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Medicare Part A

Home Health Training Manual

Palmetto GBA™
Partners in Excellence™

Regional Home Health and Hospice Intermediary

for

Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas

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1. GENERAL INFORMATION

The following general information is contained in this section:

- Partners In Excellence (PIE)
- Medicare Overview
- Hours of Operation
- Departmental Contacts
- Benefit Integrity Unit
1.1. Introduction

Palmetto GBA is the Regional Home Health Intermediary (RHHI) for freestanding and provider-based home health agencies (HHAs) in Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee and Texas. We look forward to the opportunity to work with and serve the home health providers throughout our region. We are committed to delivering quality service to all providers, beneficiaries and the Centers for Medicare & Medicaid Services (CMS).

This manual has been developed to provide HHAs with an understanding of program operational procedures, which allow Palmetto GBA to provide timely, accurate and efficient intermediary services. HHAs must also refer to the Conditions of Participation, the CMS Publication 15 and the following CMS Publications available via the Internet at http://www.cms.hhs.gov/manuals/

**Internet - Only Manuals**

- CMS Manual System, Pub 100, Introduction
- CMS Manual System, Pub 100-1, Medicare General Information, Eligibility, and Entitlement
- CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Home Health Services
- CMS Manual System, Pub 100-3, Medicare National Coverage Determination
- CMS Manual System, Pub 100-4, Medicare Claims Processing, Chapter 10, Home Health Agency Billing
- CMS Manual System, Pub 100-5, Chapters 1-7
- CMS Manual System, Pub 100-8, Program Integrity Manual, Chapters 1-13

**Paper Based Manuals**

- Provider Reimbursement Manual (PRM)-Part I
- Provider Reimbursement Manual (PRM)-Part II

We periodically issue updates and revisions to this manual, and recommend agencies maintain a current copy to ensure proper compliance with Medicare guidelines. This manual does not replace CMS manuals.

This manual is divided into 11 sections. Each section describes how different aspects of the Medicare program are administered by Palmetto GBA. Case studies and examples are provided where applicable.
1.2. Partners in Excellence

Palmetto GBA has a long-standing commitment to providing quality services. In September 1993, the Medicare division began a formal Total Quality Management process. The quality improvement process has been named “Partners in Excellence.”

The Partners in Excellence (PIE) process is built around five tenets:
- Teamwork
- Empowerment
- Customer focus
- Continuous improvement
- Data driven decision making

The total quality management journey is guided by the Partners in Excellence **Mission Statement**:

“To provide high quality, high value and error free services which exceed the expectations of our customers by fostering partnerships dedicated to excellence through continuous improvement and innovation.”

The name of our Total Quality Management process, Partners in Excellence, carries two important messages:

1. The Medicare Division’s dedication to providing services that exceed the expectations of Medicare beneficiaries, providers and the Centers for Medicare & Medicaid Services (CMS).

2. As partners, Palmetto GBA associates are individually and collectively responsible for the success of the Medicare Division. Each associate must strive to maximize his or her individual contribution as we all share responsibility.

In addition to the mission statement that anchors the premise of Partners in Excellence, there is also a tenet or **Vision Statement** that defines the partnership.

“We will be the number one government health insurance programs contractor.”

The Medicare Division holds this **Values Statement** as fundamental to our Partners in Excellence Quality Improvement process:

**Quality**: We strive to understand and exceed the expectations of our customers. Our goal is to do the right thing right the first time.
Service: Our focus is the customer. Excellent service must be the end result of all our efforts.

Innovation: To exceed the expectations of our customers, we must foster an environment that encourages creativity. To encourage innovation, we must be willing to take risks in the development and implementation of new approaches.

Communication: We value open communication between all associates, suppliers and customers that enhances timely, effective and appropriate service.

Associates: The people in our organization will ultimately determine our future. We are committed to the continuing education, development and empowerment of all associates. We encourage each associate to be an active partner in the success and growth of our organization.

Responsibility: Each associate must understand and be personally accountable for his or her contribution to the efforts of this organization.

Integrity: The organization and associates will fulfill all responsibilities in an honest and ethical manner.

1.3. Medicare Program

What is Medicare?

The Medicare program is a federal health insurance program for people 65 years of age and older and certain disabled people under the age of 65. It is run by the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services. The Medicare program has two parts. Hospital insurance (Medicare Part A) helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice care. Medical insurance (Medicare Part B) helps pay for physician services, outpatient hospital services, durable medical equipment and a number of other medical services and supplies that are not covered by Medicare Part A.

Eligibility

Medicare eligibility is determined by the Social Security Administration (SSA). There are three basic groups of individuals who are eligible for Medicare. An individual may become entitled through Social Security based on his or her own earnings or that of a spouse, parent or child. Anyone who becomes entitled to premium-free hospital insurance (Medicare Part A) is automatically enrolled in medical insurance (Medicare Part B), except in Puerto Rico. Medicare Part B is a voluntary program for which the insured must pay a monthly premium,
therefore, individuals who do not want coverage may refuse Medicare Part B enrollment. The effective date of Medicare Part B coverage depends on the month in which enrollment takes place. An individual’s Medicare Part B coverage ends when the individual requests disenrollment, does not pay premiums, dies or when hospital insurance entitlement ends for those under 65 years of age.

In order for an individual to be eligible for medical insurance (Medicare Part B), he or she must be a US citizen and/or:

1) 65 years of age,
2) Under age 65 with permanent kidney failure, or
3) Under age 65 and permanently disabled and entitled to SSA benefits.

The Medicare program does not include persons who may have chosen early retirement and are receiving social security benefits, unless they meet one of the requirements shown.

**Aged Insured (65 years of age)**

An aged insured is a person 65 years of age or older and is eligible for monthly Social Security or Railroad Retirement cash benefits, or equivalent Federal Government benefits. Premium-free hospital insurance becomes effective in the month in which the individual reaches age 65 if he or she applies for the benefit within six months of his or her birth month. Age 65 is reached on the day before the 65th birthday, so an individual born on August 1st reaches age 65 on July 31st, and hospital insurance is effective July 1st.

Some aged individuals do not qualify for premium-free hospital insurance due to insufficient Social Security Quarters of Coverage, but may purchase Medicare Part A coverage. The individual must be a United States resident and either a citizen or an alien lawfully admitted for permanent residence that has lived in the United States continuously for five years. This individual must also enroll (or already be enrolled) in Supplementary Medical Insurance (SMI). This type of enrollee must pay a monthly premium for both Medicare Part A and Medicare Part B coverage. If the premium is not paid within a specified period, coverage is terminated.

**Under Age 65 with Permanent Kidney Failure**

Eligibility for coverage for a patient with permanent kidney failure begins the third month after the month in which a course of renal dialysis begins, unless the individual receives a kidney transplant on or before the third month. In that case, eligibility begins the month the individual is admitted as an inpatient to a hospital for procedures, in preparation for, or in anticipation of, a kidney transplant, provided the transplant surgery takes place within the following two months. When the transplant is delayed more than two months after the preparatory hospitalization, eligibility begins with the second month prior to the month of transplant.
Also, Medicare entitlement can begin in the first month of a course of dialysis if the individual participates in a self-dialysis training program in a Medicare-approved facility prior to the third month after the course of dialysis. The individual is expected to complete the training and self-dialyze thereafter. If a beneficiary is entitled to Medicare only because of permanent kidney failure, Medicare protection will end 30 months after dialysis ends or 36 months after the month of a kidney transplant. If the transplant fails during or after that 36-month period and the beneficiary again resumes maintenance dialysis or receives another transplant, Medicare coverage will continue or be reinstated immediately without any waiting period.

Under Age 65 and Permanently Disabled

Medicare entitlement for the disabled begins with the 25th month after an individual has been eligible for Social Security disability benefits for 24 consecutive months. Generally, Medicare coverage will continue for one calendar month after the beneficiary has been sent notice that he or she no longer is entitled to Social Security disability payments.

How to Determine If Your Patient is Entitled to Medicare Benefits

A Medicare card is issued to every person who is entitled to Medicare benefits.

This card (red, white, and blue) identifies the Medicare beneficiary and includes the following information:

- Name (exactly as it appears on the social security records)
- Medicare Health Insurance Card (HIC) number
- Beginning date of Medicare entitlement for hospital and/or Medicare insurance
- Sex
- A place for beneficiary’s signature

The Medicare card should be checked at least once every year because the Medicare numbers and suffixes may change according to the beneficiary’s record of entitlement. This is especially important in the case of female beneficiaries, since their name, HIC number and suffix may change according to marital status.

Medicare Health Insurance Card (HIC) Number

The HIC number is the Social Security number that indicates the beneficiary is eligible for Medicare benefits. This HIC number is shown on the individuals Medicare card.

*Note: The Medicare identification number may be different than the beneficiary’s social security number.*
The format of the Social Security Administration (SSA) issued Medicare number is 000-00-0000 preceded or followed by a suffix. For a listing of possible suffixes and their meanings, agencies should contact the SSA.

The HIC number issued by the Railroad Retirement Benefits (RRB) may be Social Security numbers or six digit numbers, but they always have an alpha prefix.

A RRB-issued number looks like this (000-00-0000) or (000000) with one or more alphas in front. Possible alpha prefixes are: A, MA, WA, CA, WCA, PA, JA, WD, PD, H, MH, WH, WCH, or PH.

Note: The Medicare number is probably the most important piece of information you can have regarding your patient. Your claims cannot be paid if the Medicare number is missing or incorrect.

Palmetto GBA recommends a copy of the Medicare card be obtained and incorporated in the patient’s file for accuracy of claim submission.

Part B Deductible

During each calendar year, a Medicare Part B deductible of $110.00 must be satisfied before a benefit payment can be made. Bills for services are applied toward the deductible on the basis of incurred medical expenses, not according to payments on account or paid expenses. The deductible is applied to the approved charge; non-covered services do not count toward the deductible.

Expenses are allocated to the deductible in the order in which Medicare receives the bills.

In order for Medicare Part B to reimburse for covered medical services, a beneficiary must satisfy the annual deductible regardless of when during the calendar year he or she became eligible.

Part B Coinsurance

After the Medicare Part B deductible has been satisfied by the beneficiary, Medicare reimburses 80 percent of the amount allowed by Medicare incurred during the balance of the calendar year. The remaining 20 percent of the allowed amount is the responsibility of the patient and is referred to as the coinsurance.

Obtaining a Medicare Provider Number

A home health provider is an agency licensed by the State to provide health-related services in the patient’s home. An agency must be a Medicare certified provider in order to render
Medicare covered services to eligible patients and bill those services to Medicare for reimbursement. Although individual states license agencies, CMS assigns the Medicare provider number and the processing fiscal intermediary (FI). Information regarding issuance of a Medicare provider number should be directed to the state licensure agency within your state.

1.4. Hours of Operation

Our home health operation is structured to provide optimum intermediary services. To take full advantage of these services, please note the following important communication procedures.

**Telephone contact**

The Customer Service Representatives are available from 8:00 a.m. to 4:30 p.m. Monday through Friday, except Palmetto GBA holidays listed below.

Call our toll free numbers to access the Interactive Voice Response (IVR). The toll free number for the Southeast/Southwest Provider Contact Center is 877-272-5786, and the number for the Midwest/Gulf Coast Provider Contact Center is 866-801-5301. The IVR allows you to receive legislative information, claims status, eligibility, and financial data at your convenience without the assistance of a customer contact center representative. You can access the IVR during extended business hours when our information system is available. The IVR is mandated by CMS.

The Technology Support Center help desk (formerly known as the EMC help desk) is available from 7:30 a.m. to 5:00 p.m. (Eastern Standard Time), Monday through Friday, except Palmetto GBA holidays listed below. The toll free number for the Technology Support Center is 866-749-7301.

*Palmetto GBA Holidays*

Palmetto GBA observes the following holidays:

- New Years Day
- Martin Luther King, Jr Birthday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day (Thursday and following Friday)
- Christmas Eve
- Christmas Day
1.5. Departmental Contacts

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<thead>
<tr>
<th>For questions regarding:</th>
<th>Contact</th>
<th>Phone Number</th>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage, documentation, claims processing, MSP, or general information</td>
<td>Southeast/Southwest Region Provider Contact Center</td>
<td>Toll free 877-272-5786 Option 1</td>
<td>Provider Contact Center Mail Code: AG-620 2300 Springdale Drive P.O. Box 7004 Camden, SC 29020</td>
</tr>
<tr>
<td></td>
<td>Midwest Region Provider Contact Center</td>
<td>Toll free 866-801-5301 Option 1</td>
<td>Provider Contact Center Mail Code: AG-620 2300 Springdale Drive P.O. Box 7001 Camden, SC 29020</td>
</tr>
<tr>
<td></td>
<td>Gulf Coast Region Provider Contact Center</td>
<td>866-801-5301 Option 1</td>
<td>Provider Contact Center 34650 US Hwy 19 N, Suite 202 Palm Harbor, FL 34684-2156</td>
</tr>
<tr>
<td>Educational on-site</td>
<td>Ombudsman South West/South East Region</td>
<td>877-272-5786</td>
<td>Part A Provider Education Mail Code: AG-650 2300 Springdale Drive P.O. Box 7004 Camden, SC 29020</td>
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<td></td>
<td>Krisdee Schmale</td>
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<td>Ombudsman South West/South East</td>
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<td>Daphanie Dean</td>
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<td>Midwest Region Ombudsman</td>
<td>866-801-5301</td>
<td>Part A Provider Education Mail Code: AG-650 2300 Springdale Drive P.O. Box 7001 Camden, SC 29020</td>
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<tr>
<td></td>
<td>Mary Lynn Kramer-Stillinger</td>
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<td></td>
<td>Lucy Martinez</td>
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<td></td>
<td>Ina Parker</td>
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<td>For questions regarding:</td>
<td>Contact</td>
<td>Phone Number</td>
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<tr>
<td>Progressive Corrective Action and Medical Review</td>
<td>Consultant Dianne Sharp</td>
<td>803-735-1034 Ext. 37491</td>
<td>Medical Review Activities Mail Code: AG-210 2300 Springdale Drive P.O. Box 7004 Camden, SC 29020</td>
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<tr>
<td>Provider Audit and Reimbursement Department (PARD)</td>
<td>Southeast/Southwest Reimbursement Lisa Hutchinson</td>
<td>(877) 272-5786 Option 2</td>
<td>Palmetto GBA - PARD P.O. Box 100144 Columbia, SC 29020</td>
</tr>
<tr>
<td></td>
<td>Midwest Reimbursement</td>
<td>(217) 726-7852</td>
<td>Palmetto GBA - PARD P.O. Box 100144 Columbia, SC 29020</td>
</tr>
<tr>
<td></td>
<td>Gulf Coast Reimbursement Clay Hatfield</td>
<td>(727) 773-9225 Option 2</td>
<td>Palmetto GBA - PARD 34650 US Hwy 19 N, Suite 202 Palm Harbor, FL 34684-2156</td>
</tr>
<tr>
<td>Part A Provider Enrollment</td>
<td>SE/SW/MW/GC Regions</td>
<td>(803) 382-6167</td>
<td>Part A Provider Enrollment Mail Code: AG-330 2300 Springdale Drive P.O. Box 7004 Camden, SC 29020</td>
</tr>
<tr>
<td>Benefit Integrity Unit</td>
<td>SE/SW/MW/GC Regions</td>
<td>877-867-4852</td>
<td>Palmetto GBA Benefit Integrity Unit, AG-270 2300 Springdale Drive, Bldg One Columbia, South Carolina 29020</td>
</tr>
<tr>
<td>Technology Support Center</td>
<td>SE/SW Regions MW/GC Regions</td>
<td>866-749-4301</td>
<td>Technology Support Center Mail Code: AG-430 2300 Springdale Drive P.O. Box 7004 Camden, SC 29020</td>
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1.6.  Educational Material

The following publications should be used by home health agencies participating in the Medicare home health program to ensure regulatory compliance with Medicare guidelines.

