Recorded Webinar: Hospital Beds

Contract	DME MAC Jurisdictions B & C
Educator:	David Heller
Date Recorded:	09.07.2023

Welcome to the CGS Jurisdiction B and C hospital beds' webinar. I'd like to thank you all for taking the time out of your busy schedules to join us.

My name is David Heller and I'm a Provider Outreach and Education senior analyst with the Jurisdiction C DME MAC.

This is our standards claim slide. Medicare does change frequently and it's just a reminder that the information presented today was current and accurate at the time it was created. However, it is ultimately the responsibility of the supplier. They up to date on the Medicare rules and regulation.

Some really great ways of doing that is to sign up for our electronic mailing list. Any kind of publication news that comes out that we feel is relevant, we're going to send links and information out to you. Also, be sure to read the local coverage determinations or LCDs as well as the policy articles.

And just a reminder that supplier recordings of any portion of this presentation is explicitly prohibited by CMS.

However, this, this webinar is being recorded for future educational purposes. It's going to be recorded webinar.

Okay, so from an agenda standpoint, we're going to go through coverage and coding. I'm going to move on to documentation requirements.

We're going to look into the billing and the modifiers you need to use. Brief section about post-public health emergency or PHE.

Some short information, resources and then, for those attending live, we are going to get into our live question and answer session.

Okay, so moving into coverage and coding.

So, the first item, and it's kind of the base item, is the fixed height hospital bed. You can see on the slide that the E0250, the E251, E290, E291. the E0328. And these are covered if one or more of the following criteria on the slide are met.

So, one, the beneficiary has a medical condition that requires positioning of the body in ways not feasible, not possible with an ordinary bed. Elevation of head or upper body less than 30 degrees; that usually does not require the use of a hospital.

Number 2, the benefiary requires position of the body in ways not feasible with an ordinary bed in order to alleviate pain. That's a situation like a hip surgery where they need to change position. Or 3, the beneficial requires the head of the bed to be elevated more than 30 degrees that line, most

of the time, and that's due to things like congested part failure, chronic pulmonary disease or any problem with aspiration.

Or Number 4. The beneficiary requires traction equipment that can only be attached to a hospital bed. And again, like in the hip surgery example, where they might need to shift their weight from hip to hip or any surgery would be another similar application.

Okay, so then as we move up the line, we have variable height hospital bed. So, there we see that there's a manual head and leg elevation and as well as the height adjustments. You could raise that bed up. And the added criteria for that is that if they require a height that's different than a fixed hospital bed. And that would be to permit transfers to things like a chair or wheelchair or even into a standing position.

Now we get to the semi-electric bed, which is the most common bed that we have covered and the most utilized. And we're going to go through this kind of a little bit as a default, but later on explain how the billing of this goes.

So, the semi-electric; that's where it all, raises the head and/or the leg, okay, electronically, so someone doesn't have to lift them up and do it. And for that to be covered, it requires frequent changes in body position. Either both that head and/or the feet, that elevation for individuals recovering from say a stroke, they need that change in body position in order to alleviate the pressure. Or, and/or actually they have immediate need for a change of position for situations like the COPD where they need that head elevation aspect to assist with breathing at times such as when they have a flare up.

If you do not have any, choose any E0250 or an E0255 and they do meet the requirements for an E0260, you can provide that E0260 as a supplier convenience upgrade. So basically, if that's just what you have in stock and you guys are okay with eating the difference and they're not required to have that elevation. Well then, you can go ahead and still bill that item. You just have to provide the right modifiers and you're only going to charge eventually for the item that they actually medically need.

And again, we're gonna discuss this later on in the modifier section.

Now, I do want to point out that if you're billing one of these codes and these are parallel codes. So, some of them come with a mattress and some of them don't. So, for example, if you're billing one of those codes and suddenly, they need a pressure support mattress. Well, then you would want to stop billing, for example, the E0260 because that one has a mattress put in.

And you would want to go with the same semi-electric code, the E0261, that doesn't have a mattress attached with it. And that way you could bill that along with the appropriate pressure support surface code that's outlined separately in those specific LCD.

