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SPECIAL POINTS OF INTEREST:

- **Guidelines for Effective Use of A PA (pages 1 3-5, 8)**
- **Nuances of Coding the New Patient Visit (page 1 & 7)**
- **Modifiers-101: The –59 Modifier (pages 2 & 6)**
- **Medical Trivia (page 7)**

Maximizing You Office's Profitability & Productivity: Using a Physician's Assistant

Over the past few months, M.E.D.I.C., Inc. has received several requests for information regarding an office's use of physician assistants – most especially the use of a PA "incident to" the physician. This is not surprising, for given the constant threats to cut the physician fee schedule, providers must arrive at efficient ways to maximize their earning potential and time in the office, while not compromising patient care. This could include using a PA for office visits, thereby freeing up physician time for more and greater billable services.

Furthermore, the Office of the Inspector General of DHHS has targeted "incident to" services in its 2008 Workplan: "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." *(OEI; 09-06-00430; 09-06-00431; expected issue date FY2008; work in progress)*

Harkening back to the old classroom expression: if one person is asking the question, then at least several others are thinking it, we are assuming that others are interested in the nuances of "incident to" services billing. With that said, the following article will address Virginia's statutory requirements regarding the use of a PA, followed by some information specifically relating to Medicare's "incident to" rules.

CAVEAT: As an initial matter, all providers must recognize that the issue of whether and how third-party payors compensate for work performed by a PA is determined on an individual basis by each third-party payor company (i.e., each company has different policies regarding coverage of PA work). Should a provider have

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Consult, Referral, New Patient — Oh My!

Navigating the murky waters of coding the E/M visit can be daunting, but successful coding can not only maximize the earnings of your practice, but also can protect practice coding and billing in the event of an audit (and E/M coding is definitely a target audit area for review of practices falling beyond the norm). This article will address the coding of a new patient E/M visit — look to the next issue of the *M.E.D.I.C. News Quarterly* for a discussion of the consult and referral.

The "new patient" is defined by the CPT Handbook as "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years." This is important, for the compensation for a new patient is greater than that of an established patient, given the additional work necessary to gain an understanding of the patient's background and medical history, and the necessity of the presence of a physician, as opposed to other office staff. Clearly a patient who is walking through the door of your practice for the first time ever is a new patient. However, there are several key distinctive components to the CPT's "new patient" classification which transform an otherwise established patient into a new one for purposes of coding and claims submission:

- The patient may have been to the practice before, however three years time has elapsed since the last visit. This patient is now deemed a new patient for purposes of E/M coding.
- The patient may have been to see an internist in your practice last year, however, now he is coming to see you – a pulmonologist (i.e., a physician of a different specialty) – for purposes of coding your E/M visit, he is a new patient (note, however, that if he were returning to the internist, he would be an established patient)

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Modifiers 101: The –59 Modifier

Headlining M.E.D.I.C., Inc.'s second article addressing the proper use of modifiers is the often misused (and thusly, often investigated) Modifier -59. In fact, CMS research and investigation has revealed that the -59 modifier is one of the most incorrectly billed modifiers – especially by dermatologists, anesthesiologists, cardiologists, physical therapists and podiatrists. As such, it behooves us all to take a "refresher course" on this apparently troublesome modifier.

The *CPT Manual* defines modifier -59 as follows: **Modifier -59: "Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used." **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier-25.

History of the -59 Modifier: When components of a global procedure are separately reported, this is considered unbundling a CPT code and does not follow principles of CPT coding. For example, excision of a basal cell of the cheek with flap reconstruction is reported with CPT code 14040 - which, according to CPT rules, includes excision of the lesion. To report 11641 in addition to 14040 in this case would be unbundling (remember, the -59 modifier should not be used to unbundle appropriately bundled procedures).

Consider, however, the excision of a basal cell of the cheek with flap reconstruction performed at the same time as the excision of a basal cell carcinoma of the forehead. In this situation, 14040 and 11641 are legitimately reported together because *two distinct procedures* are performed: two lesions are excised, one on the cheek, one on the forehead. The cheek defect is reconstructed with a flap, as in the above example.

