Recorded Webinar: Parenteral Nutrition

Contract	DME MAC Jurisdictions B & C
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Today's webinar will provide an overview of the Parenteral Nutrition policy. It is designed to familiarize you with the basic coverage criteria and documentation needed. As a supplier, be sure to review the Supplier manual, the LCD and Policy Article as well as the Standard Documentation Requirements for All Claims Submitted to DME MACs just so that you get the full understanding of what is needed.

Just a couple of things from the disclaimer. The information was current at the time of the webinar so make sure to check the website and electronic email messages for updates. And the last thing, I want to remind attendees that you may not record this presentation for any reason. However, CGS may record webinars for educational purposes.

Today we'll discuss the updates to the coverage criteria for Parenteral Nutrition. I'll cover the coding and documentation requirements for the policy. I have some billing tips to discuss with you and we'll talk a little bit about the Comprehensive Error Rate Testing program or CERT. And the last part of the webinar will address the resources that are available to assist you with this policy.

First up, I want to provide an overview of the coverage criteria.

There was a recent update to the Local Coverage Determination (LCD) and LCD-related Policy Article (PA) for parenteral nutrition. The GA, GY, GZ, and KX modifiers have been added to the parenteral policy. Claims for dates of services on or after July 2, 2023, will be rejected as missing information if these modifiers are not appended to the claim as noted in the Policy Article. The use of these modifiers follows the standard documentation requirements. Suppliers must append the KX modifier to claim lines billed for parenteral nutrition, parenteral pump, and supplies but only if all of the coverage criteria listed in the policy have been met and evidence of such is retained in the supplier's files. This information must be made available to the DME MAC upon request. Now, if all of the criteria have not met, then the GA, GY or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not. When there is an expectation of a non-covered (no benefit) denial, suppliers must enter the GY modifier on the claim line. I have links to the LCD and Policy Article for your reference.

When it comes to parenteral nutrition, if the beneficiary requires nutritional support other than oral, then enteral nutrition is usually the preferred method to parenteral. Here are the reasons from the policy:

- Enteral nutrition permits delivery of all necessary nutrients in a more concentrated volume than parenteral when the beneficiary is fluid restricted.

- In the home setting, enteral allows for safer delivery of nutrients and
- Enteral lowers the risk of Central Line-Associated Bloodstream Infections.

Here are a couple of things that must be documented before parenteral nutrition can be considered reasonable and necessary. The treating practitioner must document that enteral has been considered and ruled out or that enteral was tried and found to be ineffective, or there's an exacerbation in gastrointestinal tract dysfunction when on enteral. In addition, the beneficiary must have (a) a condition involving the small intestine and/or its exocrine glands which significantly impairs the absorption of nutrients or (b) disease of the stomach and/or intestine which is a motility disorder and impairs the ability of nutrients to be transported through and absorbed by the gastrointestinal (GI) system. The beneficiary must have a permanent impairment. Parenteral Nutrition (TPN) is covered for a beneficiary with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength appropriate to the beneficiary's general condition. Parenteral nutrition is given directly into the bloodstream.

The beneficiary's medical record must contain sufficient documentation of the medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement, if applicable. Medicare will be looking for information in the medical records to include things like the beneficiary's diagnosis and other pertinent information but not limited to, duration of the beneficiary's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experiences with related items, etc.

The treating practitioner is required to evaluate the beneficiary within 30 days prior to initiation of parenteral nutrition. If the beneficiary is not seen within this timeframe, the treating practitioner must document the reason why and describe what other methods were used to monitor and to evaluate the beneficiary's parenteral nutrition needs. There must be documentation in the medical record supporting the clinical diagnosis.

Next is the test of permanence. It is stipulated in Chapter 15, Section 120, of the Medicare Benefit Policy Manual which is CMS Pub. 100-02. Coverage of parenteral nutrition requires that the beneficiary must have a permanent impairment. However, this does not require a determination that there is no possibility that the beneficiary's condition may improve sometime in the future. If the medical records, including the judgment of the treating practitioner, indicates that the impairment will be of long and indefinite duration, the test of permanence is considered met. Parenteral nutrition will be denied as non-covered in situations involving temporary impairments.

Medicare will cover Parenteral nutrition if the coverage criteria is met. Here are the items that will be covered:

- The nutrient
- Equipment (the pump and the pole when applicable)
- Supply and administration allowances

Next, I have some coding information for parenteral.

If the coverage requirements are met, one supply allowance (B4220 or B4222) and one administration allowance will be reimbursed for each day that parenteral nutrition is administered. Parenteral nutrition supply allowances (HCPCS codes B4220, B4222 and B4224) describe a daily supply fee rather than a specifically defined "kit" and these allowances include all supplies required for the administration of parenteral nutrition to the beneficiary for one day. Now, because these are allowances and provided to the individual, the items may differ from one beneficiary to another and from one day to the next. Daily allowances are considered all-inclusive and therefore refill requirements are not applicable to HCPCS codes B4220, B4222, and B4224. Again, only one unit of service may be billed for any one day.

Next, we will take a look at the equipment, specifically the pump and IV pole. When the beneficiary meets the coverage criteria for parenteral, one infusion pump (portable or stationary) is covered. The reasonable useful lifetime on a parenteral pump is eight years. Once the cap is reached, maintenance and service are allowed no more than every three months. Please note it is payable for actual incidents only. An IV pole is billable for beneficiaries in a home setting.

This slide goes into further detail regarding modifiers for the parenteral pumps. With parenteral pumps, I have the pricing modifiers listed on this slide, so you would bill based on rental, new, or used equipment. I included a couple of examples of billing according to the selection; if the

beneficiary elected to purchase in the first month, if they elected to rent the pump, or if they chose a used purchase option.

The next bullet lists the rental modifiers to indicate the month of rental being billed. The 1st month KH, 2nd and 3rd months KI and 4th through 15th KJ. Now, the last bullet point shows the rental or purchase option elected by the beneficiary. The BP, the beneficiary elected to purchase the pump; BR, they chose to rent; and BU, they did not inform the supplier of a decision after 30 days. Please note, the beneficiary may elect to purchase at any time, but they MUST be offered the opportunity to do so by the tenth month using BP, BR, or BU modifier.

When an IV pole (E0776) is used in conjunction with parenteral nutrition, the BA modifier should be added to the code. And that BA modifier is only used on the IV pole HCPCS code. The EY modifier is used if there's not an order for the service. Again, for dates of service on and after July 2, 2023, you must append the appropriate GA, GY, GZ, and/or KX modifier based on if the coverage criteria have been met or if an ABN has been issued.

The total caloric daily intake must be one that is sufficient to achieve or maintain the beneficiary's body weight. The treating practitioner must document in the medical records if the caloric intake falls outside the 20-35 calories per kilograms per day. The treating practitioner must also document the medical necessity for the following items when they fall outside of the ranges listed on the slide and that would be for protein, dextrose, lipids, or if a special formula is prescribed. Now, when it comes to the specialty formulas, they were produced for a specific disease condition and therefore, the beneficiary's medical record must adequately document the specific condition and the necessity for that special formula.

Although home mixed parenteral solutions are rarely used, they are still listed in the policy and I've concluded them for reference, if needed. The only thing I'm going to mention about the home mix is that if the beneficiary is on home mix, the components are billed separately.

Now here are the codes for the pre-mixed solutions. There's no separate billing for carbohydrates, amino acids, or additives which includes vitamins, trace elements, heparin, and electrolytes. Lipids, however, are separately billed.

Now on this slide, I have the information for the number of units designated for both codes from lipids. So, based on the description of the code, 10 grams equals one unit of service. I also have examples of how the units would be reflected on the claim based on the percentage of lipids in the solution.

- So, one unit of service again equals 10 grams. So, if you have 500 milliliters of 10% lipids contains 50 milligrams of lipids that would be 50 grams of lipids, that would be 5 units of service.
- 20% in the 500 mls, that would be 100 grams or 10 units of service
- And 30% in 500 mls that contains 150 grams which converts to 15 units of service.

So, let's take a look at some information when billing units for the nutrient. When billing codes B4189, B4193, B4197 and B4199, one unit of service represents one day's supply of protein and carbohydrates and that's regardless of the fluid volume and or the number of bags.

So, for example, if 60 grams of protein are administered per day in 2 bags of a pre-mixed solution, each containing 30 grams of amino acids, the correct code is 1-unit B4193 not 2 units of B4189. The coding is based on the total for one day's supply, regardless of the volume or the number of bags. Please note that if you have a parenteral solution which contains less than 10 grams of protein per day, those are coded using the miscellaneous code of B9999. Now, that last bullet covers the amino acids found in the special formula. Those HCPCS codes are B5000, B5100, B5200 and one unit of service is equal to one gram of amino acids.

So again, if you're providing parenteral solution containing less than 10 grams of protein per day, those are billed using that miscellaneous code, the B9999. So, when you're using a miscellaneous code, you would need to include a description of the item, the manufacturer's name, the product name or number, the supplier's price list amount and the HCPCS code of a related item if applicable, and you would also need to include the medical necessity for the item. It is recommended that suppliers contact the Pricing Data Analysis and Coding department or PDAC for guidance on the correct coding for products if there is a question of if you're using the correct billing code.

So, on the next few slides, I will go over the basic documentation requirements.

So, we're going to move on into the actual documentation requirements. I have several items listed here, but you may not need each one. It's really going to depend on the policy and the equipment or supplies that you are providing. Now for the most part, you do not need to submit the documentation with your claim unless specifically noted in the policy.

Now remember there are certain pieces of documentation that's needed prior to billing. And when it comes to the medical records, if you don't have them in your possession, make sure that you have access to them in case of an audit. That is why it is important to establish a relationship with your referral sources so that when you need medical records, they can provide them to you quickly. Now, I will say this about medical records and please note that this is a business decision on when you gather them. Now, some suppliers prefer to get them upfront while others will gather them at a later date. So, if you don't have them to review prior to billing, you may not have the complete picture of the beneficiary's condition. Now, the Office of Management and Budget approved the Advance Beneficiary Notice of Non-coverage or the ABN form for renewal. The renewal form expires January 31, 2026. The only change to the form was the expiration date. You can start using the form at any time, but you must begin using it for initial dates or initial issues on or after June 30, of this year. Now please note, I do have a bonus section at the bottom of the slide. It has references to our Online Education Courses or OECs and these are courses that suppliers can use to get additional information. Now this particular OEC focuses on the ABN. These courses are pre-recorded modules; most of them are 45 minutes or less. The OECs are located under the education tab on the JB or JC websites in the Online Education Portal. These OECs can be used to supplement your training for your new staff members.

So, let's take a closer look at the standard written order. So, the standard written order must be obtained by the supplier prior to submitting a claim and it must include the elements listed here on the slide. So, it must include:

- The beneficiary's name or the Medicare Beneficiary Identifier or MBI
- Order date
- A general description of the item. I'll talk a little bit more about what the description is on the next slide.
- Quantity to be dispensed if, that is applicable
- Treating practitioner's name or their NPI
- And the treating practitioner's signature.

Just a few, additional notes regarding the standard written order; a signature and date stamp are not allowed. Signatures must comply with the CMS Signature Standards or signature requirements that's outlined in the Program Integrity Manual which is 3.3.2 4.

So, here's what Medicare will be looking for when it comes to the description on the standard written order. As I mentioned on the previous slide, the description can be either a general one, so, it could be something like the pump or an IV pole or it can have it could be the HCPCS code, it could be the HCPCS code narrative, it could be a brand name or model number. As a supplier, you can complete the standard written order and use the description that works best for your business.

You would then send the completed standard written order to the treating practitioner for review and signature. So, for the equipment, in addition to the description of the base, the standard written order may include all concurrently ordered options, accessories, or any additional features that will be separately billed or require an upgrade code. These items should be listed separately and the same applies to supplies. You would include the base and all concurrently ordered supplies that would be billed separately and as a supplier, you want to make sure that for any HCPCS code that you're billing on the claim, that code, or that item is listed on the standard written order.

So, when it comes to the quantity to be dispense, it should correspond with the total amount of each item to be provided per refill. So, medical review will accept this information as the billing units. So, for claim review purposes, expressing your quantity as a weekly or monthly amount is preferable. Now Medicare will be looking for the quantity of items that will be refilled monthly, for example, the nutrient, lipids, or special formula. So, they're going to be looking for the amounts on those and for the pump and pole those would not include a quantity because you're billing for one, but in case you're billing for more than one of a pump or pole, then you would indicate the number.

So next, when do you need a new order? Now, here are the situations that require a new order. You're going to need a new order-

- For all purchases or initial rentals.

