPP provide a substantive portion of the E/M service
 - Services provided in an office setting
 - Must meet the incident to guidelines in **addition** to the split/shared guidelines
 - Services provided in a facility setting
 - Do not have to meet the incident to guidelines, but do have to meet the split/shared guidelines

Special Considerations for Audiology Services

- Audiologist must enroll with Medicare and receive a provider number
 - Effective October 1, 2008 and after
- The incident to requirements do not apply to audiology services
- The person performing the services must submit the charges for the services
- An audiologist cannot supervise the performance of the technical portion of a test
 - They can perform the technical component
- The MD/DO may supervise the technical component under the supervision rules based on the test performed
- A NPP may perform the technical component, but may not supervise
- The MD/DO or NPP cannot bill for services performed by an audiologist
- No separate payment for audiology services when performed in a CORF or Rehabilitation agency
- Audiology services performed in a hospital outpatient setting are not billed separately to Medicare Part B by the audiologist
 - Billed as part of the facility charge under the OPSS
- A Skilled Nursing Facility may elect to submit a separate claim for audiology services when Part B benefits exhaust, but they are not required to do so

Special Considerations for procedure code 99211

- Face-to-face service generally performed by ancillary staff
- Signature on the medical record documentation must be that of the ancillary staff performing the service
- Physician must be in the office suite at the time of the service
- Service must be under the POC of the physician or NPP
- Service is not for telephone calls
- Do not use procedure code when there is a more accurate procedure code to reflect the service performed
 - e. g. Blood draw or lab test procedure code
- Do not bill the 99211 code for injection procedures
 - Information contained in the CPT concerning procedure code 90772 does not apply to Medicare patients
- Coumadin clinics are not exempted from the rules governing code 99211
 - The medical record documentation must show an E/M service
- If the Coumadin Clinic director is not a member of the same group as the physician determining the POC
 - Then he/she cannot bill WPS Medicare for services incident to the physician
- Medical record documentations must show an E/M service

Mental Health and Incident To Provisions

- A Clinical Psychologist (CP) can have services provided as incident to under their supervision
- In a hospital setting charges incident to the CP are bundled into the hospital payment
- There are restrictions on who can perform services incident to a physician or NPP
 - Services must be provided under the scope of clinical practice as authorized by the state
 - Doctorate or Masters Level Psychologists
 - Doctorate or Masters Level Social Workers
 - Clinical Nurse Specialists (CNS)/Nurse Practitioners (NP)
 - Masters Level Licensed Marriage and Family Therapist
 - Licensed Clinical Professional Counselors (LCPC)
- A provider may not hire and supervise a practitioner outside of his/her own scope of practice
- The person providing the service signs the medical record
- Practitioners such as CP, NP, CNS, Physician Assistant (PA), Clinical Social Worker (CSW) may bill under the incident to provisions for services provided by other non-physician practitioners
 - Services provided by specialists are billed under their own provider number
- Services rendered by allowed practitioners not able to receive a Medicare provider number
 - May be billed incident to the MD/DO, CP, NP, CNS, PA, CSW

Global Surgery

- MD/DO provides surgical services
 - Services provided by NPPs or ancillary staff during the global surgery period of 0, 10 or 90 days are not paid separately
 - These services are part of the global surgery package
 - Includes nursing visits for dressing changes, removal of staples, etc.
- NPP or nursing visits dealing with infections are part of the global surgery package and not payable separately during the global period
- Surgical services provided by the NPP may be billed as incident to when all the requirements are met
 - Documentation has to support the MD/DO's decision to perform the surgical service

Radiology Services

- NPPs cannot supervise diagnostic testing
 - Supervision rules apply to MD/DO only
- NPPs can perform the professional component of the diagnostic testing under the incident to guidelines only when the guidelines are met
 - If the guidelines are not met, NPP bills under his/her own provider number

Teaching Physician

- Services provided by residents are processed under the teaching physician guidelines not the incident to provisions
 - Services provided by students are not part of the incident to guidelines