Okay, now the heavy duty. Well, those are covered if the beneficiary weighs more than 350 pounds but does not exceed 600 pounds, and that's on top of all the other general requirements for a hospital bed.

It's just that this individual is more than 350 pounds but less than 600 because if they are 600 or more, then that's where the E0302 or the E0304 would apply. Okay, do have to make sure that there's some kind of level of objective assessment medical records that document that weight if because of course that's the qualification for that specific bed.

Now, total electric bed. They are not covered. And that's because the only difference between those and the semi electric bed is the height adjustment. And that height adjustment feature, that's considered a convenience feature. Because if there's someone there to assist them, then they could raise the height manually themselves. So, for that reason, the total electric beds will be denied is not reasonable and necessary.

Now trapeze equipment. That would be covered if beneficiary needs some kind of device to help them sit up. Whether there's a respiratory situation, there's a flare up to change the body position like we give the example with the hip or just simply to get out of bed. They cannot do it without it.

Now the heavy-duty trapeze equipment, well, that's very much the same but if they weigh more than 250 pounds or more then that's where it's going to come in. And they're going to use that heavier duty instead. Now, this actually has come up, so we just mentioning that those trapeze bars, those are never covered when attached to an ordinary bed.

This is an accessory for our approved hospital bed.

Okay, next we have a few more accessories. We have that bed cradle. That's useful with burn victims, diabetic foot issues, lymphedema. Situations where you want to eliminate the touching of the body with the top sheet. Side rail. Our valid first situations where there's stroke, dementia. Anything where there's a reasonable risk of them falling out.

And you would want to include this when the side rail is needed at a later point. It shouldn't be used as part of a component of a bed that already has a side rail on it.

You can use that if that they had a thigh rail and it broke, and it's specific incident, not long term irreparable where you know it's just broke down, something happened, and then you could possibly replace that and that would be a useful application for that or if the condition changed beyond when you originally provided the item. And now they need those side rail, that's medically necessary.

Now the bed boards. Those are considered not medically necessary, not medical in nature and they would never be covered.

Okay, so when it comes to the mattresses we talked about the codes and how some of them include mattresses on them. Now, suppliers must not bill HCPCS codes for two types of mattresses concurrently. And you want to refer to the list within the HCPCS in the actual LCD. That'll let you know what the definition of the codes are and when they have a match.

And then if you need to have a pressure support surface, well, then you would go to those relevant policy articles for those particular mattress coding. So, for example. when you get E0271 or E0272. Those mattresses, whether the mattress inner spring or the phone rubber, those would not be combined, for example, with E0251, that's the hospital bed without a mattress, if you're providing it together.

Instead, what you would do is just bill the E0250, that's the hospital with fixed height with any type of side rails with a mattress. And that avoids on bundling because there is a mattress being provided within that code and that's why that's why that code exists in that way.

Now if you're replacing the mattress, or they have a pressure support surface, you would want to bill the appropriate mattress code with one of the parallel codes that does not include the mattress like using the E0251 - that's semi-electric without the mattress versus the E0250, the same electric with the mattress.

Now just to mention, you would need a qualifying reason to replace the mattress outside of changing condition within the reasonable useful lifetime or the RUL. Such as lost, stolen, or irreparably damaged in a specific incident, again, not normal wear and tear.

And again, the DME MAC reminds suppliers that bill in the hospital bed with mattress in conjunction with the mattress type support surface is considered to be a claim for duplicate items because they already have that mattress.

You have to make sure that if you have that support surface that you're billing pressure support surface your bill or you do want to make sure your billing that specific hospital bed that does not include the mattress in the code.

And you should, if you want more information on this, there is a lot more within the policy article, and within that coding information, so I hope everyone does check that out.

Okay, moving on to the documentation requirements

So, you must have a standard written order or SWO for short for all claims submitted to Medicare for payment consideration.

So now what's on that SWO? That SWO that has to include the beneficiary's name or their Medicare Beneficiary Identifier number, which is their MBI. We don't need those social security numbers anymore. So, it's either their name or that MBI, either work.

I need the order date, which is typically when the order is first communicated to the supplier. It requires a description of an item, and that description can be a general description. Example would be semi-electric hospital bed.

