AmeriHealth NEW JERSEY

PROVIDER BULLETIN
#05-2019

TO: Durable medical equipment and prosthetics and orthotics billing providers that provide covered services to AmeriHealth New Jersey members

FROM: Provider Network Services

DATE: April 15, 2019

SUBJECT: Enhanced claim edits to align with industry standard billing rules for DME and P&O billing providers

AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (collectively, AmeriHealth New Jersey) will be expanding the enhanced claim editing process to include additional rules specific to durable medical equipment (DME) and prosthetic and orthotic (P&O) billing providers **effective for claims processed beginning August 1, 2019.**

As announced previously, claims received by AmeriHealth New Jersey **on or after June 10, 2018,** are subject to an enhanced claim editing process during prepayment review. This process ensures compliance with current industry standards and supports the automated application of correct national and regional coding principles.*

The industry standard sources specific to DME and P&O include the following:

- National and Regional Centers for Medicare & Medicaid Services (CMS) policy
- Durable Medical Equipment Regional Carries (DMERC) Manual
- CMS HCPCS LEVEL II Manual coding guidelines
- Medicare Claims Processing Manual

**Self-funded groups have the option to not participate in the enhanced claim edits; therefore, prepayment review may vary by health plan.*

Modifier usage for DME and P&O billing providers

In addition to the above, AmeriHealth New Jersey will enforce CMS rules on modifier usage including the following modifiers:

- A1 – A9, GY
- AU, AV, AW, and AX
- CG
- FA – F9 and TA – T9
- K0 – K4
- KS, KX
- KX, GA, or GZ
- NU, UE, and RR
- RT/LT

For detailed requirements related to these modifiers, please read the enclosed document.

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We encourage you to share this information with appropriate members of your staff.

With the implementation of these claim edits, claims submitted with inappropriate coding will be returned or denied. Providers will be notified via the Provider Explanation of Benefits (EOB) (professional) or Provider Remittance (facility), which will include a reason code for the claim return or denial. Any returned claims must be corrected prior to resubmission. These changes should have little or no impact to billing practices for submission of claims that are in accordance with the guidelines listed above and national industry-accepted coding standards.

Identifying claims that went through the claim editor process

If you have been submitting claims in accordance with industry standards, you will have no issues with the topics in this bulletin. However, if you have not, please be advised that you may see an increase in claim rejections and/or denials due to the new claim edits. If your claim is affected by one of the new claim edits, the edit explanation will be displayed on your electronic remittance report (835) and/or paper Provider EOB or Provider Remittance. Unique alpha-numeric codes and messages have been created that begin with E8. Should your claim line contain an E8XXX code/message, it means it was affected by the enhanced claim editor. You can also find the E8XXX codes/messages on the Claim Status Inquiry Detail screen in NaviNet. To view, hover your mouse over the service line and select View Additional Detail. If you see an E8XXX code/message, the line went through an edit. Only E8XXX codes/messages are part of the enhanced claim editor. All other codes/messages are unrelated to the enhanced claim editor.

Claim review requests

We recognize there may be times when you have questions regarding the outcome of a claim edit. As with all claim review requests, these questions should be submitted using the Claim Investigation transaction on the NaviNet® web portal.

More information

Please review the *Partners in Health Update℠* article, *Reminder: Enhanced claim edits to support correct coding principles*, which was posted December 14, 2018, on the AmeriHealth Provider News Center at www.amerihealth.com/pnc.

For further questions about the enhanced claim editing process, review our *Claim edit enhancements: Frequently asked questions (FAQ)*, which can also be found in the Frequently Asked Questions archive on AmeriHealth NaviNet Plan Central or in the Quick Links menu on the right-hand side of the AmeriHealth Provider News Center. *Note:* The FAQ will be updated as more information becomes available.

If you still have questions after reviewing these resources, please send an email to ahclaimeditquestions@amerihealth.com.

Enclosure

Modifier usage for DME and P&O billing providers

AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (collectively, AmeriHealth New Jersey) will be expanding the enhanced claim editing process to include additional rules specific to durable medical equipment (DME) and prosthetic and orthotic (P&O) billing providers **effective for claims processed beginning August 1, 2019.** AmeriHealth New Jersey will enforce Centers for Medicare & Medicaid Services rules on modifier usage including the following modifiers:

Modifier	Requirements
A1 – A9, GY	All surgical dressings billed by a DME provider require a modifier indicating the number of wounds on which the surgical dressing was used. Modifiers A1 – A9, have been established to indicate that a particular item is being used as a primary or secondary dressing on a surgical or debrided wound and also to indicate the number of wounds on which that dressing is being used. The modifier number must correspond to the number of wounds on which the dressing is being used and not the total number of wounds treated. When a dressing is provided in a noncovered situation, Modifier GY must be added to the code. Additionally, when tape is furnished in conjunction with a surgical dressing (Modifier AW), Modifier A1 – A9 is required to be appended to codes indicating the number of wounds being treated.
AU, AV, AW, and AX	Modifiers have been established for use when items are furnished in conjunction with various supplies listed in multiple durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) benefit categories, DME MAC Local Coverage Determinations (LCD), and Related Policy Articles (PA) such as tape. These modifiers identify items that are eligible for reimbursement under multiple benefit or payment categories: • **AU:** Item furnished in conjunction with a urological, ostomy, or tracheostomy supply. • **AV:** Item furnished in conjunction with a prosthetic device, prosthetic, or orthotic. • **AW:** Item furnished in conjunction with a surgical dressing. • **AX:** Item furnished in conjunction with dialysis services.
CG	Spinal orthoses billed without Modifier CG (Policy criteria applied) or GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) is inappropriate. Additionally, Hand and Finger orthoses reported without Modifier CG (Policy criteria applied) is also inappropriate.
FA – F9 and TA – T9	When a finger or toe device is reported, the presence of a specific finger Modifier FA – F9 or a specific toe Modifier TA – T9 to indicate the anatomic site being treated is required.
K0 – K4	Functional modifiers have been developed to define ability. A lower limb prosthesis must be billed with one of the functional modifiers. **Functional modifiers:** • **K0:** Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility. • **K1:** Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator. • **K2:** Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator. • **K3:** Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple location. • **K4:** Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

KS, KX	Home glucose monitors must be appended with Modifier KS (Glucose monitor supply for diabetic beneficiary not treated with insulin) or Modifier KX (Documentation on file) to indicate whether the patient is insulin dependent.
KX, GA, or GZ	Certain DME must be billed with Modifier KX if all of the indications and coverage limitations criteria have been met. This includes: • controlled dose inhalation drug delivery system • multi-positional patient transfer system • ultrasonic/electronic aerosol generator with small volume nebulizer • hospital bed • power mobility device • seat and back cushions and positioning accessories • respiratory assist device (RAD) or airway pressure device • custom oral appliance for obstructive sleep apnea (OSA) • external insulin infusion pumps and insulin for use with DME • form fitting conductive garment for delivery of TENS • knee orthosis and Orthotic additions • heavy duty walker • orthopedic footwear and the associated inserts or modifications • negative pressure wound therapy pumps • urological supplies • anti-reflective coating, polycarbonate or Trivex® lenses, tints, or oversized lenses If all of the criteria have **NOT** been met, then Modifier GA or GZ must be added to the code and Modifier KX should *not* be appended.
NU, UE, and RR	Modifier NU represents a new equipment purchase and Modifier UE represents a used equipment purchase. Modifier RR is to be utilized when DME is rented, such as oxygen and oxygen equipment.
RT/LT	For those orthotics or prosthetics that may be billed bilaterally, either Modifier RT (Right) or LT (Left) must be used to define which side is being supported (orthotic) or replaced (prosthetic). It is inappropriate to also include Modifier 50 (bilateral procedure).