March 4, 2024 | Volume 38, Issue 10

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In this issue

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PBN Perspectives

Hit with a subpoena? Court order? Know the difference, respond accordingly

When a criminal or civil case embroils a practice, subpoenas or court orders requesting or demanding records may come to the front desk. You may face different types of requests that can be made in connection with the case in question, and it's vital that your staff understand the difference.

The documentation requests sometimes lead to legal cases against providers, as with a case presently before the Maine District Court concerning Meredith Norris, D.O., who has been indicted on alleged violations of the Controlled Substances Act based in part on documents obtained in an FBI search. Norris has challenged some of the document seizures on which the case against her is based.

Records are often protected by laws such as HIPAA, but that protection may not count in all circumstances. Misunderstandings about this have led to some costly errors. Consider a case adjudicated by the Connecticut Supreme Court in *Byrne v. Avery Center for Obstetrics and Gynecology* (*PBN 1/28/19*). In that case, an OB/GYN practice had surrendered patient records in response to a subpoena, apparently believing they had no choice. That turned out to be false, and cost the practice heavily in a suit brought by the patient whose protected health information (PHI) was surrendered.

Broadly speaking, PHI is protected by federal and, in some cases, state privacy laws against civil demands, though it may be surrendered in criminal matters. But it's important to understand the details.

Civil subpoenas: Easier

"Subpoenas can come from many sources," explains Alex J. Keoskey, a partner with Mandelbaum Barrett PC in Roseland, N.J. "They can be issued by plaintiff attorneys handling civil claims such as personal injury or malpractice lawsuits, other counsel handling divorce actions, government law enforcement and regulatory agencies, criminal prosecutors, state licensing authorities or state and federal government agencies which prosecute insurance fraud, misconduct or gross malpractice."

John C. Eason of Bass, Berry & Sims PLC in Nashville names the types of documents you're likely to see: a grand jury subpoena (criminal investigation), a civil investigative demand (civil investigation), an administrative investigative demand (criminal investigation), and an administrative subpoena (likely an administrative or civil investigation, but could be part of a criminal investigation). These should be identifiable on their face.

Generally speaking, subpoenas that come from a lawyer in a civil case do not require an immediate remand, and state and federal HIPAA laws will guide your response with regard to medical records. That is, you cannot give out PHI without the patient's permission.

Often these subpoenas with be accompanied by a HIPAA authorization signed by the patient that the attorney has already obtained, says Paul D. Werner of the Buttaci, Leardi & Werner law firm in Princeton, N.J.

"With your standard civil-court subpoena, nine times out of 10, you're getting served via mail or a delivery service, as opposed to somebody walking in and physically handing it to you," Werner says. But however it comes, the authorization has to be cleared with the patient for HIPAA compliance. Once it is, in most cases you should comply with the request.

When the judge asks, comply

Orders from a judge or magistrate usually require a different response. If you find a judge's name and signature on the bottom of the subpoena, chances are HIPAA is no longer operable. Note, however, that's not an ironclad rule; there can be exceptions.

Court orders are not only for criminal proceedings, says Joelle Duval, counsel with Coffey Modica LLP in White Plains, N.Y. "Even in your ordinary slip-and-fall case, you can have a judge order a subpoena directing Doctor Smith's practice to send medical records for the plaintiff to the courthouse," she notes.

Failure to comply timely can be considered contempt of court with a monetary fine. Usually, it's a modest $50 fine, says Patricia A. Mooney, a partner at Coffey Modica, though "obviously you want to be compliant with the court."

Search warrant: Must do

Take note of one thing that's an immediate-action scenario: A search warrant in a criminal investigation.

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ISSN 0893-8121. pbncustomer@decisionhealth.com Price: $699/year.

"In that instance, you've got zero control over the situation," Werner says.

The first thing staff should do when agents present a warrant is to obtain a copy and get your lawyer on the phone, Werner says. But forget about blocking the agents from doing what the warrant says they can do. "Usually, when federal officers like FBI or IRS agents come in, they will sort of segregate out the staff that's in the office, and start cataloguing and taking what they need to take," Werner says.