I can also be a HCPCS code, code narrative or the brand name model number.

It needs the quantity to be dispensed if applicable, but we assume you're only providing one hospital bed. The quantity will not be required for a single bed, but an instance is where you could have more than one or you could order more than one, then you have that quantity.

The SWO must also have the training practitioners name or their NPI number like the beneficiary with their MBI number, the NPI is what links back to that practitioner or read that training practitioner, their identity. Okay, and then that treating practitioner's signature and that the big deal signature and date stamps are not allowed. And those signatures must comply with the requirements that are outlined in the program integrity manual.

They do not have to date their signature. They just have to have the date for the order day. But without that signature, we like to say it's just a piece of paper.

And we just want make sure it's clear that if any required element just lifted our missing from that SWO, it will be considered invalid. Prior to submitting the claim to Medicare, you the supplier must have a valid SWO on file or the claim will not qualify for coverage.

So, when is a new order required? Oh, you'll need a new order in situations on the slide. So, for all claims for purchases or initial rentals, if there's a change in the order or accessories or supplies, or a regular basis. If it's documented in the documentation section of a particular medical policy, even if there is no change in order, you still want to check with that policy, such as continue use. When an item is replaced, you would need a new order to reaffirm the medical necessity the item. Or, if there is a change in supplier. Now this is reminder as this all integrates with those pressure support surfaces. If you're providing one of those pressure support surfaces, you would need a separate order to go along with that hospital bed.

Okay, so the initial need documentation, that initial need is established when the item is first ordered. So, the medical documentation demonstrating that the item is reasonable and necessary should be created, prior to, at the time of when it was provided or when you made the request for the item; they said it was needed.

Alright, so when it comes to the medical record, you want to make sure that those medical records, everything in that record was dated prior to that initial need being established and communicated to you, the supplier. For example, if there's a bed that's weight based. Well, I mentioned before, you want to make sure that weight is clearly stated in the medical record. Same applies to upgrades like height adjustment or the need for incline beyond the standard fixed hospital bed.

You want to ensure there's objective assessment, the document, at the need as well as the overall diagnosis and treatment protocol that necessitates that bed and all of the options and it's upgrade.

So, continue need. Medicare will pay for an item as long as the medical need is still present. It just needs to be documented in the medical record. And timely documentation with that, that is considered in most scenarios, unless it's just typically outlined in an LCD is 12 months prior to the data.

Okay, and here we see the slides basically outlines what Medicare will accept as of documentation of continued need. So, a recent order by the treating practitioner for refills, a recent change in prescription. While they're being phased out, the CMN and DIF, that they were still existent prior to, when they were phased out of January 1 of this year.

That would be the applicable if they had the appropriate length of the need specified. Timely documentation in the medical record showing usage of the items, just, you know, follow up saying they continue to use it for this purpose and the need still exists, but they're using it. Timely documentation again, just want to reemphasize that, unless it's that one anywhere else in the LCD, it's 12 months prior to the date of service.

Okay, so. What I do want to mention here is if they no longer use the item. You know, likely in a lot of instances, maybe they got better, or they might be in a part A stay, whether that be an inpatient hospital or a SNF, a nursing facility. At which point they're not actually using the item and you can't bill for it when they're not using it. So, you do want to make sure that if you didn't, if they improve, if they pass away or they are in another facility, you are no longer billing for that item.

And here we see, basically everything that can activate, excuse me, that could be used for that.

And move on to direct delivery, Method 1. And, so, backing up for a minute. You must have proof of delivery; that is part of Medicare's requirements to show that the beneficiary received the item you are billing for. For the most relevant method for hospital beds, that is Method 1, and that's direct delivery to the beneficiary. And in this case, the supplier, they deliver the wheelchair at the beneficiary via a company or company van, or the beneficiary picked it up at your storefront.

In either of those instances, that proof of delivery that must include everything you see listed on the slide. So, you have the beneficiary's name, the delivery address, the date delivered. Quantity delivered for hospital beds, you know, quantity is not necessary because we assume you're only

providing one hospital bed. A description of the item being delivered and similar to the standard order, you have the narrative description, the brand name, model number, the HCPCS code, or a long narrative.

And then lastly, it requires the beneficiary or their designee's signature. Now, this was a little bit of an issue during the COVID -19 pandemic; there were other flexibilities and waivers. Under normal circumstances, they would need to sign for that delivery in Method 1. But during the COVID crisis, DMEPOS temporarily waved that requirement. Now that waver period, that ended, for dates of service on or after May 12th of this year, 2023.

However, you know, since timely filing is one year from the date service and so, there could be some of those claims floating out there, unsubmitted. Situation with beneficiary did not want to sign during prior to May 12th due to COVID-19 concerns, that was okay, but the supplier would want to document that in the medical record the appropriate date of delivery and that the signature was not able to be obtained because of COVID-19. In which case, you would put the CR modifier append that to your HCPCS code and include COVID-19 written in the narrative field on your claim.

Now this brings us to the Method 2. This is where you're using delivery service; [postal service, UPS, or FedEx. In this case, you want to have a shipping invoice and a delivery service tracking slip, and you want to make sure that they are clearly linked together.

Generally, you can do this with the delivery service identification number or your invoice number along with the tracking number. You just need to have a clear paper trail that links that invoice to that proof of delivery, that tracking slip.

Now, you can use a return postage paid delivery invoice from the beneficiary as the proof of delivery, but it has to contain all the information shown on this slide shown on this slide.

Now, regarding that previous slide that a concern of the COVID-19 emergency and getting that signature. Well, that never applied to Method 2. Because Method 2, you never need a signature. You only need evidence of delivery. That signature is required in Method 1.

Another note for Method 2, the date of service is the shipping date. Now Medicare has recently adjusted the definition of what you can use as that shipping date in Method 2. The shipping date can be either the date the shipping label was created, or the date in which the shipping service picked up the item from you, as long as there's not any significant variant in those dates. Or it can be the date of delivery, the date the package was actually received by the beneficiary. Any of those will apply.

Okay. Now in some cases, it would be appropriate for supplier to deliver a medically necessary item of DME or a prosthetic or orthotic to a beneficiary's home in anticipation of discharge to a place to service that qualifies as home.

So, supplier may deliver an item, DME, a prosthetic or orthotic, not supplies, or in this case a hospital bed to a beneficiary's home in anticipation of discharge from an inpatient stay in a hospital or a skilled nursing facility, or SNF.

However, most important, the actual delivery of the item. It can't occur any sooner than two days prior to the beneficiary's anticipated discharge. So, two days prior to that discharge date, if that occurs. You would still bill a date of discharge, the date they actually discharged as the date of service for the claim, and you would make want to make sure that includes the place of service like 12, like the patient's home, that indicates that it was delivered to their home.

Now, again, I mentioned before, proof of delivery is required for all items. So, all this, even includes items that the beneficiary already had prior to being eligible for Medicare. So, in these instances, say, they need a new mattress; you would have to physically examine that base item to ensure it works and meet the Medicare requirement. And then an attestation from the supplier indicating that that occurred should be contained in the medical records.

Okay, now let's get into the billing and modifiers. Okay, so, moving down the line. KX, that indicates all criteria within the LCD has been met for the item that you're providing.

And then we get into the modifiers that indicate who's going to pay for. So, we got that GA and that indicates that there's an ABN, Advanced Beneficiary Notice, on file. And the item is expected to be denied as not reasonable, reasonable and necessary.

Maybe because it's not covered at all or because you're providing an upgraded item such as the semi-electric hospital when they don't qualify for it, and you want the difference to be made up. So

that GA could be used for that ABN, whether they're not going to, we don't expect them to pay for it at all or because you're operating that item.

Now the GZ, that indicates there is no ABN. So basically, it's a medically necessary upgrade that you didn't get an ABN for would be applicable. Then you have the GK and that's the reasonable and necessary item that's associated with that GA or GZ modifier. So, in the instances where you're billing up to, like a semi-electric bed, you would have that GK modifier on the reasonable and necessary item.

And the GA modifier, that would be if you had the ABN, that would be appended to the item that you actually provided and we're gonna have an example that we show what this looks like.

And then we have the GL. And that's essentially the supplier convenience. And that's just a medically unnecessary upgrade. They, you only have semi-electric beds and there's no need and they're not asking for it, but you just want to give them the semi-electric bed, that's what you have.

So, you would go ahead and use that GL modifier for the semi- electric bed. And a GL modifier for the bed that's actually necessary. And then write the bed that you actually provided for them in the notes section.

And just be aware that, these things, have to have a prescription. They have to have that standard written order for Medicare coverage. If they don't have that, you would have to append that EY modifier saying that's not going to be covered because they don't have that SWO or any of those required elements.

Okay, so we're looking at the supplier convivence one, okay. So here you're going to see your billing for the medically necessary item, okay, and so you have the modifier for the month of the, for the rental, the month of the rental coverage and the GL, which we like to say, the beneficiary got lucky. Because they're getting a free upgrade. So, when you bill that, you're billing the code that they actually needed.

And then in the note section, you're going to put in what you actually supply. Of course, you're only going to bill them for what they needed, not for what you supplied, in those instances.

Beneficiary, but then upgrade, when no ABN is obtained. Well, in this case, you're just giving them the difference between the two beds; the doctor's ordering it and you're providing an upgraded item. And in that instance, what you're going to do is you provide the item that you actually provided with the GZ and then you can bill the medically necessary item, with that GK.

And this is all in Chapter 6 of the Supplier Manual.

Okay, and here we see, the most common situation, the supplier has decided to charge the beneficiary for providing an upgraded item and obtained and signed an ABN. In this instance, the beneficiary would be liable for the difference between the submitted charges for difference between the GA claim line. And this submitted charges for the GK for that claim line. Okay.

For that, the GA claim line, you would want to charge your usual and customary rate fee for the upgraded item that was provided.

So, you can see here. First line got the RR, the capped rental item, the KH, that's the first month of the capped rental item. KI would be used for the second and third month and KJ is for the fourth through thirteenth and all this is available in our Advanced Modifier Engine or AME tool.

Of course, you have the KX, then saying that the policy has been met. And then upgraded with the GA. So again, you see the upgraded item; the item that they qualify for with the KX.

This is indicating that they're actually getting that upgrade, and this is actually what they got. And so that $130, $75, that additional $55, that would be, in this instance, with that ABN, you would be able to charge them that difference. Okay.

Okay, so here's what an ABN looks like. Just a little note, the form just expired and was renewed. Make sure that you are using the correct ABN form from CMS's website and we have a link for that. And the only difference between that form is the expiration date, expires 1/31/26.

Make that's the right form. Okay. And then E is where you're going to put the reason Medicare may not pay. And the, Medicare will only pay for a semi-electric hospital bed for your condition. Total electric beds are not covered. So, if you provided the total electric beds, you got the ABN, you would put that on there. Okay.

I do want to mention that any questions about ABNs, we actually do have our ABN tool on our website, CGSMedicare.com under JB or JC. If you looked on the left-hand side of our website, there's a bunch of little blue bullets, quick link options.

Bottom one is tools and calculators and then we actually have our ABN tool there and it has a form just like this, but you can hover over. Every section tells you exactly what's required and what to do there outside the specific, the specification of what to write. And in this example for the hospital bed, that's what you would write in that kind of field to indicate what they're paying for.

Okay, we are moving to the end of our webinar. But really quickly, into some public health emergency update.

As most of you are aware that the PHE or Public Health Emergency ended on May 11 of 2023. So, suppliers were after that date to discontinue the use of the CR modifiers and including Covid-19 in the claim narrative for initial dates of service on or after. May 12, 2023. Now, the CR modifier and the COVID-19 claim narrative may continue to be submitted for rental items, supplies, and accessories for items initially provided under the waiver or non-enforcement. So, basically, if it was provided under that waiver and they're still using that item then it could possibly still apply but any new dates of service going forward, any new items provided, you would not append that because it wouldn't qualify anymore.

Okay, now. That CR modifier. You should only again use it for claims, for dates of service between that March 1, 2020, when that waiver started applying and that May 11, 2023. And you want to make sure that the items provided, they fall under the scope of that blanket waiver or flexibility that's listed in the MLN Matters, Special Edition, SE2011. And you can see there's a link to that on the bottom of the slide.