- If there is a change in the order or the prescription.
    - If there's a change in the quantity, the frequency, or if there was something new added. You're going to need a new order in that case.
- You're going to need one on a regular basis, even if there was no change in the order or prescription. Now this is only when the particular medical policy states that it is required. So, if the policy states that you need to have an order every three, four, or six months, then that's what you would need to get.
- Now you also need a new order when the item is being replaced.
- You'll need an order if there is a change in the supplier.
- If the new supplier is unable to obtain a copy of a valid order or prescription from the outgoing or transferring supplier.
- And lastly, if the state law requires a prescription on the specific timeframe, some states require a new order yearly. So, as a supplier you would check with the LCD and Policy Article but you would also need to check with your individual state requirements to ensure that if the state requires that you get a new order each year, even if the policy doesn't, if the state requires a new order, then you would need to get a new order each year.

So, as you all are aware, the CMS has eliminated the CMNs and DIFs. So, this is effective for claims with dates of service on or after January 1st. So, if your claim is for date of service prior to January 1st, then you would submit the DIF or when required to process your claim, we must have one on file with a previously submitted claim. Now, for your claims with dates of service on or after January 1st, you wouldn't submit the DIF or the electronic claim equivalent of one. Electronic claim submissions with the DIF will be rejected by the Common Electronic Data Interchange or CEDI and those will be returned to the supplier for corrections. I have references to the MLN Matters Article SE22002 and the Change Request 12734.

Now, when you're submitting claims or that are submitted without the DIFs, claims will be calculated based on the units billed. And of course, you must have supporting medical records to support the amount of units that's billed on your claim. So, I did include a copy of the DIF because again, it is required for claims with dates of service prior to January 1st. So, these can be completed by the supplier in its entirety. You will need to complete sections 6 through 9 and sign and date the bottom portion. The DIF along with other documentation must be kept on file and made available upon requests. And again, this is for dates of service prior to January 1st of this year. And as I mentioned, the reason that we still have the information is because again, for dates of service prior to January, the DIFs are still applicable.

A new DIF is needed with:

- The initial claim
- The claim must include an electronic copy of the DIF.
- Resumption of parenteral therapy after two months.

A revised DIF ss needed for:

- A change in the HCPCS code for the current nutrient provided
- If there's a change in the number of days per week of administration
- If there's a change in the route of administration or when the length of need previously entered on the DIF has expired and the treating practitioner is extending the length of need for the item(s).

And as I've said several times, they're only needed for dates of service prior to January first, after that, you would need an order and medical records to support the items billed.

Now this slide highlights points specifically to parenteral nutrition. Notice that the information in red is in reference to the supply allowance code that I mentioned earlier. Now because these codes are considered all-inclusive and supplies may differ from day-to-day and beneficiary to beneficiary, it's not necessary to provide a breakdown of items furnished.

Here's just a closer look at the documentation required for refills. We do put this in a chart form just to make it easier to see what's needed at the glance. So, in that first column, if the beneficiary picks up item at your store, then you need either the signed delivery slip or an itemized receipt. Notice the documentation should indicate that the items were picked up. So, if you're using the same delivery slip for in-store pickups and for deliveries, just make sure to indicate which it

was. Our reviewers aren't allowed to assume or guess which one. Now, the next two columns, you have the requirements for refills requested in writing by the beneficiary or their authorized representatives. And by telephone contact between you and the beneficiary. I'm not going to read through all of the requirements. They're just here for your reference.

So, now we come to proof of delivery. Now proof of delivery is part of the Supplier Standards that all suppliers agree to when they sign up for the Medicare DME program. Now Medicare wants to ensure that the item delivered is the same item that was ordered by the treating practitioner, it's the same item that you billed and it's the same item that the beneficiary received. Now, it's also used to determine whether the claim was coded and billed correctly. Now there are three types of method of delivery and what requirements are needed for each.

Method 1: delivery is direct to the beneficiary. Now this includes delivery by your employees simply delivering the item to the beneficiary or handing it over the counter to them. Now the delivery date must be the date when the beneficiary or their designated representative received the item and that is your date of service.

So, then you have Method 2: When you are using a delivery service. That's either the post office, UPS, or FedEx. Those, you want to have your invoice, your shipping invoice, and the delivery service tracking information be clearly linked together. And again, you can do this by having the delivery service's identification number on your invoice and they will have yours and that would be the tracking number. You just want to make sure that both of those items match up. Now, Method 3: it's for a skilled nursing facility. Now, when the beneficiary is in a skilled nursing facility, whether you deliver it yourself or use a delivery service, you must have the information on this:

- Proof that the items were delivered
- Documentation showing that the items were accepted by the nursing facility expressly for the use of that particular beneficiary
- The quantities delivered and used must justify the quantity billed. The date of service is reflective of the method of delivery used, either direct delivery or by a shipping service.

So, when the beneficiary is in a skilled nursing facility under Part A (the beneficiary is in a covered Part A stay):

- The claim must be billed to the skilled nursing facility by the skilled nursing facility to the fiscal intermediary.
- No payment from Part B is available when parenteral nutrition services are furnished to a beneficiary in a covered Part A stay.
- Now, if the beneficiary is not covered in a Part A stay, parenteral nutrition may be billed to the DME MAC by either the skilled nursing facility or an outside supplier.

Now, I want to talk briefly about proof of delivery Method 1. So, here's how you would handle the direct delivery to the beneficiary before and after the PHE. Now if you were unable to obtain a signature from the beneficiary or their designee because of COVID-19, here are your options:

- For DOS between March 1, 2020, through May 11, 2023, you would continue to add the CR modifier and COVID-19 narrative.
- For initial setups or ongoing claims for dates of service on or after May 12, 2023, the CR modifier and COVID-19 narrative is not required. A valid signature is needed after the end of the public health emergency. At the bottom of the slide are resources to the COVID-19 page on the CGS website.

Just a couple of billing tips to assist you with your claim submissions.

For parenteral nutrition, only one month's supply is allowed regardless of utilization. Suppliers must not dispense a quantity of supplies that exceeds the beneficiary's expected utilization. Suppliers must also stay attuned to changed or atypical utilization patterns. Suppliers must verify with the treating practitioner that any changes or atypical utilizations are warranted. Parenteral payment is based on the solution components and the reasonable charge. So again, as the supplier, you want to make sure that if the beneficiary is using too much, too many of their supplies, or when you go to check for refills or the next month's supply and they still have, just about all of what they had at that point. Either you need to talk with a beneficiary just to ensure that they're using the items correctly or you may need to go back to the treating practitioner and let them know what is found and what is happening with the beneficiary and their utilization.

Now, when parenteral nutrition is administered in an outpatient facility, the pump used for its administration and the IV poll will be denied as not separately payable. The pump and pole are not considered as rentals to a single beneficiary, but rather as items of equipment used by multiple beneficiaries. Services that are associated with administration of parenteral nutrition in the beneficiary's home are not covered benefits administered by the DME MAC. So, what this is simply saying is that if someone is coming in to administer those items, that's not covered. Services are not billed to the DME MAC only equipment and or supplies needed to administer the nutrients. So, any service that's required is not billable to the DME MAC, only the equipment and the supplies.

Now, parenteral pumps can be either rented or purchased. When rented, they are processed similarly to cap rental items, but there are a few notable exceptions. One, they are not subject to the 25% reduction payment for the fourth rental month and after. And then two, the beneficiary may elect to purchase the pump at any time but must be given the option to do so in the tenth month if he or she has not already done so. Now, if the beneficiary decides to purchase the pump, once rentals have been paid, the purchase allowance will consist of the used purchase allowance less the amounts allowed to date for the rentals. Now, if the beneficiary elects to continue to rent the pump, rental payments will continue up to 15 months. The only time additional rental payments can be considered after the 15-month limit has been reached or after the pump has been purchased, is when the treating practitioner changes the prescription between parenteral and enteral nutrition. Change in suppliers during that 15-month rental period does not begin a new 15-month rental. The new supplier is entitled to the balance remaining on the 15-month rental period. The supplier that collects the last month of rentals, that is the fifteenth month rental, is responsible for ensuring that the beneficiary has a pump as long as it is medically necessary and for maintenance and servicing of the pump during the period of medical necessity. The RUL is the reasonably useful lifetime for parenteral pumps, that would be eight years. Now, when maintenance and servicing is necessary for the pump, after that 15-month rental limit is reached, that may include repairs and extensive maintenance that involves the breaking down of seal components or performing tests that require specialized testing equipment not available to the beneficiary. Payment will only be made for actual incidents of maintenance and servicing. For parenteral pumps, maintenance and servicing may be considered for payment every three months, not six months as it is with other equipment, beginning three months after that last rental month payment for the pump.

Next, I have information for you on span dates. You would include span dates on the nutrient and supply allowance, but not on the pump and IV pole. I have a link to the chart showing items that require a span date and those requiring a narrative.

Now, the lipid calculator on the CGS website can be used to calculate the units of service based on the number of days, milliliters per day, the frequency per week and percentage factor 1, 2 or 3 to reflect 10%, 20% or 30%. The tool will return the units to bill. Links to the calculator are listed here on the slide.

Now, I want to move on and talk a little bit about the Comprehensive Error Rate Testing program or CERT. It was first developed by CMS and that was back in 1996 to measure Medicare Fee for Service for the purpose of reducing costs that are associated with improperly completed and improperly paid Medicare claims. Now, the CERT contractor randomly audits claims from both jurisdictions B and C. At that time, they also received the suppliers address that's listed in the system so that they can request records for the review. Now, CERT will send up to four letters to the supplier requesting the records. And that's about one every 15 to 20 days or so. They also follow up with a phone call to the supplier to offer assistance with the request or to answer questions. Failure to respond to CERT requests for documentation may result in an error. This is why it's so important for suppliers to keep their information up to date with the National Provider Enrollment NPE East or West because the address on file is where the requests for additional documentation will be sent. But I'll talk a little bit more about the National Provider Enrollment in the resources section.

Here's the contact information for CERT. I've included the phone, fax, email, and web address. The email address listed on this slide should be used when you contact the CERT call center or when you need an ADR reprinted and sent to a different address. For details on how to submit documentation, timelines, sample letters, and FAQs, you should visit the CERT provider website. Please note that the CERT contractor underwent a name change, so effective March 21st of this year, the new name is Empower AI Inc.

So, here are the ways that the supplier can respond to requests. The options are mail, fax, esMD, encrypted CD, and encrypted email.

This information is from the CERT report from 2022. The overall DMEPOS CERT Error Rate is 25.2%, with a projected improper payment amount of 2.2 billion dollars. Now, when it comes to parenteral nutrition, the improper payment rate is 33.5% and 70.4 million dollars was the projected improper payment amount.

I have here a few tips for CERT and this is just to help you prepare for any audit situations or help you with preparing your claims for submission.

- Make sure that all your records for legible.
- You want to implement a thorough intake procedure.
- Verify that all your documentation requirements are met.
- You want to submit your documentation to the CERT contractor within the requested timeframe.
- You would use the bar code sheet as your cover letter.
- You do have appeal rights.

o If you disagree with the findings of the CERT contractor, you would send your appeal to CGS in this instance, not to the CERT contractor. As with all appeals, it starts with your redetermination request.

- The CGS CERT dedicated web page out on the website and we have information on the CID finder or claim identifier tool.

On the next several slides are some resources for you.

So, here are a couple of references to assist you with your understanding and billing. We have links to the LCD and Policy article. We have links to the Supplier Manual, links to the Advanced Modifier Engine or AME and this is used to help you determine the modifiers needed on your claims based on certain billing scenarios. And lastly, we have a link to medical review.

Now, our electronic mailing list is the best way to stay up to date on DME News for jurisdictions B and C. You can sign up to receive these electronic mailing messages on the CGS Medicare website or by using the link that is here on the slide. You would need to enter your first and last name, an email address, phone number, your complete company information and what specialty or Medicare contract that you are interested in. You must select at least one or more from the options. Click sign up and you're done.

So, here are some common resources for Jurisdiction B. The IVR, customer service, are just a few. We include this in all our webinars so you will have that information at your fingertips.

We have the same references or resources for Jurisdiction C. Just keep in mind that these are two separate contractors. The phone numbers and addresses are different. You want to make sure that whichever one you're billing to, you're using those resources or those numbers and fax information because if it's sent to the wrong one, it's just going to delay your process time. Make sure that you're using either JB or JC depending on where your beneficiary is located.

Here are a couple of other contractors that you may need to use from time to time. We talked about the Pricing Data Analysis and Coding department or PDAC. That is your contact for questions if you have products and you're not sure which HCPCS code to use for it, you can contact PDAC. Just keep in mind a HCPCS code does not indicate coverage or payment. It is simply an identifier for billing. It identifies a product for billing. You should contact CEDI or the Common Electronic Data Interchange Contractor for any questions regarding electronic claims submission. You should contact the National Provider Enrollment or NPE contractors that are responsible for provider enrollment and issuing of your PTAN. NPE East is Novitas Solutions, which handles enrollment for your suppliers that's listed east of the Mississippi and NPE West is Palmetto GBA which continues to process enrollments for suppliers west of the Mississippi.

Here we have information on how you can save time, money, and resources by using the myCGS web portal. You can submit reopening and redetermination requests through the portal as well as checking the status of those that you've already submitted. We have a user and registration guide to get you started.

This brings us to the end of the presentation portion of the webinar.