"The agents can prevent you from leaving while they conduct the search, or they can require you to leave the physical premises but remain in the general area until they've completed it," Werner adds. "They can temporarily take your pocketbooks, backpacks, cell phones, things like that, and keep them away from you while they conduct their search. Eventually they'll give you or your lawyer an inventory of what they took and leave."

During the search, agents can prohibit staff from talking to one another and from talking to other people on the phone about the search. But, Werner says, "they can't prevent you from contacting your lawyer to advise on the subpoena or search warrant. In fact, more often than not, they'll get on the phone with a lawyer and provide copies of the search warrant."

And they can't prohibit you from discussing the raid after they leave. Neither can the agents compel you to talk to them based on the warrant. But note: Your practice "can't compel your employees to *not* talk to the agents, either," Werner says.

Another must: CMS calling

There's another situation in which practices can't stonewall: Medicare investigations, such as when CMS contractors come around to confirm that you're a real practice "because there's been a lot of fraud over the years where providers put up an address purporting to be their business address, and Medicare comes out to check and it's a post office box or a nail salon, or doesn't exist at all," Werner says.

Generally these officials identify themselves and show a document which you may read "but which they will not permit you to keep or make a copy of," Werner says.

You should immediately get your lawyer on the phone for this. "We've had a lot of those phone calls where I'm on speakerphone with the office manager and talking to the Medicare contractor about the scope of what they're doing," Werner says. You may even get the contractor to wait to do their look-around until the practice is less busy.

Exceptions for 'sensitive' records

Not all orders signed by judges — even in criminal investigations – require or even allow immediate delivery of requested patient information in all cases.

Meredith Norris has challenged some of the document seizures on which the case against her is based. In one instance, she has contested admission of documents obtained with a subpoena that was served to a "federally regulated substance abuse treatment facility" with which she is associated, on grounds that such a request "requires a valid court Order authorizing disclosure pursuant to 42 U.S.C. §290dd-2 and the federal regulations implementing the same." That subpoena has since been withdrawn.

Werner notes that if a patient is in treatment for a substance use disorder (SUD), the confidentiality of their records is covered by federal law — specifically, 42 CFR Part Two, "Confidentiality of Substance Use Disorder Patient Records" — and there are a number of added steps lawyers and even government and law enforcement officials must complete before the order may be obeyed (*see resources, below*).

"If we assume, for the sake of this discussion, that the cops aren't there looking for the records of the person they're going after, then they can't get those records at all," Werner says. "If they're looking to investigate somebody other than the person they're after, they can't have the records even if the person whose records they're seeking signs [standard HIPAA] paperwork consenting to it — unless they have also signed very specific paperwork that contains very specific language that complies with Part Two, which is clear on what exactly what has to be contained within that document. Absent that, they can't comply if they don't have consent."

In fact, Werner says, even if records are those of a fugitive or someone else the authorities are empowered to apprehend, you might not be able to turn them over under Part Two, because it "has particular sections governing the use of SUD records in the context of criminal investigations, and generally speaking those records cannot be used for purposes of investigation or prosecution barring exceptional circumstances."

Also note: Some state privacy and HIPAA laws are stricter than federal HIPAA. As a rule of thumb, federal HIPAA prevails if there's a conflict with state law, except "if the state has more stringent rules, in which case the practice can follow the state's rule instead," Duval explains.

And some states have especially tight laws regarding "sensitive" patient records. In New York State, requests for "anything about mental health, drug, alcohol use, opioid addiction [and] HIV status requires specific signed authorization from the patient," Duval explains. The patient must check and initial Box 9(a) of the state authorization form before any of these sensitive records can be disclosed, and "this agreement for disclosure must be done individually for each category."

Make the call

In all of the situations described above you're advised to contact your legal counsel before doing anything. Fortunately, most such cases don't require an immediate answer, even "when it's Inspector General or FBI agents showing up at your office to serve that document," Werner says.

One example Werner cites is a civil investigative demand, often seen in False Claims Act investigations. "Those are sometimes sent in the mail, but sometimes they're served in person by agents," Werner says. "In those instances, practices may get confused — understandably, because you've got guys with badges coming in. But even in those cases, they can be treated no differently than a subpoena — they're just a request for documents and nothing else."

Chances are your lawyer will talk to their lawyer, and work to revise the requirements so they're less onerous. "That's why subpoenas have extended return dates on them," Werner says. "And we always get more time for subpoenas. In 17 years of practice, I don't think I've ever responded to a subpoena by the return date originally identified on the subpoena."

Subpoena via Twitter?

Reagan E. Boyce, partner at with the Chamblee Ryan firm in Dallas, says if your practice group is in Texas and has a social media presence, someone should check the account on a regular basis: "Texas now allows for the service of legal process such as subpoenas and citations through social media as a form of substitute service when the regular methods have failed," she says.

In such cases, a court order is still required before social media sites can be used for service, Boyce says, but "if an order is obtained, service is proper via social media platforms and all related deadlines will begin to run once service is completed." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCE

- Code of Federal Regulations, Title 42 Part Two, Confidentiality of Substance Use Disorder Patient Records: *www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2*

PBN Perspectives

When the legal papers arrive: 5 expert tips

Reagan E. Boyce, partner with the Chamblee Ryan firm in Dallas, offers five handy suggestions for situations that may arise when you practice is served papers (*see related story, p. 1*):

1. Front desk personnel should ask the sheriff or process server for the name of the person or entity being served and the nature of the document in order to confirm that the right business or person is being served. If the name provided does not match the name of the business or the name of someone who works at the practice group, front desk personnel should inform the sheriff or server that they have the wrong address. In some cases, the sheriff or server may leave the documents with the front desk even after being advised of the possible error. Do not argue with the process server or sheriff. Accept the documents and turn them over to the practice manager.
2. It is extremely important to note the date the process server delivered the paperwork, so when counsel becomes involved, they know what deadlines apply.
3. If the document is a subpoena duces tecum, meaning a subpoena requesting only documents or other tangible items be produced, the subpoena should be delivered to the practice manager, so the custodian of records can respond timely to the request.
4. If the subpoena is asking for an individual who works at the practice to appear for testimony either at trial or a deposition, then the individual named in the subpoena should contact their liability insurance carrier immediately. Most insurance policies will provide coverage for individuals who are subpoenaed to testify in civil matters.
5. If the document being served is a citation for a lawsuit naming an individual member of the practice and/or the practice as a defendant, then the individual or the practice group should notify their insurance carrier immediately. There are deadlines for the person or group served to answer the lawsuit. Legal counsel will be appointed by the insurance carrier to guide the individual and/or practice group through the process. — *Roy Edroso* (*roy.edroso@decisionhealth.com*)

Benchmark of the week

After code switch, psych and neuro tests perform well, with exceptions

After a major coding changeover, psychological and neuropsychological testing claims have continued to rise in overall utilization. But watch a few related codes that have had a harder time of it.

The codes in the chart below were introduced in 2019 as replacements for several codes for psychological and neuropsychological testing by a provider or technician (*PBN 3/13/23*). The old codes were replaced by time-based primary and add-on codes that separated the work of testing from the work of evaluating the test results, and a code for automated testing, **96146**.

While **96130-96131** are for testing by an appropriate health care professional, **96138-96139** are for testing by a technician, which must then be evaluated. Codes **96132-96133** are for testing evaluation by professionals, while **96136-96137** are for test administration and scoring by a professional.

Also in 2019, the neurobehavioral status code **96116** was split in two, to become a time-based code (96116) and an add-on code (**96121**) to be billed after the first hour.

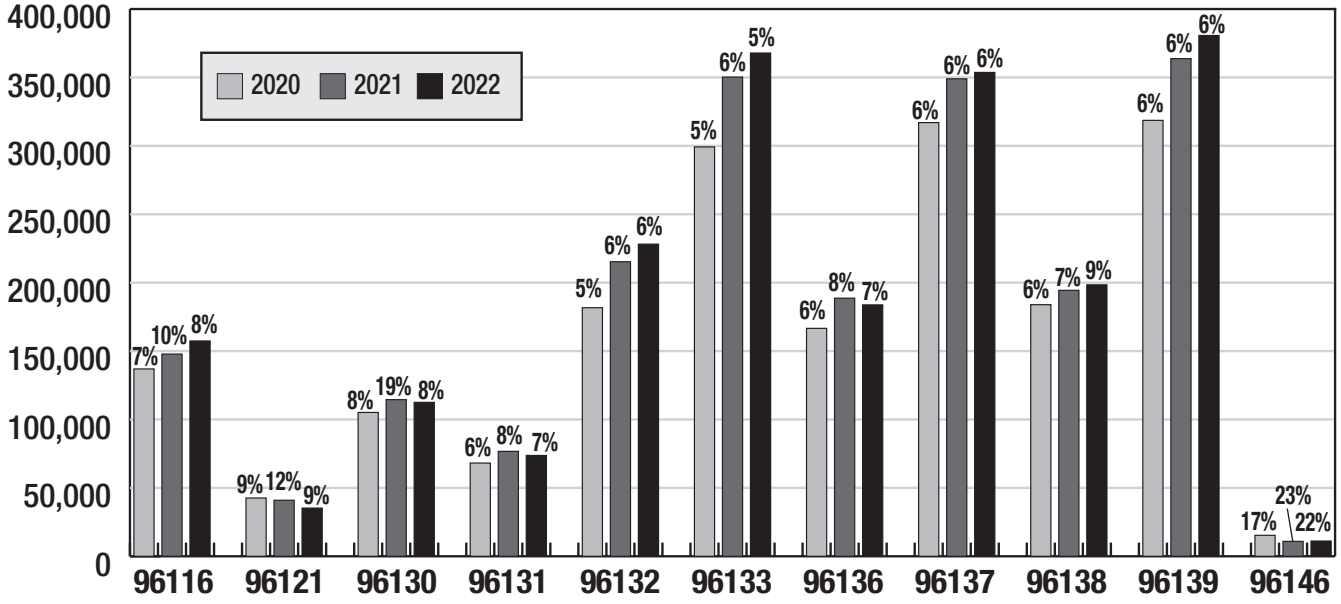
The three years since the switch — 2020 to 2022, the most recent year of available Medicare claims numbers — have shown mostly growth for these services: They jumped from 1.8 million claims to 2.1 million, a positive change of nearly 15%.

But there have been a few laggards. While the 96116 neuro status code has thrived, claims on the 96121 add-on code have steadily decreased. It would appear that fewer such tests merited more than an hour of provider time in 2022 than in 2020. (Code 96116 pays $90.37 at the non-facility rate; 96121 pays $73.67.)

Also, 96130, 96131 and 96136 took unexpected if minor tumbles. These codes saw a minor denial rise in 2021, except for 96130, which zoomed from 8% to 19%, and that may have made providers cautious about billing them. (Those denial rates have since course-corrected.)

Automated testing code 96146 remains a problem child, with low utilization and sky-high denial rates. *Part B News* has advised providers to check local coverage determinations and payer policies as to what diagnoses are appropriate for this testing (*PBN 3/18/19*).
— Roy Edroso (*roy.edroso@decisionhealth.com*)

Psychological, neuropsychological and neurobehavioral testing codes, utilization and denial rates, 2020-2022



Source: Part B News *analysis of 2020-2022 Medicare claims data*

Telehealth

Implement time, location lessons for FTF and telehealth visits: OIG audit

Take time to assess key details the HHS Office of Inspector General (OIG) found in its review of telehealth services during the first nine months of the COVID-19 public health emergency (PHE). The agency identified documentation errors that might lurk in your face-to-face (FTF) E/M services, as well as your telehealth claims.

The OIG's Feb. 13, 2024, report on telehealth claims for office/other outpatient E/M visits (**99201-99215**) analyzed claims that were filed from March 2020 to November 2020. You can use that information to refine your internal reviews.

Tune up time-based services

Make sure providers are documenting the exact time they spend on their E/M encounters across settings, if time-based coding is an option at your practice.

The OIG gave the providers top marks for their performance during the turbulent first nine months of expanded telehealth availability. But it did identify problems with time documentation during its review.

"Some providers did not document within the medical records the time spent with the enrollees," according to the audit report. "Specifically, in addition to medical decision making the change allowed providers to use time," the OIG wrote.

Beginning March 1, 2020, CMS allowed providers to use the MDM or time guidelines for their office/outpatient telehealth encounters, as an alternative to the traditional 1995/1997 documentation guidelines (*PBN blog 3/31/20*).

The OIG also signaled that it wants providers to state whether a patient is new or established. "Some providers did not document within the medical records that the enrollee was a new or established patient … the inclusion of a requirement to include patient status in the medical record documentation in any new version of the documentation guidelines CMS issues may better support billed E/M services," the agency wrote.

Flagging patients as new or established is not a requirement. But according to the OIG, indicating whether a patient is new or established would help make sure that providers don't receive improper payments.

Check telehealth charts for 3 errors

If your practice performs telehealth services, you will find pointers to making sure documentation and claims are accurate:

1. **Indicate the type of encounter.** Your providers should clearly state whether the encounter was in-person, through an audio and video connection or audio-only. This creates a complete record and facilitates accurate coding. It will also prepare practices that report level-based E/M services via telehealth for 2025, when the CPT Editorial Panel plans to release a code set for office telehealth services. "Although this did not affect the payments for these services during our audit period, if providers do not document whether the services were provided using telehealth or in-person, this may … impact future policy changes if CMS establishes different payment rates for telehealth and in-person services," the OIG warns.

Your coders should also match the type of encounter to the code. The OIG found cases where the documentation stated the visit was audio-only, which should be reported with a telephone encounter code such as **99441-99443**. However, the practice reported an office/other outpatient E/M service.

2. **Document the platform.** Remind providers they must demonstrate that each telehealth encounter was HIPAA-compliant by documenting the platform they used. During the PHE, providers could use certain platforms that weren't HIPAA-secure but the platforms still had to be non-public facing, the OIG observed in its report. The HHS Office for Civil Rights ended its waiver on Aug. 9, 2023, and restored the requirement that all audio and video telehealth services be performed on HIPAA-secure platforms (*PBN 10/16/23*).

3. **Note the patient's location.** "Some of the providers did not document within the medical record the location of the provider or enrollee (e.g., provider's office, provider's home, or enrollee's home) when services were provided via telehealth," according to the audit report. Patient location became essential to correct coding and reimbursement on Jan. 1, 2024, when new place

of service rules for telehealth services went into effect (*PBN 9/11/23*).

Keep in mind that the current PHE waiver extension will expire Dec. 31, 2024, unless Congress passes a bill that extends the waivers or makes permanent changes to Medicare's telehealth authority. And regardless of what happens to telehealth rules, the OIG and other auditors will continue to audit claims and demand overpayments when they find mistakes. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com) ■

RESOURCES

- Medicare Generally Paid for Evaluation and Management Services Provided via Telehealth During the First 9 Months of the COVID-19 Public Health Emergency That Met Medicare Requirements: https://oig.hhs.gov/oas/reports/region1/12100501.pdf
- CPT Editorial Panel summary of panel actions, Feb. 2023: www.ama-assn.org/system/files/cpt-summary-panel-actions-feb-2023.pdf

Ask Part B News

Check the payer first when selecting codes for obesity counseling

Question: *At our orthopedic practice we sometimes must postpone a patient's total joint replacement because their BMI is too high. We either refer them back to their PCP for weight loss management or to a weight loss program at another facility. One of our providers is working to become certified in weight loss counseling, which would allow her to provide this service at our practice rather than referring the patients elsewhere. My question is: how would this service be billed? Would we use the preventive medicine individual counseling codes* ***99401-99404****? If so, are there any specific documentation requirements that would need to be included in the note? (I see that these codes are time-based, so obviously the time would need to be documented.) Or would this type of visit be billed under a regular established patient E/M (****99212-99215****)?*

Answer: Codes 99401-99404 (Counseling, risk factor reduction and behavior change) would be a good fit to report for commercial payers, says Shannon McCall, senior manager for regulatory compliance at HCPro LLC.

The AMA guidelines for those codes state: "Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity."

As you mention, time should be documented for accurate selection of codes 99401-99404. AMA guidelines state: "Any E/M service reported on the same day must be distinct and reported with modifier 25, and time spent providing these services may not be used as a basis for the E/M code selection."

That is, when reporting an E/M service on the same day as an obesity counseling session, clinicians should clearly describe the medical necessity for the separate E/M visit, and make sure there is no overlapping time billed for the two services.

For Medicare, check these G codes

However, for Medicare beneficiaries, you'll need to refer to codes **G0447** (Face-to-face behavioral counseling for obesity, 15 minutes) or **G0473** (Face-to-face behavioral counseling for obesity, group [2-10], 30 minutes).

Those codes have a limitation that they may only be provided "by a qualified primary care physician or other primary care practitioner and in a primary care setting," according to Medicare's national coverage determination for intensive obesity counseling (NCD 210.12).

It would not be appropriate to report a code from 99212-99215 for obesity counseling because both the AMA and Medicare have other codes that are specific to the service. — *Laura Evans, CPC* (laura.evans@decisionhealth.com) ■

RESOURCE

- NCD 2010.12, Intensive obesity counseling: NCD - Intensive Behavioral Therapy for Obesity (210.12) (cms.gov)

Part B News brief

CMS affirms billing expansion of pulmonary, cardiac rehab services

On February 8, CMS published *MLN Matters 13513* to ensure medical group billing staff is aware of an expansion of supervising practitioners who can oversee, and bill for, pulmonary, cardiac and intensive cardiac rehabilitation services. The changes, effective Jan. 1, 2024, permit three groups of qualified health care professionals – physician assistants, nurse practitioners and clinical nurse specialists – to supervise pulmonary, cardiac and intensive cardiac rehabilitation services. With the release of associated Change Request 13513, CMS alerted billing providers and Medicare administrative contractors to updates in Chapter 15 of the Medicare Benefit Policy Manual and Chapter 32 of the Medicare Claims Processing Manual that align with the expanded billing privileges. The policy change reflects an update finalized in the 2024 Medicare physician fee schedule.

Ask Part B News

How to code when the orthopedist is called to evaluate an inpatient

Question: *One of the coders I work with consistently uses the subsequent inpatient or observation codes (**99231-99233**) to bill for hospital H&Ps by their orthopedic surgeons. A typical scenario would be when the orthopedist is called to evaluate a hospitalized patient with a known orthopedic injury who was admitted by another physician. The orthopedist has not previously seen the patient. I am seeing conflicting guidance on this from different sources. Can you please clarify?*

Answer: Both the AMA and CMS agree that such encounters should be reported with the initial inpatient or observation codes (**99221-99223**).

For example, the 2024 CPT manual states: "An initial services may be reported when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay." (Professional Edition, p. 17)

Medicare defines an initial visit as "one that occurs when the patient has not received any professional services from the physician or NPP or another physician or NPP of the same specialty who belongs to the same group practice during the stay."

In contrast, CMS states: "A subsequent service is one that occurs when the patient has received any professional services from the physician or NPP or another physician or NPP of the same specialty who belongs to the same group practice during the stay."

Note here that while the AMA recognizes subspecialties for these cases, CMS does not.

CMS has been directing providers to report inpatient consultations using the initial inpatient codes since 2010. So for a situation where a family physician admits the patient and requests the orthopedist to consult on the patient's condition (e.g., a fracture case), Medicare directs you to report an initial inpatient or observation visit with a code from the 99221-99223 series. As CMS explains:

"Physicians who provide an initial visit to a patient during inpatient hospital care that meets the code descriptor requirements shall report an initial hospital care code (99221-99223). The principal physician of record shall append modifier '**-AI**' (Principal Physician of Record) to the claim for the initial hospital care code. This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care.

"Physicians may bill initial hospital care service codes (99221-99223), for services that were reported with CPT consultation codes (**99241-99255**) prior to January 1, 2010, when the furnished service and documentation meet the Initial Hospital Inpatient or Observation Care code descriptor requirements. Physicians must meet all the requirements of the initial hospital care codes, to report CPT code 99221, which are greater than the requirements for consultation codes **99251** and **99252**."

Note: The AMA deleted consultation code 99251 effective Jan. 1, 2023. Here's how the requirements for consult code 99252 compare with initial inpatient observation code 99221:

Code	MDM	Time
99252	Straightforward	35 minutes
99221	Straightforward or low	40 minutes

Some payers still reimburse the CPT consultation codes (99252-99255) for these visits. Practices should stay current on those policies to ensure appropriate code reporting. — *Laura Evans, CPC* (*laura.evans@decisionhealth.com*) ■

RESOURCES

- Medicare Claims Processing Manual, 100-04, Chapter 12, Section 30.6.9.E: *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*
- Medicare Claims Processing Manual, 100-04, Chapter 12, Section 30.6.9.1.F: *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*

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