Or you have for dates service on an after May 12 of 2023, claims for continued rental supplies or accessories when that initial item was provided under the scope of that blanket waiver or flexibility.

And again, those codes would be listed in that MLM Matters Article. So. you can use that to reference whether it applies and again, if it's after May 12, on or after May 12, it's not generally applicable unless that item was provided during the pandemic. And even when you're using that, if there is an appropriate application to still utilize, the KX, the CG or for the oxygen, the N1, N2, or N3 modifiers, you would still append those when applicable.

Okay, so here's a little bit of a bonus thing. Every quarter, Medical Review publishes these documents. They are these reports for both JB and JC. You could see the link to the report is on the bottom of the slide.

And just to give suppliers a little more information about some of our top items being denied. Okay, so you can see our error rate for the E0260, E0261, and E0303; that was 32.7 5% for JB. And that was up from 30.11% in the previous quarter. So nearly three points in the previous quarter.

And you can see some of the top reasons. There's a different number between these two slides because the percentage is worked out. And essentially, I'm just looking at the heavy hitters, the ones that really cause the issue.

And starting with the top three, that's going to be consistent between this one and the next one for JC. So, the medical records do not support that the beneficiary requires frequent changes in body position or has an immediate need for a change in body position. That's the major requirement and it has to be in there to qualify for that item.

We mentioned whether they're in a hospital or a SNF. Well, that's one of the major reasons for denial. You do want to check with your beneficiary and be aware of their ongoing care and if they have to go to one of those facilities. You shouldn't stop billing while they're in that facility and then resume billing when they get out.

That standard written order. Remember that standard written order, it has to be signed in all elements that are required contained in it. So, if it's missing a description of the item, that's one of the big ones that will cause it to deny.

And again, these next two are more JB than JC, but they're still on the list for JC as well. And that's the medical records themselves just don't support that either of the four criteria for that base hospital bed, that fixed hospital bed, the fixed height hospital bed has been met.

And then finally the documentation. It doesn't contain a valid standard order and you know the orders are required and it's required prior to billing the item.

Okay, and here now we see JC. JC, the audit of the same code between the same period and quarterly and that one actually went. Down by about three points. So, JB went up by three points.

JC went down by three points, 30.84% this quarter prior to that it was 33.74%. And you can see a lot of the same items on the top. Okay, you could see the changing position.

You see this for SNF, hospital, inpatient stay. The SWO is missing the description. And then this one, the last contributing item was the treating practitioners' orders or in cases that applicable CMN, supplier prepared statement or the practitioner's attestation by itself. Those things do not provide sufficient documentation of medical necessity.

Okay, which is essentially means that although the order is important and you have to have it, it needs to be backed up and corroborated and a lot of times expanded upon in the medical record. You have to have access to that medical record and have it on file.

Okay, lastly, we're going to get into CERT. Now in case you're unfamiliar with CERT, CMS established CERT to measure the error rate for the Medicare Fee-for-Service payments.

And what CERT does, it selects the random sample of claims. And they review them. They ask, they'll reach out to you the supplier and ask you for that supporting documentation. And then they'll rereview the claim. And make sure essentially that CGS or whoever is actually processing this claim is doing it right.

Now in that process of determining that, they're going to reach out for those medical records and you're going to have to provide it to them.

And if they determine along the way that those medical that that claim was paid inaccurately, well CERT will go ahead and essentially ding the MAC that processed it, but also recoup that money from you that's required.

Okay, so in order to kind of avoid all that, we have some common reminders, we want to recommend. One is having a really thorough intake process. While you're doing that, you're going to ensure all the documentation requirements are met.

We do actually have a documentation checklist on our website. Hospital beds is one of those checklists and there really is a phenomenal resource to use. Alongside the LCD and Policy article because it kind of simplifies it into bullet points, but it also kind of gives you a way to check that you have that documentation.

So, I would involve that in your intake to make sure that they qualify along the way. Because if you determine that you don't have that documentation and you can't have obtain it or it doesn't contain what you're looking for in order to have them qualify whether they don't qualify or just wasn't there. Well, you want to know that before determining how to proceed, whether or not you're going to provide the item to the beneficiary.

Speaking to that, CERT reaching out to you. In order to avoid recruitment, you want to reply to all CERT documentation requests. CERT gives you an ample time to respond to that request. But by the 76th day of that audit letter, if you don't respond, that claim will be counted as a no response and your claim will be recouped.

So, by that 76th day, if you haven't responded to the documentation itself to provide them so they can do their analysis. Well, then they're going to take back that money.

When you do respond to CERT, you want to use, they have a barcode on their cover sheet. It used to be on the bottom of your CERT letter, now they move that you are. barcode out to a cover sheet. And you want to make sure that cover sheet is included with your response because that's how they're going to track that, your response, and link it back, the case that's open.

Also just make sure you have to really read through and make sure we can clearly read or decipher all the elements of that medical record. Make sure it's all there and it's legible.

If you disagree with a CERT decision, you want to file your redetermination, not with CERT, and that's a little bit confusing, but you want to follow that redetermination, appeal requests, the redeterminations is the first level of appeal with the Mac. Which would be in this, you know, your case likely, CGS, JB, or JC.

So, wherever the jurisdiction of that, of that individual, of that claim, you would want to appeal it there and not to CERT. They don't profit in that way.

And here is the CERT contact information. There are multiple ways to respond to CERT. Fax, mail, esMD portal, encrypted CD, or encrypted email. And again, if you haven't responded by the 76th day, it's the not received are accounted as an error and they will recoup that payment. But they're also going to give you phone calls to follow up prior to that. So please take it seriously and provide that documentation in order to avoid that.

Okay, now we're going to get into our resources. Now, after attending this webinar, maybe even doing this for a while, billing hospital beds, you read everything, you've gone through the checklist, you think that you're doing it right, you just want some assurance. Well, that's what CGS Connects is. And that's a resource that you can provide your documentation and we can look at and confirm that your documentation actually meets coverage criteria prior to claim submission.

So, they, you wouldn't want to use this all the time but that you're kind of new and you're not a hundred percent you're doing it right, you just want, you know that validation, know that you're good to go. Well, that's where you would use that resource.

And so you can see on the slide on the right side, the codes that are actually included for hospital beds for Connect. Some of them are the semi- electric bed and the heavy duty, along with trapeze bar.

Now. Next, I just want to give you guys a few other resources. Of course, the LCD and policy article that's your main source of information. But I do, and I do want to mention that documentation checklist I talked to you about. Absolutely, you must read, please download it and utilize it. And from this day's webinar, I hope, if anything, you got out of the webinar, is that you use this as part of your intake.

But here, this is the Dear Physician letter for hospital bed. And this is designed by our medical directors for all sorts of policies. And it's directed at your prescribing practitioner, the AB MAC person that's actually billing the AB Mac, that prescribing doctor, not the supplier.

And we understand that if suppliers, sometimes you're put in a situation where you need medical records contain certain things. And those physicians turn around and say, I don't need to do that. Well, we understand you're going up there with a hard fight and not anyone in your corner, so we've wrote these letters out to kind of give you something to use as a resource and to verify to that individual.

And that way you have a little more gravity to what's you're saying and hopefully you can get what you need that you can provide that item and the beneficiary gets what they need to have. Okay.

Is this to ever come? Just start with our Jurisdiction B and C resources. Please be sure to download your presentation or I'm going to send it to you after today's presentation for all that actually are in attendance today. So, you can utilize that as the desk reference then. Here's JC.

And here we have a few other contractors. PDAC or Pricing, Data Analysis; that's who you go to for questions about coding. CEDI is the Common Electronic Data Interchange and therefore, electronic claim submission.

NPE; those are the contractors provided for the issuance of PTAN and provider enrollment and your PTAN; that is for Provider Transaction Access Number. If you have questions for enrollment or any updates to your PTAN, you're going to contact the app, you're going to contact those NPE contractors. It used to be the NSC, but now it is the NPE and that, you have the east of the Mississippi is Novitas, and West is Palmetto GBA and we're going to get into that in a little bit of next slide, little bit of an update regarding that.

But just to let everybody know we do have a full list resources on the other contractors tab on our JB and JC website just like where I showed you with or told you where those tools and calculators are. On that left panel, with the quick links, there is "Other Contractors" tab under the resources. So, you can definitely get that information there as well.

Okay, so here is those important changes I need to share with everybody beginning August 21, which is just a few weeks away. Suppliers must submit their EFT Authorization Agreement to the applicable NPE contractor. And again, that's depending on your business location, east of the Mississippi is Novitas Solutions. West of the Mississippi, that Palmetto GBA.

And EFT enables Medicare to send Medicare payments directly into the suppliers' banking accounts rather than issuing paper check. The EFT authorization agreement must be completed to set up those electronic payments.

Now if you accidentally sent the EFT form to the DME MAC, as a courtesy, we are continuing to

forward this form to the NPE, whether that be Novitas or Palmetto, however. As of January, excuse me, November 20 of 2023, any EFT form should be that are sent to the DME MAC, those are going to be rejected and returned back to supplier.

So, you happen to have until November 20 to start sending to the right place. After that, it will be sent back and you'll have to actually send it to that NPE contractor. If you do have any questions about that, that EFT, you definitely want to contact the NPE contractor.

But CGS will no longer handle those responsibilities. That's a CMS decision. Okay.

Now, in addition, if you want the suppliers who submit the paper check, you want to consider transitioning to EFT by submitting the CMS 588 Form to the NPE contractors, a link for that on the last slide because per the Code of Federal Regulations when enrolling in the program, suppliers must agree now to receive Medicare payment via EFT.

If you are still receiving paper checks and you prefer not to transfer EFT, you don't have to do it today. But unfortunately, you will need to transfer the EFT once the enrollment contractors notify you about that transition or if you need to change something.

And at the bottom of the slide, we have the contact information for those two contractors: NPE West and NPE West, and NPE East, and again, that's back in your resources on the previous slide. And we also have a link to the Code of Federal Regulations, which actually is where you could find the resource that mandates this requirement.

Okay, I mentioned this before but our CGS Electronic Mailing List, it's really one of the tenant core legs, of the tenant core legs of the program. Because using our website, anything that we publish, any new tips or suppliers, anything we see trending, we're going to also send out a list; it used to be called ListServe, an electronic mailing list article and that's just to let you know what's out there, you know, any kind of tips, anything that's not working, any issues, it's going to be the first place we're going to get it out too. And again, it links back to the website.

So that way you know what's out there and you can reverse engineer and find it when you need it. But it's kind of queuing you to that information so you don't have to do that yourself. So, I definitely encourage everybody to sign up. Not that hard to sign up for, less than a minute, and then you could just delete the emails if it's not relevant.

I do want to mention our portal. Our portal, I'm very proud of our portal. It's one of the better portals I've seen or the kind of applications that utilizes it. Essentially every kind of CGS form that we have is actually available in digital format and available to commit directly through the myCGS portal.

It also gives the opportunity to look up items that are same and similar, look through your claims, you can get your remittance advice, saying you don't have it and you want to figure out a reconcile a check, a payment and you try to figure out who to apply to, you can see that remittance device right there on the screen. And it even breaks you into an interactive, remittance device that gives you the more user friendly, you know, simple English explanations of what occurred there.

So, in order to alleviate any fears of getting started, we have our myCGS registration guide. It's awesome. It has picture step by step instructions of exactly what you need to do. Then once you're registered, the user manual will allow you step by step instructions again with exactly how to use our different resources and functions in myCGS and why they're available and what, and what processes you can get around. Now making a phone call or whatever else you were doing, that's just available right there in my CGS.

So again, it's a really, really great interactive manual and I really encourage everybody that's not registered to register and those they are read the user manual, see some of our new functions. There's lots of new stuff. And I will be doing a webinar in December on myCGS to tell you all about it. In the meantime, please sign up so we can talk about it.

Okay, now that concludes today's webinar content. Thank you for attending our hospital, our hospital beds webinar. For those of you online, we hope to see you at future online and hopefully, in person educational events in the future.