

# Billing


[CMS Publication 100-2, Benefit Policy Manual, Chapter 15, Section 50.4.5](#)

[Local Coverage Article, A53049- Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents](#) .

## **Can we collect the co-insurance from our Medicare patients on the date of service when we know the patient does not have co-insurance coverage?**

Yes, you may collect the co-insurance on the date of the service from patients who advise you that they do not have co-insurance coverage.

## **How do we bill if both a physician and non-physician practitioner sees the patient in the office during the same encounter?**

When an evaluation and management service is a shared/split encounter between a physician and a non-physician practitioner (nurse practitioner, PA, clinical nurse specialist,  clinical nurse midwife, the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the non-physician's national provider identifier (NPI), and payment will be made at the appropriate physician fee schedule payment."



**What is the correct procedure code for the administration of the Hepatitis B vaccine?** G0010 is the correct healthcare common procedure coding system (HCPCS) code to report the administration of hepatitis B vaccine for routine immunization.

**Can I report procedure code 90471 for the immunization administration of influenza, pneumococcal pneumonia, and hepatitis?**

Do not report 90471 for the administration of influenza, pneumococcal pneumonia, and hepatitis. The correct administration codes are:

- G0008 (influenza)
- G0009 (pneumococcal pneumonia)
- G0010 (hepatitis B)

**7. If a beneficiary receives the influenza and pneumococcal pneumonia vaccinations at the same encounter, must a separate administration procedure code be billed for each vaccine.**

Yes, for Medicare purposes, even though a provider may use the same diagnosis code when a beneficiary receives both vaccinations at the same encounter, report separate administration codes.

**8. What must be included in my medical record documentation when administering medication(s)?**

Medical record documentation should include the name of the medication, the dosage and the route of administration. The site of the injection should also be documented as well as any patient reactions to the medication and signature of the person administering the medication. Documentation must be maintained in the patient's chart to support the medical necessity of the injection given. When a portion of the drug is discarded, the medical record must clearly document the amount administered and the amount wasted.

**9. Why do claims only reject or deny for one reason and not for everything that is missing or wrong on a claim?**




Medicare Part B claims process through the standard Multi-Carrier System. The standard system uses a series of edits and audits to help determine whether claims are eligible for payment. The standard system has been programmed to reject or deny a claim based on the first edit or audit that it does not pass. It does not continue to process against the rest of the edits and audits.

**10. What code should physicians report if a HCPCS code couldn't be found for the medication being administered?**


Providers should report charges for all drugs and biologicals using the correct HCPCS codes for the items rendered. It is also important that providers make certain the reported units of service for the specific HCPCS code are consistent with the quantity of the drug and/or biological.

In the situation where there is no code to accurately describe the medication being administered providers should use a not otherwise classified (NOC) code based on the HCPCS descriptor. You should only use NOC codes if there is no HCPCS or Current Procedural Terminology code available that describes the service performed. These codes should only be used if a more specific code is unavailable. Depending on the medication provided, report J3490 (unclassified drugs), J3590 (unclassified biologics), or J9999 (not otherwise classified, antineoplastic drugs).

**References**

- [CMS Publication 100-04, Claims Processing Manual, Chapter 12, Section 30.5](#) 
- [CMS Publication 100-4, Claims Processing Manual, Chapter 17](#) 
- Local Coverage Article, [A53049, Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents](#) 

**11. If auxiliary personnel perform mental health services outside the office setting, e.g., in an institution other than hospital or SNF, we understand their services are covered 'incident to' a physician's service only if there is direct supervision by the physician. Although CMS indicates that a physician in a facility setting cannot provide direct supervision when available by telephone, and being somewhere generally in the facility, we are asking whether a physician (who does not have an office in the facility) who is in the same wing and same floor as the auxiliary personnel, could be viewed as providing direct supervision. Being in the same wing and same floor would be akin to being in an "office suite" such that the physician would be in close proximity and able to immediately respond in the event necessary.**

Novitas Solutions follows the guidelines outlined in the CMS [Publication 100-02, Benefit Policy Manual, Chapter 15, Sections 60.1 & 80.2](#) , regarding 'incident to' billing. 'Incident to' within a nursing facility (not

a SNF) is met when the physician is in the same wing and on the same floor as auxiliary personnel for services other than E&M services.

## 12. If the start and stop time is not documented on an infusion, can I bill an IV push?

Since most infusion codes are time based codes, the start and stop time must be documented to support the time component and to ensure you are billing the most appropriate code. This applies to IV push as well. Remember, each encounter and drug is unique and have different administration rules; some drugs are not billable as an IV push. Therefore, recoding to an IV push may not be appropriate.

## 13. What date of service should I report when completing a diagnostic interpretation on a different date from the actual test?

We recognize that providers do not always perform the professional component on the same date as the technical component. Many providers prefer to submit a claim with a date of service that reflects the day the professional component was performed, while others prefer to use the day the technical component was performed as the date of service for their professional component.

Currently, there is no policy from CMS that requires providers to bill one way or the other. Since there is no specific policy, regulation, or other mandate from CMS on this issue, we will leave it up to the provider to determine which date of service to report for the professional component.

## 14. What code do we use to report the administration of Prolia/Xgeva Denosumab (J0897), code 96372 or 96401?

When choosing an administration code, it is up to the provider to select the administration code that best describes the reason for the injection, diagnosis, and documentation.

According to our Local Coverage Article, [A53049-Approved Drugs and Biologicals, Includes Cancer Chemotherapeutic Agents](#), "Drug administration service(s) include:

- Nonchemotherapy injection(s) (CPT codes 96372, 96373, 96374, 96375, 96377, 96379),
- Nonchemotherapy infusion service(s) (CPT codes 96365, 96366, 96367, 96368, 96369, 96370, 96371), and
- Administration of a chemotherapy injection or infusion, injection or infusion of certain cancer drugs not used to treat cancer, and monoclonal antibodies (CPT codes 96401- 96522, 96542, 96549)."

Based on our local coverage article, it appears that CPT 96372 would be an appropriate administration code for Prolia when used to treat osteoporosis. However, since Xgeva is classified as a monoclonal antibody, CPT 96401 appears to be a more appropriate administration code.

Please refer to the AAPC's article, [Prolia® \(Denosumab – J0897\) Administration](#), for a similar discussion regarding 96372 and 96401.

## 15. Can I cancel a Part B claim once it is submitted?

No, claim submissions billed in error (needs a line item removed) cannot be corrected in the IVR or Novitasphere Portal. The [Return of Monies to Medicare Form](#) or [Part B Redetermination and Clerical Error Reopening Request Form](#) must be used in these situations. Remember that the claim must be fully processed before completing one of the forms listed above.

## 16. What is the definition of a rendering physician, a referring physician, and an ordering physician? Where on the claim form is this information reported?

A 'rendering physician' is a physician/practitioner who renders/performs medical services. Report the National Provider Identifier (NPI) of the rendering physician in block 24J of the CMS 1500 claim form or electronic equivalent.

A 'referring physician' is a physician/practitioner who refers patients to another physician or facility for medical services. Report the NPI of the referring physician in blocks 17 and 17B of the CMS 1500 claim form or electronic equivalent.

An 'ordering physician' is a physician/practitioner who orders an item or service. Report the NPI of the ordering physician in blocks 17 and 17B of the CMS 1500 claim form or electronic equivalent.

## Reference

[CMS IOM Publication 100-04, Claims Processing Manual, Chapter 26](#) 

**17. Does Novitas require a resubmission reference number when resubmitting a claim?**

No, Novitas does not require the resubmission number when resubmitting a claim. If you need to add to the claim for your records please place it in block 19, or the EDI equivalent, of the claim form.

**18. How much does modifier 52 adjust RVUs?**

Novitas follows CMS guidelines that state:

"The fees for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. Thus, A/B MACs (B) may increase or decrease the payment for a service only under very unusual circumstances based upon review of medical records and other documentation."

**Reference**

[CMS IOM Publication 100-04, Claims Processing Manual, Chapter 12, Section 20.4.6](#) 

**19. When submitting information with the new Medicare numbers, do you put a dash after the numbers?**

No, just like with the HICN, the MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.

**20. What admin code do we use with Xolair, J2357?**

It is the provider's responsibility to choose the most appropriate administration code to bill with J2357. However, it appears that administration codes 96365-96379 may be appropriate.