Prior to 1996, if 14040 and 11641 were reported together in situations such as the latter, 11641 (relating to the forehead) would be disallowed by payers and bundled into the global code 14040. It was impossible to convey to the insurance companies the fact that two distinct procedures were performed, and that 11641 was not being unbundled from 14040. In 1996, a temporary modifier, "-GB," was introduced, replaced in 1997 by the current "-59" modifier. The "-59," or "distinct procedure" modifier, was created to correct this coding iniquity. The "-59" modifier indicates that codes that usually are bundled together as part of a global code are in this particular circumstance describing ***distinct*** or ***separate*** procedures.

Thus, in the above example, the appropriate coding is: **14040** Excision of basal cell of cheek with flap reconstruction; **11641-59** Excision of basal cell of forehead. Without the "-59" modifier, 11641 would be disallowed, as it would be considered part of code 14040 (as in the pre-1996 claims).

So, where does the difficulty lie? The proper use of modifier "-59" was very clear initially, and despite the fact that the descriptor has been modified several times since 1997, the use of this modifier should be relatively straightforward. Procedures "not ordinarily performed or encountered" together are appropriately reported together "under certain circumstances."

Unfortunately, payers, including Medicare, have expanded the requirements for use of "-59." Some of their requirements transcend the modifier's original intent and do not accurately comply with CPT guidelines. This is where a great deal of confusion has been created: Insurance company guidelines do not always correspond with CPT guidelines. Consider the excisions of three facial nevi, each less than 0.5 cm. By CPT rules, the procedures should be reported:

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specific questions about specific payor policies, procedures covered, etc…, then further inquiry and investigation is required, for there are as many rules as there are payors!

Virginia's Administrative Code Governing the Practice of Physician Assistants

Generally. As a general proposition, Virginia's administrative code provides that "[n]o person shall practice as a physician assistant in the Commonwealth of Virginia except as provided in this chapter," and that "[a]ll services rendered by a physician assistant shall be performed only under the continuous supervision of a doctor . . . licensed by this board to practice in the Commonwealth." What does this mean? That the supervising physician – a doctor licensed in the Commonwealth who has accepted responsibility for the supervision of the service that a physician assistant renders – has on-going, regular communications with the physician assistant on the care and treatment of patients. *18VAC85-50-10 and 18VAC85-50-40*.

Protocol. The specific text of the regulations outlines steps which must be followed in order to ensure the authorized use of a PA. First, and most important, is the drafting, submission and approval of the "protocol" under which your PA will be employed. The protocol is a "set of directions developed by the supervising physician that defines the supervisory relationship between the physician assistant and the physician and the circumstances under which the physician will see and evaluate the patient."

The requirements delineating the content of this protocol can be found at *18VAC85-50-101*. Specifically, this portion of the code states that a protocol be drafted by the PA and the supervising physician(s) ***prior to the initiation of service provision***. This protocol will detail:

- the role(s) and function(s) of the PA, accounting for issues such as: the PA's experience; the number of patients being seen; the types of illnesses treated by the supervising physician; the nature of the treatment; special procedures; the nature of the physician availability in ensuring direct physician involvement (note that direct supervision is defined as the supervising physician being present in the room in which a procedure is being performed) at an early stage and regularly thereafter;
- a performance evaluation process, "including a requirement specifying the time period, proportionate to the acuity of care and practice setting, within which the supervising physician shall review the record of services rendered by the physician assistant;"
- the name, address and telephone number of all supervising physicians, in addition to the description of their practice, as mentioned above; and
- if the responsibilities of the PA include prescribing drugs and devices, the written protocol must include those schedules and categories of drugs and devices that are within the scope of practice and proficiency of the supervising physician.

While not initially required of the protocol, the Board of Medicine can at a future date require you to provide additional information regarding the level of supervision under which the PA will work, and the PA's competence in performing certain tasks. (The varying levels of supervision are as follows: Direct Supervision contemplates the supervising physician being present in the room in which a procedure is being performed; General Supervision demands only that the supervising physician be easily available and can be physically present or accessible for consultation with the physician assistant within one hour; and Personal Supervision requires that the supervising physician is within the facility in which the physician assistant is functioning.)