Other

- The Primacy Care Incentive Payment (PCIP) Health Professional Shortage Area (HPSA), Physician Quality Reporting System (PQRS), and ePrescribing (ERX) incentive programs are only available for charges submitted under the billing provider number
 - If MD/DO not eligible for incentive program
 - Medicare will not reimburse incentives for eligible services when provided by a NPP
- The Initial Preventive Physical Exam (IPPE) and the Annual Wellness Visit (AWV) are not subject to the incident to provisions
 - The instructions on these services describe who can provide and receive reimbursement
- NPPs cannot supervise diagnostic tests
 - They can perform the technical component, but cannot supervise a technician
 - Service provided has to conform to supervision requirements for the specific procedure code
- Physical Therapy
 - A PT/OT/SLP may provide services as incident to a MD/DO
 - An PTA/OTA may provide incident services to the PT/OT/SLP only
- Ambulatory Surgical Center (ASC)
 - Services provided incident to a procedure performed by MD/DO or NPP are:
 - Part of the facility fee
 - Not separately billable to Medicare Part B

Q & A – Special Situations

- **The physician assistant (PA) sees new patient in office setting. The PA discusses the case with the MD/DO who sees the patient. The PA dictates the notes. Who can bill?**
 - In the situation described, this service is appropriately billed under the PA only. This is a new patient.
- **The MD sees the patient and determines the patient needs a joint injection. The MD has the PA give the injection. Can the MD *submit* the E/M and the PA submit the injection?**
 - Since the MD and the PA are in the same group, Medicare looks to the tax ID to determine the group. Members of the same group must bill the global surgery package. See CMS IOM

Publication 100-04, Chapter 12, Section 40.2.A.2, 40.2.A.4, and Chapter 1 of the National Correct Coding Initiative (NCCI) edit manual.

- **The treating physician refers the patient to a “Coumadin Clinic”. The treating physician determines the plan of care and is treating the disease for which the patient is on Coumadin. Can the MD responsible for the Coumadin Clinic bill for services by ancillary staff such as checking vitals and providing the results of the International Normalized Ratio (INR) test.**
 - The answer depends on whether the physicians are in the same group practice Identified by the same tax ID number.
 - Yes, if both physicians are in the same tax id and supervision requirements are met.
 - No, If not in the same tax ID number. The supervising physician at the clinic is not treating the patient for the individual disease. Therefore, he/she can only submit the services they personally provided. The office could not submit ancillary staff services under the supervising physician of the clinic.
- **The patient contacts Medicare to make a complaint about possible fraudulent billing, stating “I did not see this doctor on this date.” The patient saw NPP “Johnson” but the claim shows Dr. “Smith”. What happens in this type of situation?**
 - Medicare will request documentation from the provider office. The medical record submitted shows the service was provided and documented by the NPP. Documentation would include information indicating services were incident to the physician. If the billing physician is not the patient’s physician, but a supervising physician in the same group setting on that date, that information is included.
- **The patient had surgery and is returning for a follow up. The NPP sees the patient and determines the patient needs a new cast. Can the NPP submit this under the MD/DO provider number?**
 - The determination of whether or not a new cast is needed could be part of an incident to service if the documentation supports that the MD/DO indicated a possible need for a new cast as part of his/her plan of care.
 - If the service is during the post-operative period, the application of the cast would also need to include Modifier 58 for a staged or related service, or modifier 79 for an unrelated service based on medical record documentation.
- **The MD/DO or NPP ordered injections for a patient’s migraines. The patient returns to the office and the nurse performs the administration. How is this billed to Medicare?**
 - Since the MD/DO or NPP has the repeat injections as part of his/her POC, the MD/DO or NPP can submit this under his/her provider number when the other requirements of incident to are met.