1.6.1.  CMS Manuals

Home health agencies need access to manuals published by the Centers for Medicare & Medicaid Services (CMS). The CMS Manuals System is available on the Internet only at: [http://www.cms.hhs.gov/manuals/](http://www.cms.hhs.gov/manuals/)

**Internet - Only Manuals**

- CMS Manual System, Pub 100, Introduction
- CMS Manual System, Pub 100-1, Medicare General Information, Eligibility, and Entitlement
- CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Home Health Services
- CMS Manual System, Pub 100-3, Medicare National Coverage Determination
- CMS Manual System, Pub 100-4 Medicare Claims Processing, Chapter 10, Home Health Agency Billing
- CMS Manual System, Pub 100-5, Chapters 1-7
- CMS Manual System, Pub 100-8, Program Integrity Manual, Chapters 1-13

**Paper Based Manuals**

- Provider Reimbursement Manual (PRM)-Part I
- Provider Reimbursement Manual (PRM)-Part II

1.6.2.  Medicare Advisories

*Medicare Advisories* are published monthly and posted to our Web site section for Advisories, and as needed, to share updated information. These can be found at [www.palmettogba.com](http://www.palmettogba.com). These advisories should be shared with appropriate individuals and should be maintained for further use. Palmetto GBA notifies providers of guideline changes through the *Medicare Advisories*.

1.6.3.  Direct Data Entry Manual

This manual provides instructions on the use of Direct Data Entry (DDE) for the Fiscal Intermediary Shared System (FISS). This manual is available on our Web site, [www.PalmettoGBA.com](http://www.PalmettoGBA.com).
1.6.4. EDI Specifications Manual

This manual provides the electronic media claim (EMC) specification for submitting electronically. A free copy may be obtained by either calling the Technology Support Center at 866-749-4301 or by writing to the following address:

Technology Support Center  
Mail Code: AG-430  
2300 Springdale Drive  
PO Box 7004  
Camden, South Carolina 29020

1.7. Provider Education

Palmetto GBA offers several different types of educational opportunities to home health agencies participating in the Medicare program including workshops, Internet learning, conference calls, and on-site visits.

1.7.1. Workshops

Palmetto GBA places great emphasis on the importance of effective and thorough provider education. Educational workshops are held annually in various locations throughout the states we service. We also provide web-based training, tutorials, and workshops through our Learning and Education page on our Web site at www.PalmettoGBA.com. Registration information is published and disseminated via the Palmetto GBA Web site under the Learning Section. Palmetto GBA offers new provider training as well as refresher training workshops. During these workshops, Palmetto GBA provides education on billing, coverage and documentation, medical review and financial information. Palmetto GBA is committed to continuing education activities for home health agencies.

1.7.2. On-site Visits

Palmetto GBA offers educational on-site visits. An on-site visit provides education targeted to the particular needs of an agency. An agency may request an educational on-site visit by writing the appropriate education consultant detailing the specific educational needs, i.e., Medicare coverage, documentation, billing, etc. Please note: on-site visits are arranged as schedules permit. The agency is responsible for reimbursing Palmetto GBA for the cost associated with an on-site visit for travel and accommodations, and a fifty-dollar workshop fee.

For on-site workshops the provider may complete the following form and fax to us at (803) 935-9182.
1.7.3 On-Site Request Form

Professional Relations On-site Request Form

Palmetto GBA offers educational on-site visits. An on-site visit provides education targeted to the particular needs of each health care provider. A provider may request an educational on-site visit by completing this form and faxing to (803) 935-9182.

Provider Information

Provider Name/Physician Group ___________________________ Provider # ___________________________
Contact Person ___________________________ E-mail address ___________________________
Provider Address ________________________________________________________________
City ___________________________ State ___________________________ Zip ___________________________
Telephone Number ( ) Fax Number ( )
Please provide directions to location of on-site visit:

Outreach Options

(Check appropriate box. NOTE: When travel is required, provider will incur a nominal fee to cover expenses)

In Person Internet Other
□ Your facility ($50 fee) □ e-Meeting □ Teleconference
□ Palmetto GBA Facility □ CENTRA session

ANTICIPATED ATTENDANCE: ___________________________

REGION/SPECIALTY (check appropriate region and write specialty in space provided):

□ Lower State □ Upper State □ Midlands □ Pee Dee

REASON FOR EDUCATION (please provide additional information, where applicable):

□ Training for new staff □ Billing □ Coverage □ Medicare Overview
□ Speaker for meeting □ Other - Please explain in detail

Requested Date(s) (On-site visits are arranged as schedules permit):

We understand that we are responsible for reimbursing Palmetto GBA $50.00 for the cost associated with an on-site visit.

Provider/Group Representative

Mail To:
Palmetto GBA On-site Request
Government Finance, AG-790
PO Box 100190
Columbia, SC 29202

Palmetto GBA
A CMS Contracted Carrier
1.8. Benefit Integrity Unit (BIU)

The effort to prevent, detect and eliminate fraud, abuse and waste is a cooperative one that involves beneficiaries, Medicare contractors, providers, physicians, suppliers and numerous federal and state law enforcement organizations. As a part of this cooperative effort, Palmetto GBA has greatly strengthened the capabilities of its Benefit Integrity Unit (BIU). We have added additional investigators and implemented new statistical and data analysis procedures that will enhance our ability to proactively detect fraudulent billing practices. In cooperation with the Centers for Medicare & Medicaid Services (CMS), our approach to Program Safeguards efforts consists of three-prongs: prevention, early detection, and cooperation with enforcement agencies.

Prevention

The primary prevention goals concentrate on paying claims only for covered services thereby avoiding opportunities for fraud and abuse. This also reduces the need to recover payments on a post payment basis after we discover erroneous reimbursements.

Educating providers, beneficiaries and our contractor staff is the most effective way to prevent fraud and abuse.

- Providers receive information from various departments in Medicare but primarily through our Part A Provider Education Department per information concerning covered services, proper coding and billing. Well-informed providers make the correct coding choices and eliminate the need for claim reviews. Our specialty dedicated representatives hold training sessions for providers on how to correctly prepare and submit forms for processing.

- Beneficiaries are educated through our Outreach Program to review their Medicare Summary Notice (MSN) to make sure the services and charges are correct. They are encouraged to call the Beneficiary Services Department with any questions or discrepancies on the MSN.

- Contractor staff benefits from information provided by CMS and other sources regarding trends in fraudulent activity and “best practices” in detection and pursuit.

Detection

We have enhanced data analysis and statistical systems to identify and monitor services that may be vulnerable to abuse. By identifying abusive patterns of services to beneficiaries, we can prevent the occurrence of future problems.
Cooperation with Enforcement Agencies

As a Medicare contractor, we work closely with all agencies that have major responsibility for enforcement actions, referring cases and supporting their activities. These agencies include the Office of the Inspector General (OIG), the Department of Justice (DOJ), the Federal Bureau of Investigations (FBI) and local US Attorneys’ Office. When cases are developed which are appropriate for civil or criminal action, they are referred to the OIG. Ultimately, federal or state authorities or other investigative agencies may prosecute these cases.

1.8.1. Definitions

**Fraud** - Fraud is intentional deception or misrepresentation that the individual makes, knowing it to be false and that could result in some unauthorized benefit to them. The most frequent kind of fraud arises from a false statement or misrepresentation that is material to entitlement or payment under the Medicare program. The violator may be a participating provider, a supplier of durable medical equipment, a beneficiary or some other person or business entity.

**Abuse** - Includes incidents or practices of providers, physicians, or suppliers of services that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the Medicare Program, improper payment or payment for services that fail to meet professionally recognized standards of care or are medically unnecessary.

**Kickbacks, Bribes, Rebates** - Knowingly and willfully soliciting or receiving remuneration directly or indirectly, overtly or covertly, in cash or in kind: (1) in return for referring an individual to someone who will furnish for any item or service Medicare or Medicaid may pay for in whole or in part, or (2) in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any goods, facility, service or item Medicare or Medicaid may pay for in whole or in part. Anyone engaging in this activity will be guilty of a felony.

**Provider Agreement** - In accordance with Section 1866 of the Social Security Act (Health Insurance Benefit Agreement), the provider agrees to furnish the information the Medicare intermediary needs to determine the appropriateness of reimbursement on behalf of a beneficiary for the period in which payment is to be made, or any previous period. Providers are required to supply information to the Medicare intermediary on demand.

**Social Security Act Section 1866 (a)(1)** Requires providers to agree to limit their charges to beneficiaries to the cost of non-covered services and the deductible and coinsurance amounts allowed under federal law.

**Breach of Provider Agreement** - Each provider participating in the Medicare Program must comply with Title VI of the Civil Rights Act of 1964 and meet eligibility requirements of Title XVIII of the Social Security Act.
Administrative remedies are usually invoked to correct abusive practice. Examples include:

- Educational contact.
- Removal from Prospective Payment System.
- Withdrawal of Favorable Waiver Presumption.
- Withholding of Payments/Recovery of Overpayment.
- Referral to State Licensing Boards of Medical/Professional Societies or the Peer Review Organization.

CMS and/or OIG have the authority to suspend, exclude or terminate payment to practitioners, providers and suppliers of Medicare services.

**Sanctions** - Sanctions for violation of Medicare law may include involuntary termination or suspension of the Medicare Provider Agreement and exclusion or suspension under Federal and/or State Health Care Programs. See Public Law 100-93, the “Medicare and Medicaid Patient and Program Protection Act of 1987.”

**Penalties** - Section 208 of the Social Security Act provides penalties for obtaining or attempting to obtain services or payments by fraudulent means. When Medicare was enacted, Congress specifically extended these penalties to Title XVIII (Medicare) by Section 1872 of the Act.

The Social Security Amendments of 1972 repealed the application of the Section 1872 penalty provisions to the Medicare program and substituted new provisions applicable to the Medicare and Medicaid program when an item or service is furnished under an approved state plan. These new penalty provisions, contained in sections 1877 and 1909 of the Act, apply to any acts, statements or representations under Medicare or Medicaid that occur on or after October 30, 1972. Originally, violation of the provisions of these sections was misdemeanors. But the Medicare-Medicaid Anti-Fraud and Abuse Amendments, enacted October 25, 1977, upgraded most fraudulent acts from misdemeanors to felonies and increased maximum penalties from a $10,000 fine, one-year imprisonment or both to a $25,000 fine, five year imprisonment or both.

Under the False Claims Act, (31 U.S.C. 231) a penalty of $5000-$10,000 and treble damages may be assessed for each false claim submitted.

**1.8.2. Office of Inspector General Fraud Alert**

The Office of Inspector General was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse, and waste in Health and Human Services’ programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations and inspections.
To help reduce fraud and abuse in the Medicare and Medicaid programs, the OIG actively investigates schemes to fraudulently obtain money from these programs and, when appropriate, issues Special Fraud Alerts which identify segments of the health care industry that are particularly vulnerable to abuse.

**What is Home Health Care and Who is Eligible to Receive It?**

Medicare’s home health benefit allows people with restricted mobility to remain mobile, to remain non-institutionalized, and to receive needed care at home. Nurses and aides typically provide home health services and supplies under a physician-certified plan of care.

Medicare will pay for home health services if a beneficiary’s physician certifies that he or she:

- requires one or more of the following qualifying services: physical therapy, speech-language pathology, or intermittent skilled nursing.
- is homebound--i.e. The homebound definition was expanded in 2002 to include the following: Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in a State shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.

If a homebound patient requires a qualifying service, Medicare also covers services of medical social workers and certain personal care such as bathing, feeding and assistance with medications. However, a beneficiary who needs only this type of personal or custodial care does not qualify for the home health benefit.

**Fraud and Abuse in the Home Health Industry**

Home care is consuming a rapidly increasing portion of the federal health budget. Home health care is particularly vulnerable to fraud and abuse because:

- Medicare covers an unlimited number of visits per patient;
- Beneficiaries pay no co-payments except on medical equipment; and
- There is limited direct medical supervision of home health services provided by non-medical personnel.
The OIG has learned of several types of fraudulent conduct, outlined below, which have or could result in improper Medicare reimbursement for home health services.

**False or Fraudulent Claims relating to the Provision of Home Health Services**

The government may prosecute persons who submit or cause false or fraudulent claims for payment to be submitted to the Medicare or Medicaid programs. Examples of false or fraudulent claims include claims for services that were never provided, duplicate claims submitted for the same service and claims for services to ineligible patients. A claim for a service that a health care provider knows was not medically necessary may also be a fraudulent claim.

Submitting or causing false claims to be submitted to Medicare or Medicaid may subject a person to criminal prosecution, civil penalties including triple damages, and exclusion from participation in the Medicare and Medicaid programs. OIG has uncovered the following types of fraudulent claims related to the provision of home health services.

**Claims For Home Health Visits That Were Never Made and For Visits to Ineligible Beneficiaries**

OIG has uncovered instances where home health agencies are submitting false claims for home health visits. These include:

- Claims for visits not made.
- Claims for visits to beneficiaries not homebound.
- Claims for visits to beneficiaries not requiring a qualifying service.
- Claims for visits not authorized by a physician.

One home health agency billed Medicare for 123 home health visits to a patient who never received a single visit, and submitted claims for beneficiaries who were in an acute care hospital during the period the agency claimed to have provided home visits.

Another agency provided a home health aide to a beneficiary so mobile that he volunteered at a local hospital several times a week.

A third agency claimed nearly $26 million during one year in visits that were not made, visits to patients that were not homebound, and visits not authorized by the physician. OIG interviews indicated that beneficiary signatures were forged on visit logs and physician signatures were forged on plans of care. This agency had subcontracted with other entities to provide home health care to its patients, and claimed that the subcontractors falsely documented that visits were made and services were provided.

Medicare permits a home health agency to contract with organizations, including agencies not certified by Medicare, to provide care to its patients. However, the agency remains liable for all...
billed services provided by its subcontractors. The use of subcontracted care imposes a duty on home health agencies to monitor the care provided by the subcontractor.

Home health agencies, as well as the physicians who order home health services, are responsible for ensuring the medical necessity of claims submitted to Medicare. A physician who orders unnecessary home health care services may be liable for causing false claims to be submitted by the home health agency, even though the physician does not submit the claim. Furthermore, if agency personnel believe that services ordered by a physician are excessive or otherwise inappropriate, the agency cannot avoid liability for filing improper claims simply because a physician has ordered the services.

**Fraud in Annual Cost Reports**

In addition to submitting claims for specific services, home health agencies submit annual cost reports to Medicare for reimbursement of administrative, overhead and other general costs. For these costs to be allowable, Medicare regulations require that they are (1) reasonable, (2) necessary for the maintenance of the health care entity, and (3) related to patient care. However, the OIG has audited cost reports which include costs for entertainment, travel, lobbying, gifts and other expenses unrelated to patient care such as luxury automobiles and cruises. One home health agency claimed several million dollars in unallowable costs during one cost-reporting year. These included utility and maid service payments for the owner’s condominium, golf pro shop expenses, lease payments on a luxury car for the owner’s son at college, and payment of cable television fees for the owner’s mother.

Medicare also requires home health agencies to disclose in their cost reports the identity of related parties with whom they conducted business, in order to adjust costs that are likely to be inflated by health care providers who self-deal (i.e., purchase goods or services from related companies). A related party issue exists when there is common control or common interest between the provider and the organization with which it is doing business.

OIG has investigated home health agencies which failed to disclose ownership or other relationships with other entities with whom they contracted for accounting services, management/consulting services and medical supplies. These agencies billed Medicare unallowable amounts for marked-up supplies and services.

**Paying or Receiving Kickbacks In Exchange For Medicare or Medicaid Referrals**

A kickback in exchange for the referral of reimbursable home health services is another type of fraud that OIG has observed. The Medicare program guarantees freedom of choice to its beneficiaries in the selection of health care providers. Because kickbacks violate that principle and also increase the cost of care, they are prohibited under the Medicare and Medicaid programs. Under the anti-kickback statute, it is illegal to knowingly and willfully solicit, receive,
offer or pay anything of value to induce, or in return for, referring, recommending or arranging for the furnishing of any item or service payable by Medicare or Medicaid.

OIG is aware of home health providers offering kickbacks to physicians, beneficiaries, hospitals, and rest homes in return for referrals. Kickbacks have taken the following forms:

- Payment of a fee to a physician for each plan of care certified by the physician on behalf of the home health agency.
- Disguising referral fees as salaries by paying referring physicians for services not rendered, or in excess of fair market value for services rendered.
- Offering free services to beneficiaries, including transportation and meals, if they agree to switch home health providers.
- Providing hospital discharge planners, home care coordinators, or home care liaisons in order to induce referrals.
- Providing free services, such as 24 hour nursing coverage, to retirement homes or adult congregate living facilities in return for home health referrals.
- Subcontracting with retirement homes or adult congregate living facilities for the provision of home health services, to induce the facility to make referrals to the agency.

Parties that violate the anti-kickback statute may be criminally prosecuted, and also may be subject to exclusion from the Medicare and Medicaid programs.

**Marketing Uncovered or Unnecessary Home Care Services to Beneficiaries**

OIG has learned of high-pressure sales tactics employed by some agencies in the home health community to maximize their patient population and their profits. These agencies target beneficiaries on the street or in their homes and offer non-covered services such as grocery shopping or housekeeping in exchange for Medicare identification numbers. Physicians have also reported that some agencies attempt to pressure them to order unnecessary personal care services by informing them that their patients are requesting these services and will find another physician if their demands are not met. These abusive marketing practices can result in false claims liability on the part of agencies and/or physicians, and may also constitute illegal kickbacks.
We recognize that the vast majority of providers are as interested as we are in deterring fraudulent activity in Medicare. We appreciate any input you can provide to assist us in identifying those few providers who are involved in inappropriate billings. *If you identify potential schemes to defraud the Medicare program, please call:*

Medicare Provider Hotline (877) 867-4852,
From (2:00 p.m.-4:00 p.m.) Eastern Standard Time

Or write to:

Palmetto GBA
Medicare Benefit Integrity Unit, AG-270
2300 Springdale Drive, Building One
Columbia, South Carolina 29020
2. HOME HEALTH ELIGIBILITY CRITERIA

The following eligibility information is contained in this section:

- Homebound Status
- Under the Care of a Physician
- Skilled Need
2.1. Home Health Eligibility

Reference: CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 20

In order for a beneficiary to qualify for home health services, specific Medicare criteria must be met. The beneficiary must meet all of the criteria established: homebound, under the care of a physician, and requiring a skilled service. Although each criterion is discussed individually, the patient must meet all eligibility criteria to qualify for the Medicare home health benefit. The criteria are as follows:

2.2. Homebound Status

Reference: CMS Manual System Pub 100-2, Medicare Benefit Policy, Chapter 7, Sections 30.1, 30.1.1, and 30.1.2

The patient is homebound if he/she experiences a normal inability to leave home. The patient’s physical condition and/or physical limitations are such that it would be a considerable and taxing effort for that patient to leave home, or

The patient who has a psychiatric condition may be considered homebound if the illness manifests in a refusal to leave home or if it would be considered unsafe for the patient to leave home unattended.

Determining homebound status depends on the illness or limitations of the patient. The need for supportive devices or assistance alone does not necessarily render the patient homebound. The need for supportive devices and/or assistance in conjunction with physical limitations is a consideration when determining homebound status.

Homebound status is not affected by frequent absences from the home when the reason to leave is to receive medical treatment.

The patient is allowed brief and infrequent absences from the home for non-medical reasons. These absences could be for the purpose of an occasional trip to the barber/beauty shop, walk around the block, etc. However, these absences should be infrequent and of short duration. Any absence to attend a religious service is deemed an absence of infrequent or of short duration and therefore does not negate the homebound status of the beneficiary.

Adult Day Care Facilities

Reference: CMS Manual System Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 30.1.1B
Homebound criteria may be met for a beneficiary who leaves the home when the purpose is attributable to the patient receiving medical treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day care program that is licensed or certified by a State, or accredited, to furnish adult day care services in the State.

**Place of Residence**

The patient’s residence may be wherever he/she makes his/her home (e.g., his/her own dwelling, an apartment, a relative’s home, a home for the aged, or some other type of institution).

An institution may not be considered a patient’s residence if it meets at least the basic requirement in the definition of a:

- hospital,
- skilled nursing facility (SNF), or
- intermediate care facility (ICF).

Check with your intermediary or the CMS regional office if you are unsure whether a facility may be a beneficiary’s home.

If the patient is homeless, the agency needs to establish a place of residence and physical limitations. (Example: The nurse must meet the patient at the same place every visit, e.g., Red Cross center, homeless shelter, etc.) The agency may use their own mailing address if the patient has no mailing address.

**2.3. Under the Care of a Physician**

**Reference:** CMS Manual System, Pub 100-2, Chapter 7, Section 30.2.1

A medical treatment plan of care (POC) or the optional Form 485, must be established by the attending physician, or where appropriate, in conjunction with a home health agency nurse, regarding nursing and home health aide services, and/or by skilled therapists regarding specific therapy treatment. These plans of care may be incorporated within the physician’s plan of care or separately prepared.

The physician’s signature on the POC (CMS Manual System Pub 100-2, Chapter 7, Section 30.2.1, or the optional CMS Form 485) must be obtained as soon as possible and must be obtained prior to billing for reimbursement from Medicare. (CMS Manual System Pub 100-2, Medicare Benefit Policy, Chapter 7 Home Health Services, Section 30.2.4).
The plan of care must be reviewed by the physician at least once every sixty days (60 days).

**Note:** The POC for home health outpatient therapy services as defined in CMS Manual System Pub 100-2, Medicare Benefit Policy, Chapter 7 Home Health Services, Section 50.6, must be reviewed and signed at an interval of every 30 days.

**Physician Signature**

Under the Medicare home health benefit, the following physicians may order home health services:

- Medical Doctor
- Osteopath
- Podiatrist
- Psychiatrist
  - Psychiatric nursing services may be ordered by a MD effective May 24, 1996. The psychiatric services need to be rendered by a qualified psychiatric nurse, please see the Local Coverage Determination for Psychiatric Nursing listed under Medical Policies on our Web site

**Note:** Optometrists, Physician Assistants, Nurse Practitioners, and Chiropractors may not sign orders for Medicare home health services.

### 2.4. Skilled Service Requirement

**Reference:** CMS Manual System, Pub 100-2, Chapter 7, Section 30.4, also see Section 6 and 7 of this Manual for additional requirements for coverage

Skilled services are those services that are medically reasonable and necessary to the treatment of a patient’s illness or injury.

These skilled services may only be performed by a licensed nurse, under the direct supervision of a registered nurse, registered physical therapist, speech language pathologist, or registered occupational therapist.

Services provided by an occupational therapist must be started under another discipline, i.e., intermittent SN, PT, or SLP. Once established, OT becomes a qualifying discipline and may remain in the home as long as OT services are required and the patient meets all the eligibility criteria.

When nursing is the only skilled service being rendered, intermittent is defined as the medically predictable recurring need for at least one skilled nursing service in a 60-day period. If the
medically predictable need for nursing services is ordered which is longer than every 60 days, the interval may not be longer than once every 90 days, i.e., indwelling silicone catheter 1Q90.

When home health aide services are rendered in conjunction with skilled nursing services or alone (if the beneficiary qualifies for coverage), the definition of intermittency is based upon hours of service(s) rendered rather than number of visits. Up to 35 hours per week (8 hours per day) of skilled nursing and home health aide services (combined) or up to 35 hours per week (8 hours per day) of home health aide services qualify for coverage and meet the definition of intermittency.

Note: When skilled nursing services are being rendered daily, other guidelines must also be met. Refer to the endpoint criteria in this manual in Section 7.
3. ELECTRONIC DATA INTERCHANGE (EDI)

The following is an overview of the different services and functions of the Palmetto GBA Electronic Data Interchange (EDI) Department. It is the goal of the EDI department to provide quality customer service. To achieve this goal, it is important that providers understand how to use the EDI services and functions. The following EDI information is contained in this section:

- Palmetto GBA EDI Technology Support Center
- Passport and the Bulletin Board System
- Claims Acceptance Reports
- Electronic Remittance Advices (ERA)
- Electronic Funds Transfer (EFT)
- Personal Computer Automated Claims Entry System (PC-ACE)
- Direct Data Entry (DDE)
- How to get HIPAA Update Information (providers can receive updates by registering for E-Mail Updates from the Website)
3.1. Technology Support Center Functions

The Palmetto GBA EDI Technology Support Center provides first level support, including resetting of passwords and RACFs. The Technology Support Center also dispatches calls to the EDI department that may require its support. All calls from providers regarding the following should be directed to the EDI Operations, toll-free at 1-866-749-4301 or the provider can access forms from our website.

- EDI Enrollment Packet requests (new Submitter ID’s, Electronic Remittance Advices (ERA))
- PC-ACE Pro32 – Claim Entry Software
- PC-Print software
- EDI manuals and specifications
- Assistance with the following EDI functions:
  - Transmitting electronic claims & connectivity issues
  - Retrieving Electronic Remittance Advices (ERAs)
  - Connecting (only) to the Palmetto GBA host using PC-ACE Pro32 software.
    (Questions regarding general use of PC-ACE Pro32 should be referred to EDI Operations and billing issues to the Medicare Part A Provider Customer Contact Center for your region. SE/SW providers call 1-877-272-5786 and MW/GC providers call 1-866-801-5301.)
  - Connecting to the Palmetto GBA host and printing ERAs using Palmetto GBA’s PC-Print software
  - Connecting to the Palmetto GBA host to utilize Direct Data Entry (DDE)

Please direct calls regarding billing, usage of PC-ACE Pro32 software, and usage of the DDE functions, claims payment status, and Return to Provider (RTP) claims to the Medicare Part A Provider Contact Center.

Both the Technology Support Center and EDI Operations associates respond to customer assistance calls in the order they are received at the Technology Support Center. By logging a call to the Technology Support Center, you can be assured that Palmetto GBA is aware of your call and will respond to it promptly. Palmetto GBA uses an internal electronic problem management system called “INFO” that allows comprehensive documentation of all calls handled by the Technology Support Center. It is a Palmetto GBA goal to respond to calls logged through the Technology Support Center within 24 to 48 working hours.

Palmetto GBA requests that all customer calls be made to the Technology Support Center and not directly to Palmetto GBA associates’ personal extensions. We cannot guarantee timely responses to calls left on personal phone-mail systems, due to unforeseen absences, meetings or general workday delays. Further, our INFO problem management system tracks the progress
of calls logged through the Technology Support Center. Therefore, calls made to personal extensions interrupt a valuable documentation trail that can be very helpful in problem resolution.

### 3.2. Claim Transmission and Reports

Claim Acceptance Response Reports (GPNet) are produced by Palmetto GBA and made available for electronic retrieval. These reports will reflect the total number of claims submitted and rejected.

*Note: Please do not resubmit your claims until you have verified via the Acceptance Report that we did not receive your claims file the first time. Needless resubmitting claims to our system can result in duplicate claims rejections.*

Providers can retrieve their **Claim Acceptance Response Reports** electronically. To receive reports electronically, providers must complete the forms in the **Medicare Part A EDI Enrollment Packet** and return to Palmetto GBA.

Please refer to the GPNet Communications Manual (GPNET) for instructions on how to retrieve your reports electronically.

Note: Palmetto GBA Manuals can be downloaded from our Web site at [www.PalmettoGBA.com](http://www.PalmettoGBA.com). From the Web site home page select Electronic Data Interchange (EDI), then select Part A Intermediary and then select Software & Manuals. This will access all the EDI manuals, just click on the manual you need.

### 3.3. Electronic Remittance Advice (ERA)

Electronic Remittance Advices (ERAs) are available to any provider submitting their claims electronically. The ANSI 835 version 4010A1 is the current CMS mandated standard format for ERA. ERAs are available the day after a transmission is processed. The process for receiving ERAs is very similar to that of receiving claims acceptance reports. Providers can request to receive ERAs by selecting that option on the **Electronic Data Interchange Application Form**, located in the **Medicare Part A EDI Enrollment Packet** and return it to Palmetto GBA.

*Note: The Medicare Part A EDI Enrollment Packet can be downloaded from our Web site at [www.PalmettoGBA.com](http://www.PalmettoGBA.com). From the home page, select EDI, select Part A Intermediary, and then make form selection. You can also enroll for an ERA online by completing the Online ERA Enrollment Form.*
3.4. Electronic Funds Transfer

Electronic Funds Transfer (EFT) eliminates paper checks and a potentially lengthy mailing time by automatically depositing your Medicare payments into your checking or savings account within 48 hours. To elect Electronic Funds Transfer (EFT), providers must complete the EFT Enrollment Form, which you can request by calling the Technology Support Center or by going to our Web site at www.PalmettoGBA.com. From the home page, select Providers, Part A Intermediary, EDI Enrollment, and finally select SC Part A & RHHI Electronic Funds Transfer (EFT) Enrollment Packet.

Once you have completed the form and returned it to Palmetto GBA (Medicare Finance), your enrollment will be processed (including pre-notification testing with the Automated Clearing House). The process generally takes 30 days from receipt of your request. You will receive a letter confirming the effective date of your EFT.

3.5. PC-ACE Pro32 Software

PC-ACE Pro32 software is available to providers who do not have other electronic claims submission capabilities. Providers may key their claim information directly into their PC-ACE Pro32 software and build an ANSI 837 claim file for transmission to Palmetto GBA’s GPNets, Palmetto GBA’s communication gateway. PC-ACE Pro32 is Windows-based software that uses the ANSI 837 format. Minimum system requirements for PC-ACE Pro32 include:

- Pentium 133 MHz processor (Pentium II-350 for larger claim volume)
- 64 MB system memory (128 MB recommended)
- CD_ROM drive
- SVGA monitor resolution (800 x 600)*
- Windows ’95, ’98, 2000, Me, XP or NT 4.0 operating system
- Adobe Acrobat Reader Version 4.0 or later (for overlaid claim printing)

This free software can be downloaded from the Adobe Web site (www.adobe.com)

Palmetto GBA will provide PC-ACE Pro32 software to providers at no initial cost. Providers requesting PC-ACE Pro32 must complete and return the Medicare Part A EDI Application Form, the EDI Enrollment Agreement and the Software Order Form. Upon processing, you will be sent instructions for downloading the software from the Website, a Submitter ID, and user documentation.

3.6. Direct Data Entry (DDE)

Palmetto GBA makes claim entry available directly into the claims processing system via on-line Direct Data Entry (DDE). Access to Palmetto GBA’s system is made available through the IVANS/AT&T Network. Providers using DDE for claim submission, sign-on to Palmetto GBA’s claims processing system, and enter claims on-line, similarly to the way data entry operators enter paper claims submitted to Palmetto GBA. Palmetto GBA charges $25.00 per
month per User ID. These DDE charges are billed twice a year. The IVANS Network is required is for communication to the DDE system.

<<<BELOW IS THE CURRENT CHARGES PRINTED ON THE IVANS COMMUNICATION SERVICE AGREEMENT REGARDING CHARGES:>>>>

- Monthly Service Charge: $3.00
- Secure IP Dial Access: $4.35 /hour
- SNA Application Access: $.75 per hour session
- Additional Charge for Fee #800 Service, if used $5.50 /hour

DDE is also available to all providers who use other methods of electronic claim submission but wish to check status of claims, beneficiary eligibility and correct claims on-line through the DDE system. For the DDE software to work properly, you must install this software on a system that meets the following minimum hardware requirements.

Your personal computer must be a 386 or greater Microprocessor; running Windows 95, Windows 98, or Windows NT, Windows 2000, Windows 2003 Server, Windows XP as your operating system; with:

♦ 2 megabytes of free hard drive space
♦ 4 megabytes of free random access memory (RAM)
♦ 520k largest executable program size
♦ CD ROM or downloaded from the Website
♦ A mouse (optional, but highly recommended)
♦ A Hayes-compatible asynchronous modem that is 2400 BPS or faster,* with:
  o An analog telephone line attached to your modem
  o A serial port

* Note: The IVANS/AT&T Network supports many modem types with speeds up to 56K BPS. Actual connection speeds are determined by the requested speed and the capable speeds of your hardware, software and modem, and those of the network modems. Not all the speeds available to your modem may be available on the network.

To enroll in DDE, call the Technology Support Center and request a Medicare Part A EDI Enrollment Packet or download the packet from the Palmetto GBA Web site at www.palmettogba.com.

Upon processing, all DDE enrollees will be sent a system User ID(s), and instructions for downloading the software from the Website.
The following DDE options are available:

- Eligibility Verification
- Claims Inquiry
- Claims Correction
- Roster Billing/Single Claim Entry
- Limited Financial Information

Please refer to the *Direct Data Entry (DDE) Manual* for more detailed instructions regarding the use of the DDE functions. This manual is available on our Web site at www.PalmettoGBA.com.