Supervising Physician's Responsibilities. Regardless of the tasks outlined in the protocol and the competence of the practice's PA, the supervising physician must maintain responsibility for certain functions as outlined in Virginia's code (*18VAC85-50-110*):

- See and evaluate any patient who presents the same complaint twice in a single episode of care and has failed to improve significantly. Such physician involvement shall occur not less frequently than every fourth visit for a continuing illness.
- Be responsible for all invasive procedures
- *Generally supervise* (easily available & can be present for consultation with PA within 1 hour) a physician assistant's insertion of a nasogastric tube, bladder

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catheter, needle, or peripheral intravenous catheter (but not a flow-directed catheter), and performance of minor suturing, venipuncture, and subcutaneous intramuscular or intravenous injection.

- *Directly supervise* (in room with PA) all other invasive procedures not listed above, unless, after directly supervising the performance of a specific invasive procedure three times or more, the supervising physician attests to the competence of the physician assistant to perform the specific procedure without direct supervision by certifying to the board in writing the number of times the specific procedure has been performed and that the physician assistant is competent to perform the specific procedure. After such certification has been accepted and approved by the board, the physician assistant may perform the procedure under general supervision.
- Be responsible for all prescriptions issued by the assistant and attest to the competence of the assistant to prescribe drugs and devices.

Physician Assistant Responsibilities. Virginia law provides that the physician assistant *shall not render independent health care*, but shall do the following (*18VAC85-50-115*):

- Perform only those medical care services that are within the scope of the practice and proficiency of the supervising physician as prescribed in the physician assistant's protocol. When a physician assistant is to be supervised by an alternate supervising physician outside the scope of specialty of the supervising physician, then the physician assistant's functions shall be limited to those areas not requiring specialized clinical judgment, unless a separate protocol for that alternate supervising physician is approved and on file with the board.
- Prescribe only those drugs and devices as allowed in 18VAC85-50-130 *et seq*.
- Wear, during the course of performing his duties, identification showing clearly that he is a physician assistant.

Prescriptive Authority. In order for a Virginia PA to prescribe medications and devices, the following requirements must be met (*18VAC85-50-130*):

- PA must hold a current, unrestricted VA license as a physician assistant
- Ability to prescribe medications and/or devices must be contained in the protocol which is filed and approved by the board prior to issuance of prescriptive authority
- PA must submit evidence of his/her successful passing of the NCCPA exam
- PA must submit evidence of successful completion of a minimum of 35 hours of acceptable training to the board in pharmacology.

Approved drugs and devices. *Section 54.1-2952.1* of the Virginia code provides for the ability of a physician's assistant to prescribe medications and/or devices. However, there is definite oversight of and limitations to the extent of a PA's prescriptive authority:

- the PA may prescribe only those categories of drugs and devices included in the practice agreement as submitted for authorization;
- the supervising physician retains the authority to restrict certain drugs within these approved categories;
- the PA shall only dispense manufacturer's professional samples or administer controlled substances in good faith for medical or therapeutic purposes within the course of his professional practice;
- the protocol which is filed with and approved by the Board prior to a PA assuming responsibilities must address the prescriptive responsibilities with which the PA will be entrusted, and that PA can only prescribe drugs and/or devices within the scope of that protocol. (*18VAC85-50-101 & 150*);
- every prescription that is ordered by a PA must bear the name of the supervising physician in addition to that of the PA… the PA must disclose to the patient (may simply be on the prescription pad, or otherwise in writing to the patient) not only that (s)he is a licensed physician assistant, but also the name, address and telephone number of the supervising physician. (*18VAC85-50-160*)

Alternate Supervising Physician. An alternate supervising physician is a member of the same group, professional corporation or partnership of any licensee, hospital or any commercial enterprise with the supervising physician. Any alternating supervising physician shall be a physician licensed in the Commonwealth who has registered with the board and who has accepted responsibility for the supervision of the service that a physician assistant renders.