- **The NPP sees an established patient under the incident to guidelines for ongoing knee pain and injection. The NPP requests an x-ray of the knee which is performed in the office. The NPP performs the professional component of the x-ray.**
 - What is the appropriate billing for this service when the MD/DO is in the office suite?
 - Charges can be submitted under the MD/DO billing number if the incident to requirements are met. The billing would include the injection and the global x-ray. The E/M service is only billed if the documentation meets the modifier 25 exception.
 - What is the appropriate billing for this service when the MD/DO is **not** in the office suite?
 - The charge for the injection, professional component of the x-ray and possibly the E/M (when meeting the modifier 25 guidelines) can only be billed under the NPP provider number. The technical component of the x-ray can only be billed under the MD/DO provider number.
 - **The MD/DO orders drug x at x dosage. The NPP sees the patient in follow up and determines x drug at x dosage is not working and changes to y drug at y dosage. Can the service be billed under the MD/DO provider number?**
 - No, because the NPP is now determining the plan of care for the patient, the service no longer meets the incident to requirements.
- Editor's Note: This response to the question was updated 3/14 with clarification received from CMS.*
- **Can I bill under my MD/DO provider number for services provided by a new physician to our group who is currently in the provider enrollment process? They *have a National Provider Identifier (NPI)* number.**
 - *A physician can bill for incident to services provided by another physician. This would be a very rare circumstance. The situations would have to follow the incident to guidelines including the billing physician must be in the office suite, and the performing physician cannot change anything in the billing physician's plan of care.*
 - **A non-skilled nursing facility provides office space for physicians to use. I bring my ancillary staff to assist me. If I am in the facility, but not in the designated space, do I still meet the requirement of direct supervision?**
 - No.
 - **The NPP is seeing a patient for a follow up for diabetes treatment. The service meets all the incident to requirements and then the patient says "Oh, by the way – Can you look at this rash on my elbow?" Is the service still billable under the incident to guidelines?**
 - No – the new problem (rash on the elbow) removes the service from the incident to guidelines and therefore the NPP must bill under his/her provider number.

References

➤ CMS Internet-Only Manual (IOM); Publication 100-02, Medicare Benefit Policy Manual

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html?DLPage=1&DLSort=0&DLSortDir=ascending>

- Chapter 6 – Hospital Services Covered Under Part B
 - Section 10
 - Section 20.4
 - Section 20.5.1 and 20.5.2
- Chapter 12 – Comprehensive Outpatient Rehabilitation Facility
 - Section 10
- Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
 - Section 10 and 10.2
 - Section 60 and 60.2
 - Section 110
 - Section 130
 - Section 150
- Chapter 15 – Covered Medical and Other Health Services
 - Section 16
 - Section 30.5
 - Section 50.3
 - Section 60, 60.1, 60.2, 60.3
 - Section 300

➤ CMS Internet-Only Manual (IOM); Publication 100-03, Medicare National Coverage Determinations (NCD) Manual

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html?DLPage=1&DLSort=0&DLSortDir=ascending>

- Chapter 1 – Coverage Determinations, Part 1
 - Section 70.3

➤ CMS Internet-Only Manual (IOM); Publication 100-04, Medicare Claims Processing Manual

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascending>

- Chapter 1 – General Billing Requirements
 - Section 30.2.10 and 30.3.12.3
 - Section 80.3.2.1.3
- Chapter 3 – Inpatient Hospital Billing

- Section 10.4
 - Section 40.3
 - Section 110.9
- Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS)
 - Section 20.1
 - Section 250.2, 250.2.2 and 250.12.2
 - Section 300.4
- Chapter 5 – Part Outpatient Rehabilitation and CORF /OPT Services
 - Section 10.6
- Chapter 8 – Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims
 - Section 90.5.1
- Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers
 - Section 40
 - Section 181
- Chapter 12 – Physicians/NonPhysician Practitioners
 - Section 30.3, 30.5, 30.6.1, 30.6.4, and 30.3.13
 - Section 80.2
 - Section 90.4.5
 - Section 170
 - Section 230.1
- Chapter 13 – Radiology Service and Other Diagnostic Procedures
 - Section 30.1.3
 - Section 50.2
- Chapter 14 – Ambulatory Surgical Centers
 - Section 10.2
- Chapter 17 – Drugs and Biologicals
 - Section 10
- Chapter 18 – Preventive and Screening Services
 - Section 10.2.2
- Chapter 23 – Fee Schedule Administration and Coding Requirements
 - Section 30
- Chapter 32 – Billing Requirements for Special Services
 - Section 12.3
 - Section 140.1

➤ Federally Qualified Health Centers Fact Sheet

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf>

➤ Rural Health Clinic Fact Sheet

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfactsht.pdf>

➤ Intensive Behavioral Therapy (IBT) for Obesity Fact Sheet

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ICN907800.pdf>

➤ MLN Matters Article # SE0570

<http://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/downloads/JA0570.pdf>

➤ E/M Service Guide

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

➤ SNF Best Practices Guidelines Page

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/BestPractices.html>

➤ MLN Matters Article # SE0441

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf>

➤ MLN Matters Articles # MM6447

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6447.pdf>

➤ MLN Matters Articles # SE0816

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0816.pdf>

➤ Consolidated Billing

<http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>

➤ IPPE & AWP Own Benefit Category

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

➤ Preventive Quick Reference Information Chart

http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf