Coding and Billing Instructions

FOR CMS 1500 FORM

While all coding decisions should be made by the physician based on independent review of the patient's condition, below is a list of codes you may find helpful.

BOX 21 - DIAGNOSIS CODES

Enter the appropriate ICD-10-CM code in Box 21

→ **Box 21**	R15	Fecal incontinence
	R15.0	Incomplete defecation
	R15.1	Fecal smearing
	R15.2	Fecal urgency
	R15.9	Full incontinence of feces

COLUMN 24D AND BOX 19 - MEDICATION INFORMATION

The below codes may be used:

→ **Column 24D**	HCPCS L8605	Injectable bulking agent, dextranomer/ hyaluronic acid copolymer implant, anal canal, 1 mL, includes shipping and necessary supplies
→ **Box 19**	NHRIC 89114-0850-03	Solesta Injectable Gel – 1 carton of four 1 mL prefilled syringes

COLUMN 24D - ADMINISTRATION CODE

Since Solesta does not have a unique CPT code for administration, physicians may file for reimbursement for the injection of Solesta using:

→ **Column 24D**	CPT 46999	Unlisted procedure, anus

Please note: for guidance and additional information regarding billing and administration of Solesta, check with your local Medicare carrier.

COLUMN 24G - MEDICATION QUANTITY

→ **Column 24G**	Indicate the quantity of medication administered Enter the number of units as "4" 4 units = 1 carton of four (4) 1 mL prefilled syringes

CODING AND BILLING INSTRUCTIONS FOR CMS 1500 FORM

SOLESTA IMPLANT,
Stocked by Physician and Administered in the Office

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY / SEX M F				4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other				7. INSURED'S ADDRESS (No., Street)
CITY	STATE		8. RESERVED FOR NUCC USE				CITY
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) YES NO				a. INSURED'S DATE OF BIRTH MM DD YY / SEX M
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? YES NO PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? YES NO				c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 89114-0850-03 Solesta 1 carton (four 1 mL prefilled syringes)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. R15 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	RENDERING PROVIDER ID. #
1			L8605			$X,XXX	4		NPI	
2			46999			$X,XXX			NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.		

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

PHYSICIAN OR SUPPLIER INFORMATION — PATIENT AND INSURED INFORMATION — PAYER

BOX 19 - MEDICATION INFORMATION

Enter the NHRIC number, device name, and dosage administered into the appropriate narrative field.

Note: narrative information requested will vary by payer

BOX 21 - DIAGNOSIS CODES

Enter the appropriate ICD-10-CM code in Box 21.

example: **R15:** Fecal incontinence

COLUMN 24D - PROCEDURES, SERVICES OR SUPPLIES

Enter appropriate HCPCS Code

example: **L8605:** Inj bulking agent anal canal

COLUMN 24D - PROCEDURES, SERVICES OR SUPPLIES

Enter appropriate CPT Code(s) for drug administration services

example: **46999:** Unlisted procedure, anus

COLUMN 24G - QUANTITY OF MEDICATION USED

4 units = 1 carton of four (4) 1 mL prefilled syringes

COLUMN 24F - MEDICATION CHARGE

For product information, adverse event reports, and product complaint reports, contact:
Palette Life Sciences – Medical Information Department Tel: 844.350.9656 Fax: 510.595.8183 Email: palettemc@dlss.com

Palette LIFE SCIENCES