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If the PA is being supervised by an alternate supervising physician who specializes in a different area of medicine from that of the regular supervising physician, then the PA shall not perform any services which require specialized clinical judgment UNLESS a separate protocol has been submitted and approved covering the Alternate Supervising Physician's area(s) of specialty.

Unavailability of Supervising Physician. If, due to illness, vacation, or unexpected absence, the supervising physician is unable to supervise the activities of his/her PA, such supervising physician may temporarily delegate the responsibility to another doctor of medicine, osteopathy, or podiatry. The supervising physician so delegating his responsibility shall report such arrangement for coverage — including the reason — to the board office in writing, subject to the following provisions:

- Planned absence. Such notification shall be received at the board office *at least one month prior* to the supervising physician's absence;
- Sudden illness or other unexpected absence. The board office shall be notified *as promptly as possible, but in no event later than one week*; and
- Temporary coverage may not exceed four weeks unless special permission is granted by the board.

While these sections of the Virginia Administrative Code address the most frequently encountered issues relating to the practice of a PA in Virginia, the entire body of the code can be found at http://leg1.state.va.us/000/reg/TOC18085.HTM#C0050. This link will take the researcher to the table of contents of the administrative code for Section 50, which pertains to the practice of PAs. From there, all sub-sections are listed and available for review.

Medicare's Policies Relating To Physician's Assistants:

As mentioned above, each provider has a different policy relating to the use of and compensation for the services of a PA. M.E.D.I.C., Inc. will detail some specific policies that Medicare has established below, however, to gain a full understanding of the appropriate use of and compensation for the services of a PA, providers must analyze the guidelines of each and every payor with which they participate. So, without further ado, we present Medicare's policies as relating to a PA's practice in Virginia:

Qualifications: must 1) graduate from a PA program accredited by ARCEPA (or predecessors); 2) pass national certification exam of the NCCPA; and 3) be licensed in Virginia to practice as a PA.

Billing: Medicare has a unique policy whereby PAs must receive and bill under their own Medicare provider number. Again, this is unique, most payors do not issue identification numbers to non-physician providers. To get this number, PAs must complete the Medicare HCFA-855 application. Any questions or requests should be directed to : Medicare Provider Services, P.O. Box 5858 Timonium, MD 21094-5858, (866) 828-6254.

- One exception to this rule is that if the PA is billing "incident to" the services of a physician, then the PA would not use his/her Medicare number, but rather that of the physician.

Surgery: services of a PA are covered when 1st assistant at surgery (when the procedure is covered for an assist); use the AS-modifier when billing surgery assist.

Reimbursement: reimbursement will only be made to the PA's employer;

- Medicare calculates PA's allowables at 85% the Physician Fee Schedule, and then pays at 80% of that amount… this is for all valid places of service for office visits;
- for surgery assists, physicians are approved at 16% of the surgical allowance; therefore, the PA will be paid 85% of the 16% that the 1st assistant would have received if a physician;
- "incident to" services are approved at 100% of the physician fee schedule and paid at 80% of that amount; bill using the supervising physician's number

Supervision: as a general rule, Medicare requires *general supervision* of PAs (no need to be physically present, however, supervising physician must be immediately available to PA for consultation via telephone or "other effective means of communication" (e.g., blackberry)). However, *direct supervision* is required for "incident to" services (not in room, but on premises). Note that per VA code, "direct supervision" requires that the physician be in the room with the PA, so "personal supervision" (in the facility, but not the room) is the standard for "incident to "services.

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Modifiers 101: The –59 Modifier

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11440 Excision lesion 1; **11440-51** Excision lesion 2; **11440-51** Excision lesion 3

The CPT book reads: "When multiple procedures... are performed at the same session, report the most significant procedure first, with all other procedures listed with modifier 51 appended." This is certainly clear and the coding above follows this guideline. Unfortunately, many payers require the use of "-59" rather than "-51" in the above circumstance. The assumption by the insurance company is, if the coder does not indicate that each lesion excision is a "distinct procedure," then the surgeon is billing three times for the excision of a single lesion. Although CPT guidelines indicate otherwise, some payers require the above procedures to be reported:

11440 Excision lesion 1; **11440-59** Excision lesion 2; **11440-59** Excision lesion 3

Still others, including some Medicare intermediaries, require ***both*** modifiers:

11440 Excision lesion 1; **11440-59-51** Excision lesion 2; **11440-59-51** Excision lesion 3

Yes, it ***is*** illogical and confusing, since the CPT book reads: "When another already established modifier is appropriate it should be used rather than modifier 59." Essentially the lesson to be gleaned is that *each carrier's rules must be analyzed to ensure compliance with their policy relating to the reporting of separate and distinct procedures*, generally, and the specific use of the –59 modifier.

How is the -59 Modifier Misused? Modifier -59 (and other NCCI associated modifiers, for that matter) should NOT be used to bypass an NCCI edits unless the proper criteria for use of the modifier has been met. Perhaps of preeminent importance when using this modifier is the proper documentation in the patient's medical record, which must reflect that the modifier has been used appropriately to describe separate services. Remember, accurate, proper and real-time medical documentation is required to support the medical necessity of a procedure – if it is not documented, then it is viewed never to have occurred!

Another common misuse of modifier –59 relates to the portion of the definition which allowing for the -59 modifier to be used to describe a "different procedure or surgery." Proper use of modifier -59 to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. By that same token, different diagnoses are not necessarily adequate criteria for use of modifier -59. *The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.*

From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does *not* include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site; treatment of posterior segment structures in the eye constitutes a single anatomic site.

Finally, studies conducted by various payor organizations have shown that misuse of the -59 modifier has manifested itself in the following ways:

- Services were submitted with the -59 modifier when the procedure codes should have in fact been bundled per CCI edits, and the documentation did not reflect a *distinct and separate* service warranting the unbundling/use of modifier
- The modifier was inappropriately appended to the comprehensive code rather than the component code
- The modifier was inappropriately appended to subsequent codes for repeated services
- The modifier was inappropriately used when some other descriptive modifier was applicable to the situation
- The modifier was inappropriately appended to E&M codes (ranging from 99201-99499)

Avoidance of these common pitfalls, in conjunction with adherence to both the CPT-Manual's defined use of the –59 modifier and carrier rules should ensure successful and valid coding of your "separate and distinct" procedures.

This article includes excerpted material from CPT Corner (May 2006) "Is it modifier -59 or -51? Which do I use?" by Raymond Janevicius, M.D.)

MEDICAL TRIVIA

Kiss it and make it better??? Where in the world did this expression derive from??? Why would anyone think that a kiss could make an injury better??? WELL, for those of you who have ever pondered the etymologies of words or the origins of common phrases, this should be interesting!

According to Myron Korach & John Mordock, the authors of *Common Phrases (and where they come from)*: [t]his phrase actually has its origin with a snakebite. It was observed that a foreign substance entered the body at the point of the bite, and swelling, pain, and sometimes death shortly followed. Through the process of trial and error, somebody realized that the bite should be sucked so that the poison could be removed. The process worked, and before long this remedy was being applied to all infectious wounds. Soon certain people were credited with remarkable ability to heal wounds by sucking. 'Kiss it and make it better' is thus a relic of one of our first medical procedures." Mordock, John & Myron Korach. Common Phrases (and where they come from). Guilford: The Lyons Press, 2001. 145. Now you know… sometimes kissing it WILL make it all better!

What about the **Adam's Apple** — how did that ever come to be the name of the forward protrusion of the thyroid cartilage — the largest and most prominent cartilage of the larynx that grows during puberty and sticks our at the front of men's throats??? Well…. One theory harkens to biblical lore. It has been said that when Adam swallowed the forbidden fruit, one large piece of the apple remained lodged in his throat and formed a lump. That lump in every man's throat was thusly named for the very first man, and so the "Adam's Apple" was coined. *Id.* at 70.

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This analysis is taken to the subspecialty level as well. Drawing for the example above, if your practice contains subspecialties of pulmonology, then a patient seeing Dr. Jones who practices in subspecialty A would in fact be deemed a new patient of Dr. Smith, who practices in subspecialty B.

A nuanced exception to this standard of classification is the situation in which a physician sees a patient of one of his or her colleagues, as a result of having been on call for another physician in the practice who is of a different specialty. This patient is classified as new or established based on the relationship with the physician who was not available and being covered for. Using the example above: patient is an existing patient of the internist; the pulmonologist is on call and covering for the internist when the patient presents; thus the visit is classified as one for an established patient (even though the pulmonologist had never seen the patient and is of a different specialty).

It is worth noting that the new versus established patient distinction is only applicable to the office visits deemed "office or other outpatient services" in the CPT Handbook (see CPT codes 99201-99215).* Observations, hospital care, consultations (office/outpatient or inpatient), and emergency department services are all blind to the distinction, and all visits, regardless of the patient's status as new or established, will be coded will be coded and billed similarly.

* *Note that this article has specifically excluded from discussion nursing facilities; domiciliary, rest homes or custodial care services, and home services— all of which do distinguish between the new and established patient.*

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Services covered: as a general proposition, Medicare defers to the VA Administrative Code (or any other state, for that matter) as to the determination of what constitutes a covered service. That being said, Medicare will compensate for a PA's services if the following criteria have been met: PA services are the types that would be considered physician services if performed by an MD/DO; PA services are performed by person meeting all qualifications of a PA; PA must be employed; PA services are performed under *general supervision* of an MD/DO; PA services are not otherwise non-covered by Medicare. Examples of PA services which would be covered and compensated by Medicare: physical exams (including all levels of E&M codes, so long as allowed by the state and generally supervised), minor surgery, setting casts for simple fractures, interpreting x-rays, other services involving independent evaluation/treatment of patient condition.

Excluded Services: Medicare will exclude from compensation services of a PA which would otherwise have been excluded from coverage per Medicare —regardless of whether the service would have been permitted under state law.

"Incident To" Services: Incident to services are defined by Medicare as those "commonly furnished in a physician's office, which are 'incident to' the professional services of a physician or non-physician practitioner and provided by auxiliary personnel," and limited to "those situations in which there is direct physician/non-physician personal supervision." To see a patient "incident to" a physician:

- the PA must be employed by the physician,
- the physician must have seen the patient at his/her initial office visit,
- the physician must *directly supervise* the PA (not in room, but on premises — again, recall that in Virginia this level of supervision is referred to as "personal supervision" as opposed to "direct supervision"), and
- the physician must have active, on-going participation in the care of the patient (what is "active and ongoing" varies from state to state, sometimes it is one out of every 4 visits
- services must be performed in the office setting… those services provided in the inpatient or outpatient setting are not deemed to be "incident to."

Use of PAs in an office setting is extremely efficient, for the PA can see patients in the global period following a surgery/procedure, which is generally non-compensatable, thereby freeing the physician to perform reimbursable tasks. Taken to the next level, using PAs "incident to" the services of the physician ensures compensation for the PAs services at 100% (as opposed to 85%) of the MD/DO's earnings, but again, freeing the MD/DO to attend to initial patient visits and other more intricate and expert procedures that are non-permissible for the non-physician practitioner (such as the PA) to perform.

One final point regarding Medicare's "incident to" rules: the PA can also be deemed the supervising entity whose services are being enhanced when the auxiliary personnel performing the incident to services are nurses (other than nurse practitioners or clinical nurse specialists), technicians, therapists, or other non-physician providers. In such instances, the PA would have to have seen the patient during the initial visit (but only received the PA compensation amount based on 85% of the Physician's Fee Schedule), and then auxiliary personnel would be able to conduct follow up services pursuant to the same aforelisted prerequisites, and bill using the PA's identifier (as opposed to the physician's). The limitation here is that only PAs, NPs, CNSs, and nurse midwives are able to bill for E&M codes above a 99211.

For additional information directly from Trailblazers and/or CMS relating to billing for non-physician providers, see http://www.trailblazerhealth.com/Publications/Training%20Manual/nonphysicianpractitioners.pdf, http://www.trailblazerhealth.com/Publications/Training%20Manual/incident_to.pdf, and http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf respectively.