**THE REMAINING SECTIONS DO NOT APPLY TO EDI**

### 3.6.1. Standards and Conventions

<table>
<thead>
<tr>
<th>Key</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARROW Keys</td>
<td>Move one character at a time in any direction.</td>
</tr>
<tr>
<td>TAB</td>
<td>Press TAB to move forward between fields. Press SHIFT + TAB to move backwards between fields.</td>
</tr>
<tr>
<td>CTRL-R</td>
<td>If your screen “freezes up” or “locks ups,” hold down the CTRL key and press the R key to reset the screen. Should not be used in conjunction with the symbol below.</td>
</tr>
<tr>
<td>CURSOR</td>
<td>The cursor is the flashing underline that shows you where you are on the screen.</td>
</tr>
<tr>
<td>( ) X</td>
<td>When this symbol displays at the bottom of the screen, the system is processing your request. Do not press any keys until the symbol goes away.</td>
</tr>
</tbody>
</table>
### PF Function Keys

<table>
<thead>
<tr>
<th>PF Keys</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF1</td>
<td>Access the reason code file</td>
</tr>
<tr>
<td>PF3</td>
<td>Exit the system from main menu or Exit a submenu</td>
</tr>
<tr>
<td>PF4</td>
<td>Quick exit from anywhere within the system</td>
</tr>
<tr>
<td>PF5</td>
<td>Scroll backwards within a screen page</td>
</tr>
<tr>
<td>PF6</td>
<td>Scroll forward within a screen page</td>
</tr>
<tr>
<td>PF7</td>
<td>View previous page</td>
</tr>
<tr>
<td>PF8</td>
<td>View next page</td>
</tr>
<tr>
<td>PF9</td>
<td>Update the data and re-send the claim</td>
</tr>
</tbody>
</table>

*Note:* If your keyboard does not have PF function keys, ALT and the corresponding number will perform the same function.
### 3.6.2. DDE Menu Selection

The following information provides an overview of the DDE menu structure.

#### Main Menu

- **01** Inquiries
- **02** Claims/Attachments (Entry)
- **03** Claims Corrections (Adjustments)
- **04** On-Line Reports View

#### Inquiry Menu (Submenu)

- **10** Beneficiary/CWF
- **11** DRG (Pricer/Grouper)
- **12** Claims
- **13** Revenue Codes
- **14** HCPCS
- **15** DX/Proc Codes
- **16** Adjustment Reason Codes
- **17** Reason Codes
- **56** Claim Count Summary
- **68** ANSI Reason Codes
- **FI** Check History Screen

#### Claims Entry/Attachments (Submenu)

- **20** Inpatient
- **22** Outpatient
- **24** SNF
- **26** Home Health
- **28** Hospice
- **49** Hospice Elections
- **87** Roster Bill Entry

#### Claims Corrections (Submenu)

- **21** Inpatient
- **23** Outpatient
- **25** SNF
- **27** Home Health
- **29** Hospice

#### Claim Adjustment (Submenu)

- **30** Inpatient
- **31** Outpatient
- **32** SNF
- **33** Home Health
- **35** Hospice

#### Attachment Entry (Submenu)

- **41** Home Health
- **54** DME History
- **57** ESRD CMS-382 Form

#### Claim Cancels (Submenu)

- **50** Inpatient
- **51** Outpatient
- **52** SNF
- **53** Home Health
- **55** Hospice

#### Attachments (Submenu)

- **42** Pacemaker
- **43** Ambulance
- **44** Therapy
- **45** Home Health
3.6.3. Inquiry

The claims inquiry transaction allows access to various on-line files, for example, claims history, revenue codes and reason codes. This transaction only permits information to be viewed, not to be updated.

3.6.3.1. Claims Summary Inquiry

Claims inquiry transactions allow you to view claims history. This includes claims that have been paid (“P” status), denied based on a medical review of documentation (“D” status), rejected for a claims processing denial (“R” status), RTP’d due to missing or incomplete information on the claim (“T” status) or suspended for Palmetto GBA processing (“S” status).

PROCEDURE:
STEP 1 – Select Option 01 from the Main Menu (Figure 5) and press ENTER.

<table>
<thead>
<tr>
<th>MAP1701</th>
<th>PALMETTO GBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAIN MENU FOR REGION A6502A1P</td>
<td></td>
</tr>
<tr>
<td>01  INQUIRIES</td>
<td></td>
</tr>
<tr>
<td>02  CLAIMS/ATTACHMENTS</td>
<td></td>
</tr>
<tr>
<td>03  CLAIMS CORRECTION</td>
<td></td>
</tr>
<tr>
<td>04  ONLINE REPORTS VIEW</td>
<td></td>
</tr>
</tbody>
</table>

ENTER MENU SELECTION: _01

PLEASE ENTER DATA – OR PRESS PF3 TO EXIT

Figure 5 – The Main Menu
STEP 2 – From the Inquiry Menu (Figure 6), select Option 12 for claims inquiry and press ENTER.

<table>
<thead>
<tr>
<th>MAP 1702</th>
<th>PALMETTO GBA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>INQUIRY MENU</td>
</tr>
<tr>
<td>14</td>
<td>BENEFICIARY/CWF 10 HCPC</td>
</tr>
<tr>
<td>15</td>
<td>DRG (PRICER/GROUPER) 11 DX/PROC CODES</td>
</tr>
<tr>
<td>16</td>
<td>CLAIMS 12 ADJUSTMENT REASON CODES</td>
</tr>
<tr>
<td>17</td>
<td>REVENUE CODES 13 REASON CODES</td>
</tr>
<tr>
<td>68</td>
<td>CLAIM COUNT SUMMARY 56 ANSI REASON CODES</td>
</tr>
<tr>
<td></td>
<td>CHECK HISTORY SCREEN FI</td>
</tr>
</tbody>
</table>

**Figure 6 – The Inquiry Menu**

STEP 3 – On the Claim Summary Inquiry screen (Figure 7), type the patient’s Medicare HIC number and press ENTER. The inquiry transaction will summarize every claim for this patient.

You may also make your search more specific by entering:
- Status Location (S/LOC)
- Type of Bill (TOB)
- Date of Service (DOS)

<table>
<thead>
<tr>
<th>MAP 1741</th>
<th>MEDICARE A ONLINE SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CLAIM SUMMARY INQUIRY</td>
</tr>
<tr>
<td>HIC</td>
<td>PROVIDER S/LOC</td>
</tr>
<tr>
<td>TOB</td>
<td>OPERATOR ID</td>
</tr>
<tr>
<td>MEDICAL REVIEW SELECT</td>
<td>FROM DATE TO DATE</td>
</tr>
<tr>
<td>HIC</td>
<td>PROV S/LOC TOB ADM DT FRM DT THRU DT</td>
</tr>
<tr>
<td>REC DT</td>
<td>SEL LAST NAME FIRST INIT TOT CHG PROV REIMB PD DT REAS</td>
</tr>
<tr>
<td>NPC</td>
<td>#DAYS</td>
</tr>
</tbody>
</table>

**Figure 7 – Sample Claim Summary Inquiry Fields**
3.6.3.2. Revenue Code Inquiry

PROCEDURE:
STEP 1 – Select Option 01 from the Main Menu (Figure 8) and press ENTER.

<table>
<thead>
<tr>
<th>MAP1701</th>
<th>PALMETTO GBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAIN MENU FOR REGION A6502A1P</td>
<td></td>
</tr>
<tr>
<td>01 INQUIRIES</td>
<td></td>
</tr>
<tr>
<td>02 CLAIMS/ATTACHMENTS</td>
<td></td>
</tr>
<tr>
<td>03 CLAIMS CORRECTION</td>
<td></td>
</tr>
<tr>
<td>04 ONLINE REPORTS VIEW</td>
<td></td>
</tr>
</tbody>
</table>

ENTER MENU SELECTION: _01
PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

Figure 8 – The Main Menu

STEP 2 – From the Inquiry Menu (Figure 9), select Option 13 and press ENTER to access the revenue code tables.

<table>
<thead>
<tr>
<th>MAP 1702</th>
<th>PALMETTO GBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>INQUIRY MENU</td>
<td></td>
</tr>
<tr>
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<td>10 HCPC</td>
</tr>
<tr>
<td>DRG (PRICER/GROUPE)</td>
<td>11 DX/PROC CODES</td>
</tr>
<tr>
<td>CLAIMS</td>
<td>12 ADJUSTMENT REASON CODES</td>
</tr>
<tr>
<td>REVENUE CODES</td>
<td>13 REASON CODES</td>
</tr>
<tr>
<td>CLAIM COUNT SUMMARY</td>
<td>56 ANSI REASON CODES</td>
</tr>
<tr>
<td>CHECK HISTORY SCREEN</td>
<td>FI</td>
</tr>
</tbody>
</table>

ENTER MENU SELECTION: 13
PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

Figure 9 – The Inquiry Menu
STEP 3 – On the Revenue Code Table Inquiry screen (Figure 10), type the four-digit revenue code and press **ENTER**.

![Figure 10 – Revenue Code Table Inquiry Screen](image)

STEP 4 – To make additional inquiries, type over the existing revenue code with the next revenue code and press **ENTER**.

### 3.6.3.3. Reason Code Inquiry

Reason codes identify specific conditions detected during processing. Reason codes also indicate how a claim will be adjudicated (e.g., rejected, RTP, etc.).

**PROCEDURE:**

**STEP 1** – Select Option 01 from the Main Menu (Figure 11) and press **ENTER**.

![Figure 11 – The Main Menu](image)
**SECTION 3**

**STEP 2** – On the Inquiry Menu (Figure 12), select Option 17 to select the reason code files and press **ENTER**.

<table>
<thead>
<tr>
<th>MAP 1702</th>
<th>PALMETTO GBA INQUIRY MENU</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>BENEFICIARY/CWF 10 HCPC</td>
</tr>
<tr>
<td>15</td>
<td>DRG (PRICER/GROUPE) 11 DX/PROC CODES</td>
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<td>17</td>
<td>REVENUE CODES 13 REASON CODES</td>
</tr>
<tr>
<td>68</td>
<td>CLAIM COUNT SUMMARY 56 ANSI REASON CODES</td>
</tr>
</tbody>
</table>

**Figure 12 – The Inquiry Menu**
STEP 3 – On the Reason Code Inquiry screen (Figure 13), type the five-character reason code and press ENTER.

The reason code data will display and indicate the effective date and how the claim will adjudicate. The S/LOC field identifies the status and location to be set on an automated claim when it encounters the condition for a particular reason code. S/LOC values:
- P – Paid/Processed
- R – Reject
- T – RTP

<table>
<thead>
<tr>
<th>MAP1881</th>
<th>MEDICARE</th>
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<td>TYPE DATE</td>
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<td>ST/LOC</td>
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<td>A B NP CD</td>
<td>A B HD CPY A B</td>
</tr>
<tr>
<td>CAL DY</td>
<td></td>
<td>A B NB ADR</td>
</tr>
</tbody>
</table>

----------------------------- NARRATIVE -----------------------------
--------

THIS HOME HEALTH CLAIM IS AN EXACT DUPLICATE OF A PREVIOUSLY SUBMITTED HOME HEALTH CLAIM

PROCESS COMPLETED ---- NO MORE DATA THIS TYPE
PRESS PF3-EXIT PF6-SCROLL FWD PF8-NEXT

Figure 13 – Reason Code Inquiry Screen, Example 2

STEP 4 – To make additional inquiries, type over the existing reason code with the next reason code and press ENTER.

3.6.4. Claims Entry

The DDE claims entry function is an on-line process. The claims entry transaction allows for either a single claim or a roster bill to be entered online into the FISS for processing.
3.6.4.1. Single Claim Entry via DDE

The following information outlines the steps in submitting a single claim to the FISS via DDE.

PROCEDURE:

STEP 1 – Select Option 02 from the Main Menu (Figure 14) and press ENTER.

STEP 2 – On the Claim and Attachment Entry Menu (Figure 15), select Home Health, Option 26, and press ENTER.
STEP 3 – On PAGE 1 of the UB-92 Claim Entry screen (Figure 16), type in the appropriate information and press ENTER. *Enter your provider Metropolitan Statistical Area (MSA) Code.

![Figure 16 – UB-92 Claim Entry Screen, Page 1](image-url)
STEP 4 – Enter charges on PAGE 2 (Figure 17). Including the 0023 Revenue Code line with the appropriate HIPPS Code.

<table>
<thead>
<tr>
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<td>100.00</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

PROCESS COMPLETED --- PLEASE CONTINUE

PRESS PF2-171A PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UPDT PF11- RIGHT

Figure 17 – UB-92 Claim Entry Revenue Screen
STEP 5 – Enter appropriate information for PAGE 3 (Figure 18).

MAP1713 M E D I C A R E A O N L I N E S Y S T E M C L A I M
PAGE 03 UB-92 CLAIM ENTRY
SC
HIC nnnnnnnnA TOB 329 S/LOC S B0100 PROVIDER nnnnnn
CD ID PAYER PROVIDER NO. RI AB PRIOR PAY EST
AMT DUE
A A AETNA LIFE nnnnnn Y Y
B Z MEDICARE nnnnnn Y Y
C
DUE FROM PATIENT 0.00
MEDICAL RECORD NBR COST RPT DAYS NON COST RPT
DAYS
DIAGNOSIS CODES 1 28500 2 3 4 5
6 7 8 9
ADMITTING DIAGNOSIS E CODE HOSPICE TERM
ILL IND
PROCEDURE CODES AND DATES 1 2
3 4 5 6
ESRD HOURS ADJUSTMENT REASON CODE REJECT CODE NON
PAY CODE
ATTENDING PHYS nnnnnn LN DOE FN JOHN
MI
OPERATING PHYS LN FN
MI
OTHER PHYS LN FN
MI
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT PF9-
UPDT

Figure 18 – UB-92 Claim Entry, Page 3

STEP 6 – If applicable, enter information in the remarks field on PAGE 4, MSP information on PAGE 5, and the insurer address on PAGE 6 of the claim.

STEP 7 – Press the PF9 function key to update the claim.
3.6.4.2. Roster Bill Entry via DDE

The roster bill entry function should be used when five or more patients were vaccinated at one location on one date of service. (Note: The only vaccine which may be roster billed is the influenza virus vaccine / Flu).

PROCEDURE:

STEP 1 – Select Option 02 from the Main Menu (Figure 19) and press ENTER.

```
Figure 19 – The Main Menu
```

STEP 2 – From the Claims and Attachments Entry Menu screen (Figure 20), select Option 87 and press ENTER.

```
Figure 20 – Claim and Attachments Entry Menu
```
STEP 3 – Enter the appropriate information on the Roster Billing screen (Figure 21).

Note: Reimbursement for the flu vaccine is at 100% of your outpatient reimbursement rate based on reasonable cost.

3.6.5. Claims Correction

When a claim is received that cannot be processed due to missing or incorrect information, Palmetto GBA will suspend that claim and send it back to the provider for action. The mechanism used to notify the provider that a claim is unable to be processed is a Return To Provider (RTP) report. Refer to RTP information in this document.

Corrections may be made either in hard copy or electronically. Hard copy corrections would be made directly on the RTP and mailed to Palmetto GBA. Electronic corrections are made via DDE in a Claims Correction transaction. Claims that require provider action due to missing or incorrect information are in a S/LOC of T B9997. Claims will remain in a “T” status for up to 60 days if not corrected. If the “T” status claim is not corrected, the claim will be purged from the FISS. If the claim purges from the system and the provider still means to correct it, the provider should resubmit the claim as a brand new claim, ensuring that all previous errors have been corrected.

All claims in an RTP status/location are the responsibility of the provider. Online corrections may be made via DDE by following the steps indicated in the next section.
3.6.5.1. Online Corrections

The following steps detail on-line claim corrections via DDE.

**PROCEDURE:**

**STEP 1** – Select Option 03 from the Main Menu (Figure 22) and press **ENTER** for claim’s corrections.

```
MAP1701                           PALMETTO GBA
MAIN MENU FOR REGION A6502A1P

01 INQUIRIES                      
02 CLAIMS/ATTACHMENTS             
03 CLAIMS CORRECTION             
04 ONLINE REPORTS VIEW

ENTER MENU SELECTION: _03
PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

*Figure 22 – The Main Menu*

**STEP 2** – From the Claim and Attachments Entry Menu (Figure 23), select Option 27 for home health corrections and press **ENTER**.

```
MAP1704                           PALMETTO GBA
CLAIM AND ATTACHMENTS CORRECTION MENU

CLAIMS CORRECTION
INPATIENT                      21
OUTPATIENT                     23
SNF                            24
HOME HEALTH                    27
HOSPICE                        29

CLAIMS ADJUSTMENTS CANCELS
INPATIENT                      30    50
OUTPATIENT                     31    51
SNF                            32    52
HOME HEALTH                    33    53
HOSPICE                        35    55
ATTACHMENTS
PACEMAKER                     42
THERAPY                        44
HOME HEALTH                    45

ENTER MENU SELECTION: 27
PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

*Figure 23 – Claim and Attachments Entry Menu*
STEP 3 – From the list of claims (Figure 24), select the claim to be corrected by tabbing to the “SEL” field to the left of the specific claim. Type a “U” and press ENTER.

![Figure 24 – Sample Claim Summary Inquiry Fields](image_url)
### SECTION 3

#### STEP 4 – The patient’s original UB-92 claim will display on the screen (Figure 25). Press the **PF1** function key to access the reason code file. The reason code message will identify the fields that are in error and will suggest corrective action. Press the **PF3** function key to return to the claim.

![Figure 25 – UB-92 Claim Entry Screen, Page 1](image)

#### STEP 5 – Make all necessary corrections to your claim. If you find a revenue item was left off or charges are incorrect (billed too many or not enough), you may add them at this point. This RTP’d claim is not considered a claim until it is processable.

To correct the patient’s HIC number, enter **Y** and the new HIC number in the **PROCESS NEW HIC number** field. This field is located near the top right corner of PAGE 1.
STEP 6 – Press the PF9 function key to update the claim for reprocessing and payment consideration.

STEP 7 – If the claim still has errors, reason codes will display at the bottom of the screen. Continue the correction process until the system accepts the claim. When the CORRECTED claim has been successfully updated, the claims will no longer display on the screen. The following message will display at the bottom of the screen: PROCESS COMPLETED – ENTER NEXT DATA.

3.6.6. Adjustments/Cancellations

The FISS is able to accept adjustments (xx7) and cancellations (xx8) either in hard copy or electronically. Palmetto GBA encourages all providers to submit their adjustments/cancellations electronically. If your UB-92 software does not have the capability of submitting adjustment/cancellation bills electronically, providers may access the DDE system and enter an online adjustment or cancellation. The following information discusses on-line DDE adjustments/cancellations.

3.6.6.1. Adjustments/Cancellations via DDE

The claim adjustment option allows providers to adjust or cancel paid claims. After a claim is paid in FISS, it is given a status/location of P B9997.

Note: A Claim cannot be adjusted or canceled unless it has been processed and appears on a remittance advice.

Providers must be very careful when making adjustments or cancellations. If you go into the adjustment system and update a claim without making the corrections, the adjustment or cancellation will still be created and processed through the system. Errors could cause payments to be taken back unnecessarily. Also, once a claim has been canceled, no other processing can occur on that bill.

No adjustments can be made on the following claims:

- **T** Status - RTP claims
- **D** Status - Medically denied claims
- Type of bill XXP (PRO adjustment) or XXI (intermediary adjustment)
If a claim has been denied with a full or partial medical denial, you cannot submit an adjustment. Any attempted adjustments will reject with reason code 30904.

Adjustment bill types are XX7.

**VOIDS/CANCELS**

All bill types can be voided except those that have been denied with a full or partial medical denial.

Do not void Type of Bill XXP (PRO adjustments) or XXI (intermediary adjustments).

Cancellation bill types are XX8.

3.6.6.2. Adjustments via DDE

**PROCEDURE:**

**STEP 1** – Select 03 (Claims Correction) from the Main Menu (Figure 26) and press **ENTER**.

```
MAP1701                           PALMETTO GBA
MAIN MENU FOR REGION A6502A1P

01   INQUIRIES
02   CLAIMS/ATTACHMENTS
03   CLAIMS CORRECTION
04   ONLINE REPORTS VIEW

ENTER MENU SELECTION: __03
PLEASE ENTER DATA – OR PRESS PF3 TO EXIT

Figure 26 – The Main Menu
```
STEP 2 – From the Claim and Attachment Correction Menu (Figure 27), select 33 for Home Health and press ENTER.

**NOTE:** The screen will now have your provider number, type of bill, your user ID, and a P in the S/LOC field.

*Remember, you can only adjust a PAID claim (P)*

![Figure 27 – Claim and Attachments Entry Menu](image)

STEP 3 – Enter the desired HIC number of the claim you wish to adjust. Also, you may want to enter the From and Thru dates of the claim in the appropriate fields. Press ENTER.
SECTION 3

STEP 4 – On the Claim Summary Inquiry screen (Figure 28), type a “U” for update in the “SEL” field next to the claim, and press ENTER.

NOTE: The system will have already changed the bill type to an XX7 for you.

MAP1741              MEDICA E ONLINE SYSTEM
SC                   CLAIM SUMMARY INQUIRY
HIC                  PROVIDER     S/LOC
TOB                  OPERATOR ID
MEDICAL REVIEW SELECT
HIC  PROV  S/LOC  TOB  ADM DT  FRM DT  THRU DT
REC DT                SEL             LAST NAME  FIRST INIT  TOT CHG  PROV REIMB  PD DT  REAS
NPC #DAYS

PLEASE ENTER DATA – OR PRESS PF3 TO EXIT
PRESS PF3 – EXIT   PF5–SCROLL BKWD   PF6–SCROLL FWD

Figure 28 – Sample Claim Summary Inquiry Fields

STEP 5 – Enter the adjustment CONDITION CODE on PAGE 1 of the claim and press ENTER. Note valid values:

D0 Changes to service dates
D1 Changes to charges
D2 Changes to revenue codes/HCPCS
D3 Second or subsequent interim PPS bill (Hospital Only)
D4 Change in GROUPER input
D5 Cancel only to correct a HIC number or provider ID number
D6 Cancel only to repay a duplicate payment or OIG overpayment. (Includes cancellation of an outpatient bill containing services required to be included on the inpatient bill).
D7 Change to make Medicare the secondary payer
D8 Change to make Medicare primary payer
D9 Any other change
E1 Change in patient status

Note: Use condition code D1 when you have multiple changes and one of them is a change in charges. All changes in charges supercede all other changes.
### SECTION 3

**STEP 6** – Make appropriate changes on the claim (Figure 29). For example, if you need to make a change in charges, make the change and don’t forget to change the total charges.

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<td>TOB</td>
<td>329</td>
</tr>
<tr>
<td>S/LOC</td>
<td>S B0100</td>
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<tr>
<td>PROVIDER</td>
<td>nnnnnn</td>
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<td>HOSPICE PROVIDER</td>
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<td>PRESS</td>
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</tr>
</tbody>
</table>

Figure 29 – UB-92 Claim Entry Screen, Page 1

---

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3-28
**STEP 7** – On page 3 of the claim (Figure 30), enter the correct **ADJUSTMENT REASON CODE**.

**NOTE:** You can access your Adjustment Reason Code file by putting your cursor next to “SC” on the top left corner of the screen, type “16” and then press **ENTER**. Press **ENTER** again and a list of the codes will display. Adjustment reason codes are also located on pages D.37 and D.38 in the DDE User’s Manual.

```
MAP1713       MEDICAIRE ONLINE SYSTEM  CLAIM
PAGE  03      UB-92 CLAIM ENTRY
SC
HIC nnnnnnnnA TOB 329 S/LOC S B0100 PROVIDER nnnnnn
CD ID PAYER PROVIDER NO. RI AB PRIOR PAY EST
AMT DUE
A A   AETNA LIFE nnnnnn Y Y
B Z   MEDICARE nnnnnn Y Y
C
DUE FROM PATIENT 0.00
MEDICAL RECORD NBR COST RPT DAYS NON COST RPT DAYS
DIAGNOSIS CODES 1 28500 2 3 4 5
                6 7 8 9
ADMITTING DIAGNOSIS E CODE HOSPICE TERM ILL IND
PROCEDURE CODES AND DATES 1 2
                        3 5
                4 6
ESRD HOURS ADJUSTMENT REASON CODE REJECT CODE NON PAY CODE
ATTENDING PHYS nnnnnn LN DOE FN JOHN MI
OPERATING PHYS LN FN MI
OTHER PHYS LN FN MI
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT PF9-UPDT
```

Figure 30 – UB-92 Claim Entry, Page 3
STEP 8 – On PAGE 4 of the claim (Figure 31), enter any REMARKS that further describe the adjustment.

STEP 9 – Press the PF9 function key to UPDATE the adjustment to the Medicare system.

NOTE: You will be able to see your adjusted claim on the claims summary file the next day, and the status should be an S. It may take up to two weeks to process the adjustment.

3.7. HIPAA Update Information

HIPAA Update information is available on the Palmetto GBA Web site. Just go to www.PalmettoGBA.com and click on the HIPAA button located at the bottom of the page.
4. CLAIMS PROCESSING

The Claims Processing Section will discuss various issues surrounding claims processing and payment. In addition to covering the general Medicare billing procedures, this section provides instructions and suggestions for billing home health claims. Please follow these instructions and procedures to avoid delays in the processing of your claims. The following information is included in this section:

- Foreword: Home Health Prospective Payment System
- Claims Flow Chart
- Common Working File (CWF) Verification
- Timely Filing Standards and Payment Floor and Ceiling
- Frequency of Billing
- Return to Provider (RTP)
- Common RTP Reason Codes
- UB-92 Field Descriptions
- Adjustments/Late Charge Claims
- Home Health Advance Beneficiary Notice (HH ABN)
Foreword

4.1. Home Health Prospective Payment System (HH PPS)

As directed by Section 4603 (a) of the Balanced Budget Act of 1997 (BBA), a prospective payment system (PPS) was developed for all Medicare-covered home health services covered and paid on a reasonable cost basis. The HH PPS was implemented effective for home health services provided on or after October 1, 2000. The law requires that all payments be made to the home health agency (HHA) for all services and medical supplies, excluding DME, that are furnished to the beneficiary while under a home health plan of care. HHAs may provide these covered home health services directly, or under arrangement with another facility. (See the CMS Online Manual Publication 100-1, Chapter 5, Section 10.3 for requirements on providing services under arrangement). Agencies will be paid a predetermined base payment that is further adjusted to reflect the health condition, care needs and geographic location of the patient.

4.1.2. Unit of Payment

Reference: CMS Manual System, Pub 100-2, Chapter 7, Section 10.1

Section 1895 (b) (1) of the Social Security Act (the Act) requires the establishment of a unit of payment or, “prospective payment amount,” for all home health services, including medical supplies covered and paid for on a reasonable cost basis. The HH PPS unit of payment is a national 60-day episode rate. Under HH PPS, payments to HHAs are no longer based on the quantity and type of service provided. Rather, payments are reimbursed using a fixed rate for each 60-day episode of care. The episode rate was developed from audited cost reports of previous years’ data and includes:

- amounts for the six home health service disciplines updated for inflation (skilled nursing, physical therapy, speech-language pathology, occupational therapy, home health aide and medical social services)
- amounts for both routine medical supplies and non-routine medical supplies and therapy services that previously could have been separately billed to Medicare Part B
- amounts for the ongoing reporting costs associated with the Outcome and Assessment Information Set (OASIS) and a one-time first year (FY 2000 only) PPS cost adjustment reflecting the implementation costs of OASIS

The rate is then adjusted for budget neutrality and divided by 1.05 to subtract the amount withheld for outlier payments. The result is the Standardized Prospective Payment rate. Finally, the rate is further adjusted to reflect the individual care needs (case mix) and the geographic wage variance (Metropolitan Statistical Analysis, MSA) for each patient.
4.1.3. OASIS and the Case Mix Adjustment

Reference: CMS Manual System Pub 100-2, Chapter 7, Section 10.2 A

The HH PPS unit of payment uses the answers to 23 specific data elements contained in the OASIS assessment to adjust the episode rate to reflect the anticipated costs and resource needs of the individual patient. This helps to assure that HHAs will continue to serve the higher cost patients. The case mix group, expresses as a value (weight), the individual characteristics, care and resource needs of the beneficiary for the episode. The case mix is determined from the responses of the 23 OASIS data elements. The data elements are grouped into 3 severity domains (clinical severity, functional severity and service utilization); and each domain produces a value. The values are combined (grouped) to create the patient’s case mix, known as the Home Health Resource Group (HHRG). There are a total of 80 possible HHRGs that may be derived from the different combinations of values across the three severity domains.

4.1.4. Labor Adjustment

Reference: CMS Manual System, Pub 100-2, Chapter 7, Section 10.2 B

The labor adjustment reflects the beneficiary’s site of service and is based on the wage index for the area where the service was performed. Home Health PPS rates are adjusted based on the pre-floor and pre-classified hospital wage index that is available at the time of publication of the HH PPS rate updates. The wage index that corresponds to the Metropolitan Statistical Area (MSA) code for the beneficiary’s location determines the labor adjustment. CMS has determined that 77.668% of the standardized PPS rate represents labor costs.

4.1.5. Full Episode Payment

The result of the case mix and wage index adjustments to the standard episode rate, is the full episode payment. In order to qualify for the full episode payment, the HHA must provide a minimum of five or more billable visits to the beneficiary during the 60-day episode. If the agency does not provide the minimum five visits, then the services will be reimbursed on a per-visit cost basis, rather than a prospective payment amount.

4.1.6. 60-day Episode

Reference: CMS Manual System Pub 100-2, Chapter 7, Section 10.4

The 60-day episode is the basic unit of payment under HH PPS. Continuous episode recertifications are allowed under HH PPS for patients who continue to be eligible for the Medicare home health benefit. The following is an example of continuous 60-day episodes:
Therefore, with HH PPS, the 60-day episode needs to be discussed in terms of two distinct episode types: the initial 60-day episode; and the subsequent 60-day episode. This distinction becomes very important in some of the billing aspects of HH PPS.

The initial (start of care) episode begins on day 1 with the start of care, and ends on and includes day 60 (the 59th consecutive day from day 1). The “From” date (day 1 of the episode) must match the start of care (SOC) date and the first billable visit date of the episode. The “To” date may be up to and include the last day of the episode, but must not be more than 59 days from the “From” date.

The subsequent (recertification) episode begins on the day immediately following the 60th day of the previous episode. This will be day 61, day 121, day 181, and so on. The subsequent episode will end on and include day 60 of that episode (the 59th consecutive day from the beginning date of that episode). This will be day 120, day 180, day 240, and so on.

The 60-day episode:
- may not be longer than 60 consecutive calendar days
- covers a beneficiary for 60-days of care, regardless of the number of days of care actually rendered
- must coordinate and coincide with the certification and recertification dates of the patient’s plan of care (POC), as well as with the 60-day OASIS assessment.

### 4.1.7. Episode Exceptions

There are four intervening events that can occur during the course of an episode to further alter the final payment amount that the HHA ultimately receives. The intervening events are known as episode exceptions and are commonly referred to and identified by their acronyms. The following episode exceptions apply only to claims, not requests for anticipated payment (RAPs).

#### 4.1.7.1. Partial Episode Payment (PEP)

**Reference:** CMS Manual System Pub 100-2, Chapter 7, Section 10.8, and CMS Manual System Pub 100-4, Chapter 10, Section 10.1.15
A PEP, or *Partial Episode Payment* adjustment will occur anytime a beneficiary is readmitted to home health care during a 60-day episode. This can occur three ways:

1) when a beneficiary elects to transfer to another HHA or,
2) when a beneficiary discharges and returns to the same HHA during a 60-day episode or,
3) when a beneficiary becomes HMO eligible and is discharged from traditional Medicare during the episode

When a PEP occurs, the episode ends as of the last billable visit date prior to the discharge. The episode payment for the original episode is proportionally adjusted to reflect the actual length of time that the beneficiary was in the care of the HHA. The proportional adjustment is determined by the span of days between the first and last billable visit dates prior to the discharge. A new, full episode will begin on the date of readmission to home health, be it with the same or different HHA.

Example:

A beneficiary at HHA1 is assigned to an HHRG for which the full episode payment is valued at $4000. The beneficiary’s first billable visit of the episode occurred on Day 1. The beneficiary elects to transfer to HHA2 on Day 35 of the episode. The last billable visit provided by HHA1 was also performed on Day 30 of the episode. HHA1’s episode will end with the date of the last billable visit, which in this example, is Day 30. HHA1 receives a proportional payment to reflect the actual time the beneficiary was in their care. In this example, the beneficiary was in the care of HHA1 for 30 days, so the proportional payment would be 30/60ths of the full episode payment. 30/60ths of $4000 is $2000. Therefore, HHA1 would receive a (PEP) payment of $2000 upon billing their FC.

A new full 60-day episode would begin with the date of the beneficiary’s readmission to home health at HHA2, and HHA2 would be eligible for a full 60-day episode payment assuming no intervening events occur during the new episode.

The purpose of the PEP adjustment is to ensure that Medicare does not pay overlapping days or more than one episode at a time for a beneficiary.

### 4.1.7.1.1. Verifying Beneficiary Elected Transfers

**Reference:** CMS Manual System Pub 100-2, Chapter 7, Section 10.8 E and CMS Manual System Pub 100-4, Chapter 10, Section 10.1.13

By law, beneficiaries have the right to transfer, or change HHAs during an episode. When a beneficiary transfers from one HHA to another HHA, the receiving HHA (HHA2) is responsible for documenting:

- that it contacted the initial HHA (HHA1) to alert them of the transfer
• that it informed the beneficiary that (HHA1) will no longer provide or receive payment for Medicare covered services after the date of transfer and,
• that it (HHA2) accessed the Health Insurance Query for Home Health Agencies (HIQH) system to verify whether or not the patient was already under a home health plan of care.

Should a dispute arise between the two agencies concerning the transfer of the patient, the HHAs should make all efforts to settle the issue themselves. However, if they are unable to do so, then Palmetto GBA may be called to settle it for them. In such case, Palmetto GBA will contact HHA2 by phone to inform them of the dates in dispute and to request proof that the transfer documentation requirements were met. HHA2 will be informed at the time of this request that failure to produce timely documentation could result in the cancellation of their episode (RAP or claim). The following documentation will be requested:

• a faxed copy of materials from HHA2’s admission package that shows language explaining to the beneficiary that their decision to transfer stops Medicare payment to HHA1, accompanied by the beneficiary’s dated signature (in accordance with patients’ rights under the COP).
• a faxed copy of HHA2’s dated telephone log indicating their contact with (or attempts to contact) HHA1 to alert them of the transfer.
• a faxed copy of the HIQH screen-print demonstrating HHA2 inquired into the beneficiary’s HH status, dated to indicate when the screen print was made. (Since the date on the printout may be software dependent, HHA2 must ensure the date is valid or annotate the copy with the accurate date and the reason for any error.) For providers without DDE access, or in periods where online access may be down, an additional copy from the provider’s dated telephone log, indicating the HHA made an inquiry to RHHI customer service, may be provided instead.

The documentation must be dated on the day of admission to HHA2 or not later than 2 business days after the day of admission. The requested fax documentation must be received by the RHHI within 5 business days of the date of the successful phone contact. After this period, the documentation will be considered unavailable and the following action will be taken:

If the documentation is not produced or is not complete, HHA2’s RAP or claim will be referred to the Palmetto GBA claims department. Claims staff will submit a cancellation of the RAP or claim. Provider contact center representatives will contact HHA1, or HHA1’s RHHI if different, and instruct them to cancel the RAP or claim for their PEP’d episode and resubmit the RAP and claim with accurate dates of service.
However, if the documentation is received from HHA2 and judged complete by the RHHI, HHA1 will be contacted and informed that the transfer will stand. All three documents must be received in order for the documentation to be complete. No further action is necessary.

4.1.7.2. Significant Change In Condition (SCIC) *(pronounced “sick”)*

**Reference:** CMS Manual System Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 10.9 and CMS Manual System, Pub 100-4, Chapter 10, Section 10.1.20

A SCIC will occur if the beneficiary experiences a change in condition that was *not* originally anticipated in the plan of care as part of the beneficiary’s expected response to the course of treatment. In order for an *unanticipated* change to be considered a SCIC, it must meet two additional criteria:

1. The change in condition must result in a new case mix assignment (HHRG/HIPPS code) as a result of the completion of the appropriate OASIS assessment.
2. The HHA must obtain physician change orders reflecting a change in the treatment approach in the plan of care.

If all of these conditions are met, then a SCIC is considered to have occurred. When a SCIC occurs and is billed on the claim, the episode does not end *(unlike the PEP adjustment)*, but remains open/continues. The HHA reports both HIPPS codes, (the original HIPPS and the new HIPPS resulting from the SCIC) on the UB-92. Medicare systems allow up to six HIPPS codes to be reported on a given claim. *(The patient may experience up to five SCICs during the 60-day episode).*

If an unanticipated change in condition occurs and one or more of the above conditions are *not* met, then the HHA may *not* report a SCIC on the claim. Instead, the HHA must bill the entire episode under the original HHRG/HIPPS code. Please refer to the CMS On-line Manual Publication 100-4, Chapter 10, Section 10.1.20, for a decision tree that can be used to determine whether or not a SCIC adjustment must be reported.

When a SCIC adjustment occurs, the episode payment is prorated by the span of days between the first and last billable visits that were rendered while the beneficiary was under the original HIPPS code; and the span of days between the first and last billable visits that were rendered while the beneficiary was under each subsequent HIPPS code(s). These prorated payments are then summed to produce the new adjusted episode payment amount.

There is no limit to the number of SCIC adjustments that can occur during an episode. However, payment will be made based on six HIPPS, determined by Palmetto GBA medical review staff, if more than six HIPPS are billed on a single claim.
4.1.7.2.1. Option to bill SCIC

Reference: CMS Manual System, Pub 100-2, Chapter 7, Sections 10.9(B)

When a patient meets the qualifications of a SCIC, the provider is granted the option to bill the SCIC in situations where the HIPPS code weight increases indicating a decline in the patient’s condition. If the pro-ration of days in the SCIC adjustment results in a financial disadvantage for the agency, then the provider may choose to not bill/report the SCIC on the claim. The weight associated with the HIPPS code is considered to increase if the values in the second, third or fourth position of the HIPPS advance (move forward) in the alphabet. For example:

HAEL1 changing to HAEM1 increases the weight, as the L in the fourth position _advanced_ in the alphabet to M.

HAEL1 changing to HAEK1 decreases the weight, as the L in the fourth _position moved backwards_ in the alphabet to K.

HAEL1 changing to HAEK2 does _not_ change the weight of the HIPPS, as the change occurred only in the fifth position.

However, if a patient qualifies for a SCIC and the HIPPS code weight _decreases_ due to an unanticipated improvement in the patient’s condition, then the HHA does not have an option, the SCIC adjustment _must_ be billed on the claim.

4.1.7.3. Low Utilization Payment Adjustment (LUPA)

Reference: CMS Manual System Pub 100-2, Medicare Benefit Policy Manual, Chapter 7, Section 10.7 and CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 10, Sections 10.1.17 and Section 10.1.18

If the HHA provides four or fewer billable visits during the 60-day episode, the payment will be subject to a LUPA. On a LUPA claim, the visits are paid on a per-visit basis, according to the national average payment rates for each service discipline. Although LUPA claims are not case mix adjusted, they are still wage adjusted to reflect the beneficiary’s site of service. Episode claims that are paid on a LUPA basis are not subject to the therapy threshold, PEP or SCIC adjustments, and are not eligible for outlier payments. Even though LUPA claims are not paid on an episode basis, they must report the 0023 revenue line and HIPPS code for the episode. Although a RAP is not required when billing a LUPA claim it is strongly encouraged.
4.1.7.4. Outlier Payment


For episodes in which an unusually high number of visits are rendered, the HHA may receive an outlier payment for the episode. The outlier is paid in addition to the regular 60-day episode payment. The key to whether or not an outlier will be paid is service utilization. The outlier is paid when the cost of providing care for that episode exceeds the payment amount and is determined by the total number of medically necessary visits billed in any or all of the home health disciplines in a given episode. A fixed dollar loss amount is calculated for each episode. This amount is the same regardless of if the episode is paid as a full 60-day episode or is PEP or SCIC adjusted. The fixed dollar loss amount is then added to the episodic payment to produce the total outlier threshold amount.

The next step in determining the outlier payment is to compute the total imputed cost per-visit amount for the episode. The total imputed cost per-visit amount is determined by multiplying the number of visits rendered during the episode by the national standardized per-visit rate for each discipline. The product is then wage adjusted to reflect the site of service for the geographic location of the patient.

To determine if the episode qualifies for an outlier payment, simply compare the outlier threshold amount to the total imputed cost per-visit amount. If the total imputed cost per-visit amount exceeds the threshold amount, then an outlier payment will be made on the claim. The provider will receive 80% of the difference between the two amounts as the outlier payment and will be identified on the claim by the Value code 17 and a dollar amount.

If the total imputed cost per-visit amount is less than the outlier threshold amount, then no outlier payment will be made for that episode.

It is important to note that HHAs will not bill for outlier payments. The Pricer system will automatically run these calculations for each claim that is processed to determine if the episode qualifies for an outlier payment.

4.1.8. Split Percentage Payment Approach

To ensure adequate cash flow to HHAs, a split percentage payment will be made for most episode periods. Providers will submit a Request for Anticipated Payment (RAP) at the beginning of the episode and then a Final Claim (FC) at the end of the episode. Added together, the two payments equal 100% of the total episode payment. For the initial episodes of a home health admission, providers will be paid 60% of the total episode payment upon processing the RAP at the beginning of the episode and the remaining 40% upon processing the FC at the end of the episode. All subsequent episodes of continuous care will be paid at a 50/50-split percentage. That is, 50% of the total episode payment paid with the RAP and 50% paid with the FC.

4.1.9. Requirements for Submitting the RAP and FC

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 10, Section 10

4.1.9.1. RAP Characteristics


A RAP must be submitted for each episode that qualifies for full episode payment (any episode not paid as a LUPA). The RAP begins the 60-day episode, posts the episode to the Common Working File (CWF) and establishes the HHA as the primary home health agency for that episode. RAPs do not meet the definition of a claim for filing purposes and are not subject to many of the stipulations applied to claims in regulations. In particular, RAPs are not subject to any type of payment floor, are not subject to interest payment if delayed in processing, and do not have appeal rights. Electronically submitted RAPs should adjudicate and pay within 3 to 5 days, on average.

RAPs are not subject to Medical Review, although payment on a RAP may be withheld at the discretion of Medical Review for providers who have very high denial rates or are on corrective action plans. This does not constitute a Medicare denial and cannot be appealed.

RAPs may not be adjusted. However, the HHA may cancel the erroneous RAP by submitting a cancellation RAP.

4.1.9.2 RAP Submission

Reference: CMS Manual System Pub 100-2, Medicare Benefit Policy Manual, Chapter 7, Section 10.1.6 A

Since the RAP is a request for payment and is not a Medicare claim, the HHA is not required to obtain the physician signed plan of care (POC) prior to submitting the RAP. If
the HHA has not received the physician signed plan of care (POC) at the beginning of the episode, the agency may submit the RAP for payment based on physician signed verbal orders OR, a signed physician referral.

All verbal orders must be recorded in the plan of care (POC) and include: a description of the patient’s condition, the services to be rendered by the HHA, and an attestation (relating to the physician’s orders and the date received) signed and dated by the registered nurse or qualified therapist responsible for supervising or furnishing the ordered services in the POC. The plan of care should immediately be copied and sent to the physician.

After the assessment is completed and locked for transmission, and once a physician’s verbal orders for home care have been received and documented, a plan of care has been established and the first service visit under that plan has been delivered, the HHA can submit a RAP.

**4.1.9.3. Automatic RAP Cancellation**

**Reference:** CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 10, Section 30.7, 30.11 and 40.1

A RAP will be automatically cancelled in the system and it’s payment recouped if the corresponding FC is not received within the greater of 120 days from the start date of the episode, or 60-days from the date that the RAP paid. However, even though the RAP is auto-cancelled, the episode remains open on the CWF, protecting the HHA’s primary agency status for that episode. In order to reclaim payment for the episode, a new RAP (identical to the original RAP) must be submitted and followed up with the FC within 60-days from the date that the newly submitted RAP pays.

**4.1.9.4. RAPs and Medicare Secondary Payer (MSP)**

**Reference:** CMS Manual System Pub 100-5, Medicare Secondary Payer Manual, Chapter 3, Section 30.10

All RAPs should be submitted Medicare primary. Medicare payment for MSP claims will be settled with the FC.

**4.1.10 Final Claim (FC) Submission**

**Reference:** CMS Manual System, Pub 100-2, Medicare Benefit Policy Manual, Chapter 7, Sections 10.6 B

A FC must be submitted for every episode and is subject to all claim requirements including, the claims payment floor and applicable interest, Medical Review and
Medicare Secondary Payer. The FC for each episode may be submitted once the HHA has received the signed and dated plan of care from the physician, and after the last Medicare billable service for that episode has been provided. **Reminder: All verbal orders must also be signed by the physician prior to the HHA billing the FC. (See Section 7.2, Verbal Orders)** If the patient is discharged prior to the end of the episode, the FC may be billed upon discharge or transfer. The claim represents the actual service utilization and must contain all line item details for all visits provided during the episode. Denials for services may be appealed by the appropriate party. FCs may be both adjusted and cancelled by the provider.

### 4.1.11. Therapy Threshold

**Reference:** CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 10, Section 10.1.19

The therapy threshold represents the projected number of therapy hours expected to be provided over the course of the episode. This may consist of any combination of physical, occupational and speech therapy provided. Episodes that meet the requirements for the therapy threshold are reimbursed at a higher level than episodes that do not meet the threshold requirements (less than ten therapy visits provided). To meet this requirement, therapy hours are proxied from visits provided during the episode. Ten therapy visits represent eight hours of therapy delivered. Therefore, in order for an episode to qualify for the therapy threshold, ten therapy visits must be provided during the 60-day episode. Even though the reimbursement for the therapy threshold is determined only by the 10 visit requirement, hours will be monitored through 15 minute increments for data analysis purposes.

The therapy threshold is specific to each individual episode of care. Therapy visits may not cross episodes. In other words, therapy from one 60-day episode may not be counted toward the therapy threshold for a different episode.

HH PPS was developed so that two HIPPS codes represent each payment group (40 of the 80 HHRGs represent the therapy level of reimbursement). One HIPPS code for a beneficiary who meets the therapy threshold, and one HIPPS code for a beneficiary who does not meet the therapy threshold. HIPPS codes that represent beneficiaries who do not meet the ten-therapy visit threshold are known as “fall back” HIPPS codes. When a claim is billed with a HIPPS code that reflects the higher therapy reimbursement, but the claim line items do not include the necessary ten therapy visits (therapy threshold is not met), the original HIPPS code automatically “falls back” to the non-therapy HIPPS code. Medicare claims processing systems will make the proper payment corrections and automatically downcode the claim. No action from the provider is required. However, Medicare systems will not automatically up code a claim that contains ten or more therapy visits, yet does not have a therapy level HIPPS code.
4.1.11.1. Application of the Therapy Threshold and the SCIC Adjustment


Therapy visits are not combined across episodes. However, since the SCIC adjustment occurs entirely within a single episode, all therapy visits provided during a SCIC adjusted episode are counted toward the therapy threshold for that episode. If the therapy threshold is the only case mix item that requires adjustment, the HHA may cancel and resubmit a RAP with the corrected HHRG that reflects the therapy level HIPPS code for the entire episode.

4.1.12. Home Health PPS Consolidated Billing


HH PPS requires that while a patient is under a home health plan of care, payment for all home health services and supplies (excluding DME) must be made to the primary home health agency. The services and supplies must be provided by the primary HHA, directly or under arrangement. The HHA must submit all Medicare claims for all home health services, and payment for such services and supplies, with the exception of the osteoporosis drugs and DME, are included in the PPS episodic rate. The agency that establishes the episode is the only entity that can bill and receive payment for home health services and medical supplies during an episode for a patient under a home health plan of care.

The home health services subject to the HH PPS consolidated billing requirements are:

- Part-time or intermittent skilled nursing services
- Part-time or intermittent home health aide services
- Physical Therapy
- Speech-Language Pathology
- Occupational Therapy
- Medical Social Services
- Routine and Non-routine Medical Supplies (including Part B supplies that could previously have been unbundled and billed to Part B)
- Part B Therapies that could have previously been unbundled and billed to Part B
- Covered Osteoporosis drug
• Medical services provided by an intern or resident in-training of the program of the hospital in the case of an HHA that is affiliated or under common control with a hospital with an approved teaching program; and

• Home health services defined in §1861(m) provided under arrangement at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring to the home or are furnished while the patient is at the facility to receive such services.

• The consolidated billing requirements governing home health PPS requires that the HHA provide all covered home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care. Providing services either directly or under arrangement requires knowledge of services provided during the episode. In addition, in accordance with current Medicare conditions of participation and Medicare coverage guidelines governing home health, the patient’s plan of care must reflect the physician ordered services that the HHA provides either directly or under arrangement. An HHA would not be responsible for payment in the situation in which they have no prior knowledge of the services provided by an entity during an episode to a patient who is under their home health plan of care. An HHA is responsible for payment in the situation in which services are provided to a patient by another entity, under arrangement with the HHA, during an episode in which the patient is under HHA’s home health plan of care. However, it is in the best interest of future business relationships to discuss the situation with any entity that seeks payment from the HHA during an episode in an effort to resolve any misunderstanding and avoid such situations in the future.

4.1.12.1. Routine and Non-routine Medical Supplies

Reference: CMS Manual System Pub 100-2, Medicare Benefit Policy Manual, Chapter 7, Sections 10.12 B, 50.4.1.1, 50.4.1.2 and 50.4.1.3

Routine and non-routine medical supplies are bundled to the primary HHA while the patient is under a home health plan of care. Amounts for these medical supplies are included in the base rates for all PPS episodes, regardless of whether the supplies are provided during the episode or not. Furthermore, if a patient who has a pre-existing condition that requires the use of a non-routine supply, the HHA is required to provide and bill for the needed non-routine supply even if the reason for home care is not related to the pre-existing condition.

Example:

A patient who has a pre-existing condition (ostomy) is admitted under a home health plan of care to provide wound care to a decubitus ulcer. Since non-routine supplies are bundled while the patient is under a home health plan of care, the HHA is responsible for providing the necessary ostomy bags for the patient while under the plan of care.
Once the patient is discharged and no longer under a home health plan of care, the HHA is no longer responsible for the medical supplies.

4.1.12.2. Part B Therapies Included in the Baseline Rates That Could Have Been Unbundled Prior to PPS


In addition to therapies that had been paid on a cost basis under home health, Part B therapies that could have been unbundled prior to PPS are also subject to the HH PPS consolidated billing requirements. These therapies must be provided directly or under arrangement on behalf of the HHA while a patient is under a home health plan of care, and cannot be separately billed to Part B during an open 60-day episode.

CMS originally released a list of 178 non-routine medical supplies and 54 Part B therapy procedures subject to the HH PPS consolidated billing requirements in the PPS Final Rule published in the July 3, Federal Register. However, that original list was later updated and expanded to 194 non-routine supplies and 69 therapy procedures. The current list is available on the CMS Web site at: http://www.cms.hhs.gov/providers/hha From this web site under Coding/Billing/Payment Systems, select Home Health Prospective Payment System. From this next page under Prospective Payment System Coding and Billing, select Home Health Consolidated Billing Master Code List.

4.1.12.3. Durable Medical Equipment (DME)

Reference: CMS Manual System Pub 100-2, Medicare Benefit Policy Manual, Chapter 7, Section 50.4.2 and CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 10, Section 10.1.25

DME and supplies covered as DME, parenteral and enteral nutrition, prosthetics and orthotics are not considered medical supplies. They are paid separately from the PPS rates and are not subject to the bundling and consolidated billing requirements. The determining factor is the medical classification of the supply, not the diagnosis of the patient. For example, infusion therapy will continue to be covered under the DME benefit separately paid from the PPS rate and excluded from the consolidated billing requirements governing PPS. The DME supplies that are currently covered and paid in accordance with the DME fee schedule as category SU are billed under the DME benefit and not included in the bundled HHA episodic payment rate. The HHAs are not required to do consolidated billing of SU supplies.
4.2 WORKFLOW OF SUBMISSION AND PROCESSING OF CLAIMS

- **Hardcopy**

- **Mailroom**

  - **Workflow**
    - bills & attachments are batched

  - **Imaged**
    - bills & attachments are imaged and assigned DCNs

- **Bill Processing**
  - bills & attachments are keyed into our system

- **EMC**

  - **Errors**
    - the bill generates a Return to Provider (RTP)

    - **No errors**
      - bill processed

        - **CWF**
          - **Claim Adjudicates**

            - **Reject**
              - remittance advice with reject code

            - **Reimbursement check & remittance advice**

        - **OR**

    - **OR**

      - **Suspense**
        - bill that need further work by the intermediary

          - After processing bill may:

            - **Complete processing**
              - **CWF**

              - **Claim Adjudicates**

                - **Denial**
                  - remittance advice with denial code

              - **Reimbursement check & remittance advice**

            - **Suspend to Medical Review**

            - **Suspend to Bill Review**

            - **Suspend to MSP**

            - **Pend to MSP**
4.3. Common Working File

The Common Working File (CWF) represents an effort by the CMS to improve the functioning of the Part A and Part B Medicare claims processes. The CWF concept is based on the merging of Part A and Part B beneficiary-specific data into several regionally based, common working files. Each of these files, comprised of claims data for the beneficiaries residing within a specific area (called hosts or sectors), will be maintained at a CWF host site and will be readily accessible to all sites within that sector. CMS also maintains a central file to point to the sector to which a particular beneficiary has been assigned. This allows communication between host sites for out-of-sector services. The common working file (CWF) verifies all claims. The CWF maintains all of the beneficiary eligibility records. To maintain these records effectively, the CMS divided the United States into nine regions called host sites. Each beneficiary record is located at one of the nine host sites. Home health providers have access to this information via direct data entry (DDE). DDE provides access to this information via HIQH and HIQA (see the DDE manual for details).

The CWF verifies eligibility and benefit utilization prior to claim payment. A series of CWF host edits determine whether or not Palmetto GBA can pay the claim. If a claim does not pass the CWF edit, it is returned to Palmetto GBA for necessary action. At any stage in claims processing, Palmetto GBA may request additional information to process your claim accurately. If additional information is required, Palmetto GBA will send your agency an additional development request (ADR) or a return to provider (RTP) report. Additional information regarding ADRs and RTPs is detailed in this manual.

The CWF contains an inquiry system (HIQH) that is available to home health agencies via RHHI remote access, through which HHAs can determine if an episode has already been opened for a beneficiary by another home health agency, and track episodes of beneficiaries for whom they are the primary provider.

4.4. Timely Filing Standards

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 1, Section 70

To be considered timely, a claim must be submitted within an established timeliness standard. To comply with the timely filing standards home health claims must be filed on or before December 31 of the calendar year following the year services were furnished. For timeliness purposes, services furnished in the last quarter of the year are considered furnished in the following year. This guideline applies to all bill types, including adjustments and late charge bills. The following time parameters apply:
4.5. Frequency of Billing

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 10, Sections 10.1.10.3 and Section 10.1.10.4

Providers will submit a RAP and a FC for each 60-day episode. The RAP may be submitted upon receiving a verbal order or referral from the physician, once the first billable visit has been provided and the OASIS has been locked for transmission. Upon processing the RAP, the episode will be created at the CWF and appear in HIQH. Providers should submit the RAP as soon as possible to best ensure being established as the primary HHA for the episode. The RAP must have processed prior to submitting a Final Claim.

RAPs must be submitted and processed before the final claim for all episodes in which five or more billable visits will be provided. Episode that will be paid as a LUPA (four or fewer visits) do not require the submission of a RAP, but is strongly encouraged. Instead, a FC known as a No-RAP-LUPA claim may be submitted after all services have been provided.

The FC may be submitted once the HHA receives the physician signed plan of care and all visits have been provided for the episode. If the patient will continue to require home health care and be recertified for a subsequent episode, the HHA may not bill the FC until after day 60 of the episode.

Reminder: A RAP will be automatically cancelled in the system and it’s payment recouped if the corresponding FC is not received within the greater of 120 days from the start date of the episode, or 60-days from the date that the RAP paid. However, even though the RAP is auto-cancelled, the episode remains open on the CWF, protecting the HHA’s primary agency status for that episode. In order to reclaim payment for the episode, a new RAP (identical to the original RAP) must be submitted and followed up with the FC within 60-days from the date that the newly submitted RAP pays.

4.5.1. RAP Cancellation Examples:

Example 1:

- Episode From 10/01/02 — Through 11/29/02
• RAP submitted and paid on 10/10/02
• 120 days from start date of episode (10/01/02) is 01/28/03
• 60-days from paid date of RAP (10/10/02) is 12/09/02

In this example, 120 days from the start date of the episode is the greater of the two dates. If the FC is not submitted by 01/28/03, the RAP will be automatically cancelled.

Example 2:

• Episode From 10/01/02 — Through 11/29/02
• RAP submitted and paid on 12/15/02
• 120 days from start date of episode (10/01/02) is 01/28/03
• 60-days from paid date of RAP is 02/13/03

In this example, 60-days from the paid date of the RAP is the greater of the two dates. If the FC is not submitted by 02/13/03, the RAP will be automatically cancelled.

4.6. Payment Floor and Ceilings and Interest Payments

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 1, Section 80.2.1.2

In accordance with Section 4031 of Public Law 100-203, the Omnibus Budget Reconciliation Act of 1987, Palmetto GBA will not pay, issue, mail, or otherwise reimburse for any claims received within the payment floor (waiting period) list below. The count for the number of days begins on the day after the date of receipt. The term payment floor refers to the period of time that Palmetto GBA must wait before making payment on clean claims. Payment floor guidelines are determined by the CMS. The payment floor is the earliest date Palmetto GBA can pay a clean claim. A clean claim is a claim that Palmetto GBA does not have to investigate or develop externally on a prepayment basis. The payment floor on a clean claim is as follows:

- Hard copy Claims  27 days, payment on the 28th
- EMC   13 days, payment on the 14th

The Medicare statute provides for claim payment floors and ceilings. A floor is the minimum amount of time a claim must be held before payment. A ceiling is the maximum time allowed for processing a clean claim before Medicare owes interest to a provider. These floors and ceilings apply to all payments except “periodic interim payment”.

4.6.1. Definitions for Electronic and Paper Claims

An “electronic claim” is one that is submitted to the contractor by the provider or EMC vendor via central processing unit (CPU) to CPU transmission, tape, DDE, direct wire,
dial-in telephone, or personal computer upload or download. A paper claim is one that is submitted on paper, including optical character recognition claims and claims that are converted to electronic form by the Medicare contractor or its agent.

4.6.2. Interest Payment on Non-PIP Claims Not Paid Timely

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 1, Section 80.2.2

Interest must be paid on clean non-PIP claims when payment to the provider does not meet the timely processing requirements. Interest is paid on a per-bill basis at the time of payment. The Treasury Department, on a six-month basis, determines the interest rate, and providers are notified by a newsletter of any interest rate changes.

Interest will begin to accrue on the 31st day after the day of receipt of a clean, electronic or hardcopy claim. The following formula should be used to calculate interest: 

\[
\text{Interest payment} = \frac{\text{reimbursement amount} \times \text{interest rate} \times \text{days due}}{365}
\]

An EMC example:

<table>
<thead>
<tr>
<th>Date received</th>
<th>July 01, 1996</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment due</td>
<td>August 1, 1996</td>
</tr>
<tr>
<td>Payment made</td>
<td>August 4, 1996</td>
</tr>
<tr>
<td>Interest begins</td>
<td>August 2, 1996</td>
</tr>
<tr>
<td>Interest ends</td>
<td>August 4, 1996</td>
</tr>
<tr>
<td>Days for which interest is due</td>
<td>3</td>
</tr>
</tbody>
</table>

Amount of Reimbursement $100
Annual interest rate (for this example) 9.0%

An example of this formula applied would be:

\[
\frac{100 \times .09 \times 3}{365} = \$0.073 \text{ or } \$.07
\]

Interest is not paid on:

- Claims requiring external investigation or development by the intermediary
- Claims for which no payment is due
- Full denials
- Claims for which you are receiving PIP (PIPs were phased out with the implementation of HH PPS)
- HH PPS RAPs
4.7. Completing the UB-92 Field Descriptors

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 10, Section 40

Items not listed do not need to be completed, although you may complete them when billing multiple payers. The abbreviation “FL” stands for “Field Locator”.

4.7.1 Request for Anticipated Payment (RAP) UB-92 Field Descriptors

Reference: CMS Manual System Publication 100-4, Medicare Claims Processing Manual, Chapter 10, Sections 40.1

---

**FL 1 - PROVIDER IDENTIFICATION (Required)**

Enter the provider name and address. Include the following information, if not preprinted:

- PROVIDER NAME
- STREET NAME AND NUMBER OR PO BOX NUMBER (OPTIONAL)
- CITY, STATE ZIP CODE
- TELEPHONE NUMBER (OPTIONAL)
- FAX (OPTIONAL)

**FL 3 - PATIENT ACCOUNT/CONTROL NUMBER (If Applicable)**

Enter the patient account number if you use them. Palmetto GBA does not key this information when included on a hard copy claim.

**FL 4 - TYPE OF BILL (Required)**

**Code Structure**

<table>
<thead>
<tr>
<th>1st Digit</th>
<th>TYPE OF FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Home Health</td>
</tr>
</tbody>
</table>
2nd Digit BILL CLASSIFICATION

2  Part B visits under a Plan of Care when the beneficiary is entitled to Part A and B or Part B only and use of durable medical equipment (DME).

As a result of the BBA of 1997, submit the 32x TOB for all patients entitled to both Medicare Part A and Part B. The CWF will verify that the services are post-institutional home health services (100 visits under Part A) or ‘regular’ home health services. This is effective for DOS 010198.

3  Part A visits under a Plan of Care and use of DME.

This TOB should only be used when the patient is only entitled to Medicare Part A. All services will be reimbursed out of the Part A trust fund. HHAs are encouraged to submit all RAPs with a bill classification 2. (Medicare systems will determine which trust fund the claim should be paid from and change the 32x TOB to a 33x TOB as necessary.)

3rd Digit FREQUENCY

2  Interim (First Claim)--Use this code for the submission of all original or subsequent RAPs

XX8  Void/Cancel of Prior Claim--Use this code to cancel a previously submitted and paid RAP. The bill should be an exact duplicate of the original incorrect bill. Once the original RAP is cancelled, a new 322 bill must be submitted to replace the cancelled RAP in order for the episode to be paid.

FL 5 - FEDERAL TAX NUMBER (Not Required)

Enter the agency’s employer identification number.

FL 6 - STATEMENT COVERS PERIOD (Required)

These are the “from” and “through” dates of the bill. Typically, they represent the beginning and ending dates of the period covered by the bill. However, with a RAP, submit the same date in both the “from” and “through” date fields. Submit all dates in the MMDDYY format.
On RAPs for the initial episode of an admission, the “from” and “through” dates should match the admission (start of care) date in FL 17, as well as the first billable visit date in FL 45 of the 0023 revenue line.

On RAPs for subsequent episodes, the “from” and “through” dates represent the first date of the episode and should be the date that immediately follows the last day of the previous episode. This will be day 61, day 121, day 181, etc…

**FL 12 - PATIENT NAME (Required)**

Enter the patient’s last name, first name, and middle initial. Be consistent with the health insurance card.

**FL 13 - PATIENT'S ADDRESS (Required)**

Enter the patient’s full mailing address (include zip code).

**FL 14 - BIRTH DATE (Required)**

Enter the month, day, and year of birth of patient in MM-DD-CCYY format. If the correct full date is not known, leave this item blank.

**FL 15 - SEX (Required)**

Enter the sex of the patient as recorded on the date care started.

M - Male  
F - Female

**FL 17 - DATE OF ADMISSION/SERVICE (Required)**

Enter the date the patient started home health care (MM-DD-YYYY). This will be the first Medicare billable service date. It is also the same as the Start of Care (SOC) date listed on the Plan of Care.
On the initial RAP of an admission, this date will match the “FROM” date is FL 6 (Statement Covers Period), and the first billable service date in FL 45 of the 0023 revenue line.

On RAPs for subsequent episodes of continuous care, this date should remain constant and reflect the original admission date.

**Reminder:** The admit date on RAPs for subsequent episodes should match the admit date on the initial RAP.

---

### FL 20 - SOURCE OF ADMISSION (Required)

Enter the code that defines the patient’s source of admission to home care. This item will be used to establish and track all home health PPS episodes.

The valid Source of Admission codes are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physician Referral</td>
<td>7</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>2</td>
<td>Clinic Referral</td>
<td>8</td>
<td>Court/Law Enforcement</td>
</tr>
<tr>
<td>3</td>
<td>HMO Referral</td>
<td>9</td>
<td>Information Not Available</td>
</tr>
<tr>
<td>4</td>
<td>Transfer from a Hospital</td>
<td>A</td>
<td>Transfer from a Critical Access</td>
</tr>
<tr>
<td>5</td>
<td>Transfer from a SNF</td>
<td></td>
<td>Hospital (CAH)</td>
</tr>
<tr>
<td>6</td>
<td>Transfer from Another Health Care Facility</td>
<td>B</td>
<td>Transfer from Another HHA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C</td>
<td>Readmission to Same HHA</td>
</tr>
</tbody>
</table>

**Using the Source of Admission code**

The Source of Admission reported on the FC must always match the Source of Admission reported on the corresponding RAP for that episode.

For the first RAP of an admission (any RAP in which the “from” date matches the start of care or “admission” date), the source of admission code should reflect to the closest degree, the actual source of the patient’s admission to your agency.

For subsequent episode RAPs (any RAP in which the “from date does not match the “admission” date), the source of admission should be reported as a physician referral (Source of Admission code 1). This indicates that the beneficiary continues to receive physician ordered services under a plan of care and is not a new admission.
Be certain to use the “B” and “C” Source of Admission codes properly and only when appropriate. These codes indicate to the Common Working File (CWF) that the patient is readmitting to home health care (transfer to another HHA or discharge/readmit to the same HHA) and will cause the original provider’s episode to receive a PEP adjustment.

**Reminder:** The “B” and “C” Source of Admission Codes are only used when the admission dates of service fall within the dates of a previously established home health episode.

Ex: CWF shows episode 100102-112902. Provider is readmitting with an admission date of 111502

### FL 22 - PATIENT STATUS (Required)

Enter the code that reflects the patient’s status as of the “through” date of the bill. Since the purpose of a RAP is to establish the episode of care, the “through” date must match the “from” date. A patient will never be discharged with a RAP. As a result, only one patient status code is acceptable for RAPs.

**Code Structure**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>Still a patient</td>
</tr>
</tbody>
</table>

### FL 23 – MEDICAL RECORD NUMBER (Optional)

Enter the number assigned to the patient’s health record. The number will remain on the claim through adjudication and display on the Remittance Advice (RA) or Electronic Remittance Advice (ERA).

### FLs 24 THROUGH 30 - CONDITION CODES (If applicable)

Enter the corresponding code to describe any of the following conditions that apply to the RAP.

- 02 Condition is Employment Related
- 04 Patient is HMO Enrollee
- 06 ESRD Patient in Coordination Period Covered by EGHP
- 07 Treatment of Non-terminal Condition for Hospice Patient
08 Beneficiary Would Not Provide Information Concerning Other Insurance Coverage

09 Neither Patient nor Spouse is Employed

10 Patient and/or Spouse is Employed but No EGHP Coverage Exists

11 Disabled Beneficiary, but No LGHP Coverage

20 Beneficiary Requested Billing (Demand Bill)

21 Billing for Denial Notice

28 Patient and/or Spouse’s EGHP is Secondary to Medicare. In response to development questions, the patient and/or spouse has indicated that one is (or both are) employed. Also, there is a group health insurance from an EGHP, other employer sponsored, or provided health insurance that covers the patient but that either (1) is a single employer plan and the employer has fewer than 20 full and part-time employees, or (2) the EGHP is a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.

29 Disabled Beneficiary and/or Family Member’s LGHP is Secondary to Medicare. In response to development questions, the patient and/or family member(s) have indicated that one is or more are employed and that there is group health insurance from an LGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and the employer has fewer than 100 full and part-time employees; or (2) the LGHP is a multi or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.

77 You Accept or Are Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as payment in full.

When canceling a RAP, you must report one of the following condition codes:

D5 Cancel to Correct HIC number or Provider ID

D6 Cancel Only to Repay a Duplicate or OIG Overpayment

*If the reason for canceling the RAP is not one of the reasons listed for D5 or D6, you must select one of them to report on the RAP. Then list the real reason for the cancellation in the Remarks field (FL 84) of the claim.*
FLs 32A THROUGH 35B - OCCURRENCE CODES (If applicable)

Enter the appropriate codes and dates where one or more occurrences are applicable.

- 01 Auto Accident
- 02 No-Fault Insurance Involved - Including Auto Accident/Other
- 03 Accident/Tort Liability
- 04 Accident/Employment Related
- 05 Other Accident
- 18 Date of Retirement for the Patient/Beneficiary
- 19 Date of Retirement – Spouse
- 24 Date Insurance Denied
- 33 First Month of the 30 Month Coordination Period for ESRD, Beneficiaries Covered by EGHP

FL 37 - DOCUMENT CONTROL NUMBER (If Applicable)

When canceling a RAP, place the document control number of the RAP you are canceling in this field. (328 TOB)

FLs 39A THROUGH 41D - VALUE CODES AND AMOUNTS (Required)

Enter the corresponding code and amount. The Metropolitan Statistical Area (MSA) code is required on all 32X and 33X bill types. RAPs will not be processed without the MSA Code (Value Code 61).

Medicare Secondary Payer (MSP) value codes should be used when appropriate.

The amount field is defined as a dollar amount field.
61 Metropolitan Statistical Area (MSA) (Required)

Enter value code 61 and the MSA number corresponding to the site where care was rendered, **not** agency location. This is required for 32x and 33x type of bills. It is not allowed on a 34x type of bill.

Enter the four-digit MSA number in the value code amount field followed by a decimal and two zeros (XXXX.00). Value codes that represent units (not dollars) must end with zeros in the cents field. The MSA numbers for rural areas only have two (2) digits; therefore, it is necessary to submit the MSA number with two 9s preceding the MSA number (99XX.00).

**Example:** 61 XXXX.00

<table>
<thead>
<tr>
<th>MSA #</th>
<th>VALUE AMOUNT</th>
<th>CODE</th>
<th>PATIENT LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0040</td>
<td>0040.00</td>
<td></td>
<td>Abilene, TX</td>
</tr>
<tr>
<td>2680</td>
<td>2680.00</td>
<td></td>
<td>Ft. Lauderdale, Fl</td>
</tr>
<tr>
<td>01</td>
<td>9901.00</td>
<td></td>
<td>Rural Alabama</td>
</tr>
</tbody>
</table>

**FL 42 - REVENUE CODE (Required)**

Only one revenue code is required on the RAP. The 0023 revenue line is used to report the HIPPS code for which the anticipated payment is based. A charge amount is not submitted on the 0023 revenue line.

**Code Structure**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0023</td>
<td>Home Health Services</td>
</tr>
<tr>
<td>0001</td>
<td>Total*</td>
</tr>
</tbody>
</table>

*The 0001 Total line is optional for the RAP. It may be reported, but it is not required. However, it must be reported on the FC.

There are some vendor and billing software packages that require an additional revenue code and line-item service to be reported on the RAP. In these cases, other acceptable home health revenue codes may be reported on the RAP.
FL 44 - HCPCS CODES (If applicable)

Report the HIPPS code in FL 44 of the 0023 revenue line on the RAP.

If additional revenue code lines are submitted on the RAP, then report the appropriate HCPCS code for the revenue code listed.

The following HCPCS codes are required for reporting 15 minute increments for revenue codes 042X, 043X, 044X, 055X, 056X, and 057X:

- G0151 Physical Therapy
- G0152 Occupational Therapy
- G0153 Speech Pathologist
- G0154 Skilled Nurse
- G0155 Social Worker
- G0156 Home Health Aide

FL 45 - SERVICE DATE (Required)

Report the date of the first billable service, for the episode, in FL 45 of the 0023 revenue line on the RAP.

If additional revenue code lines are submitted on the RAP, then report the appropriate service dates for each revenue code listed.

FL 46 - UNITS OF SERVICE (Required)

Units of service are not required to be reported on the 0023 revenue code line.

If additional revenue code lines are submitted on the RAP, then report the appropriate units for each revenue code listed. Units for visits submitted for the six home health disciplines must be reported in 15 minute increments for 32X and 33X bill types. This item does not need to be completed when billing for supplies (revenue code 0270).

Use the following chart to assist in calculating the 15 minute increment units:

<table>
<thead>
<tr>
<th>Units</th>
<th>Time Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 minute to &lt; 23 minutes</td>
</tr>
<tr>
<td>2</td>
<td>23 minutes to &lt; 38 minutes</td>
</tr>
<tr>
<td>3</td>
<td>38 minutes to &lt; 53 minutes</td>
</tr>
<tr>
<td>4</td>
<td>53 minutes to &lt; 68 minutes</td>
</tr>
<tr>
<td>5</td>
<td>68 minutes to &lt; 83 minutes</td>
</tr>
<tr>
<td>6</td>
<td>83 minutes to &lt; 98 minutes</td>
</tr>
<tr>
<td>7</td>
<td>98 minutes to &lt; 113 minutes</td>
</tr>
<tr>
<td>8</td>
<td>113 minutes to &lt; 123 minutes</td>
</tr>
</tbody>
</table>

The pattern continues for longer periods of time.
**FL 47 - TOTAL CHARGES (Required)**

Enter the total charge for each revenue code.

On the 0023 revenue code line, the total charges must be reported as zero on in FL 47. If no other charges are present on the RAP, then the total charges in FL 47 of the 0023 and 0001 revenue lines must be zero.

If additional revenue code lines are reported on the RAP, enter the total charge for each revenue code. On the 0001 total line, enter the sum of all total charges listed for each revenue code in FL 47.

**FL 51 - A,B,C - PROVIDER NUMBER (Required)**

Enter the provider number assigned for your agency in FL 50 on line A, B or C, corresponding to the payer Medicare.

**FL 52 - A,B,C - RELEASE OF INFORMATION CERTIFICATE (Required)**

Enter the code to indicate whether the provider has on file a signed statement permitting the provider to release information to other organizations in order to adjudicate the claim.

**Code Structure**

- **Y** Yes. The provider has a signed written authority to release medical/billing information for the purposes of claiming insurance benefits.

- **R** Restricted or modified release. The provider has limited or restricted authority to release some medical/billing information for purposes of claiming insurance benefits.

- **N** No. The provider does not have permission to release any medical/billing information.
**FL 54 A,B,C - PRIOR PAYMENTS (If Applicable)**

- Enter the amount received from the primary payer on the appropriate line when Medicare is secondary or tertiary and payment has been made to the primary payer.

**FL 58 - INSURED’S NAME (Required)**

On the same lettered line (A, B or C) that corresponds to the line on which Medicare payer information is shown in FL 50, enter the patient’s name as shown on his or her Medicare Health Insurance card.

**FL 60 - CERTIFICATE NUMBER, SOCIAL SECURITY NUMBER, HEALTH INSURANCE CLAIM NUMBER, IDENTIFICATION NUMBER (Required)**

On the same lettered line (A, B or C) that corresponds to the line on which Medicare payer information was shown in Items 50 - 55, enter the patient’s Medicare health insurance number.

The HIC number must agree with the HIC number entered on all documentation.

**FL 63 – TREATMENT AUTHORIZATION CODE (Required)**

Enter the eighteen digit OASIS Matching Key produced from the Grouper software. This links the RAP to the specific OASIS assessment that was used to produce the HIPPS code submitted in FL 44 of the RAP.

The code consists of the three OASIS items that contain the start of care date (MO030), the date the assessment was completed (MO090) and the reason for the assessment (MO100). The matching key must be reported on the RAP and claim exactly as it is produced by the Grouper and will appear in one of the following two formats:

```
MMDDCCYYMMDDCCYYXX or,
CCYYMMDDCCYYMMDDXX
```

The OASIS Matching Key must be reported on the same line that Medicare is listed in the payer fields.
FL 67 - PRINCIPAL DIAGNOSIS CODE (Required)

Enter the ICD-9-CM code for the principle diagnosis which should reflect the primary reason for home health services. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting.

Report the full ICD-9-CM Diagnosis code, including all five digits where applicable. The principle diagnosis code reported in FL 67 must match the primary diagnosis code reported in MO230 (Primary Diagnosis) on the OASIS assessment, and in item 11 on the Form CMS-485, Plan of Care.

FLs 68 THROUGH 75 - OTHER DIAGNOSES CODES (Required)

Enter the ICD-9-CM codes for up to eight additional diagnoses conditions co-existing according to the attending physician at the time the plan of care was established.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses), and on the Form CMS-485, form item 13 (Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, place them in order to best reflect the seriousness of the patient’s condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9-CM guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on all forms. Surgical and V codes which are not acceptable in the other diagnosis fields (M0240 on the OASIS, or on the Form CMS-485, form item 13, may be reported in FLs 68-75 on the RAP if they are reported in the narrative form item 21 of the Form CMS-485.

FL 82 - UNIQUE PHYSICIAN IDENTIFICATION NUMBER (Required)

This field should contain information regarding the attending physician that has established the plan of care with verbal orders/signed the POC.

Enter the physician’s UPIN in this field followed by his/her last name, first name and middle initial.

EXAMPLE: B12345 Smith John M
If the physician does not have an assigned UPIN, use one of the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>INT000</td>
<td>Intern</td>
</tr>
<tr>
<td>RES000</td>
<td>Resident</td>
</tr>
<tr>
<td>PHS000</td>
<td>Public Health Servant</td>
</tr>
<tr>
<td>VAD000</td>
<td>Veteran’s Affairs</td>
</tr>
<tr>
<td>RET000</td>
<td>Retired</td>
</tr>
<tr>
<td>OTH000</td>
<td>Other</td>
</tr>
</tbody>
</table>

**FL 84 - REMARKS (If Applicable)**

Enter any remarks needed to provide information that is not shown elsewhere on the bill but is necessary for proper payment. Remarks are necessary when canceling a RAP, to indicate the reason for the cancellation.

**FL 85 - PROVIDER REPRESENTATIVE SIGNATURE (Not Required)**

A stamped or computer generated signature is acceptable. Enter the date the provider representative signed the form.

**4.7.1.1. RAP UB-92 Examples**

The following are examples of a RAP UB-92.

4.7.1.2. RAP Non-Transfer UB-92 Example
4.7.1.3. RAP Non-Transfer With Line Item UB-92 Example
4.7.1.4. RAP Subsequent Episode UB-92 Example
4.7.1.5. RAP Transfer Situation UB-92 Example
4.7.1.6. RAP Discharge and Re-Admit UB-92 Example
4.7.1.7. RAP Cancellation UB-92 Example

*Please refer to the attachment file for the RAP UB-92 Examples*
<table>
<thead>
<tr>
<th>12 PATIENT NAME</th>
<th>Doe, Jane M</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 PATIENT ADDRESS</td>
<td>1800 South Avenue, Anywhere, SC 90210</td>
</tr>
</tbody>
</table>

**ADMISSION**

| 07101910 | F | 06012005 | 1 | 30 |

**CONDITION CODES**

<table>
<thead>
<tr>
<th>24</th>
<th>26</th>
<th>27</th>
<th>28</th>
<th>30</th>
</tr>
</thead>
</table>

**OCCURRENCE**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DATE</th>
<th>CODE</th>
<th>DATE</th>
<th>CODE</th>
<th>DATE</th>
<th>CODE</th>
<th>DATE</th>
<th>OCCURRENCE</th>
<th>OCCURRENCE</th>
<th>OCCURRENCE</th>
<th>OCCURRENCE</th>
<th>OCCURRENCE SPAN</th>
</tr>
</thead>
</table>

**VALUE CODES**

<table>
<thead>
<tr>
<th>CODE</th>
<th>AMOUNT</th>
<th>CODE</th>
<th>AMOUNT</th>
<th>CODE</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>0023</td>
<td>Home Health Services</td>
<td>HDHL1</td>
<td>06012002</td>
<td>0</td>
<td>00</td>
</tr>
<tr>
<td>0001</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>00</td>
</tr>
</tbody>
</table>

**PAYER**

Medicare A

**DUE FROM PATIENT**

Doe, Jane M

**OTHER DIAG. CODES**

| 152881 | 25011 |

**82 ATTENDING PHYS. ID**

A Good MD

**83 OTHER PHYS. ID**

OTHER PHY

(RAP-NON-TRANSFER SITUATION)
### UB-92 Example

#### 4.7.1.3. RAP NON-TRANSFER WITH LINE ITEM

**Patient Control No.** 000002

**Type of Bill** 322

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>1800 South Avenue Columbia, SC 90210</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>07101910</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>MS</th>
<th>Admission Date</th>
<th>Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>1</td>
<td>06012005</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occurrence</th>
<th>Value Code</th>
<th>From</th>
<th>Through</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>61</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>HCPCS/Rates</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Non-Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services</td>
<td>HDHL1</td>
<td>06012002</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bill Type</th>
<th>Medicare A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Insured's Name</th>
<th>Group Name</th>
<th>Insurance Group No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe, Jane M</td>
<td>nnnnnnnA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Authorization Codes</th>
<th>60 CERT-SSN-HIC-ID No.</th>
<th>61 GROUP NAME</th>
<th>62 INSURANCE GROUP NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01</td>
<td>nnnnnnnnnA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>64 ESC</th>
<th>65 Employer Name</th>
<th>66 Employer Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>060120020601200201</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Remarks**

(RAP-NON-TRANSFER W/LINE ITEM)
**HOME HEALTH ADDRESS**
- City, State, Zip: [Redacted]
- Telephone: [Redacted]

**PATIENT NAME**
- Doe, Jane M

**ADMISSION**
- ADMISSION CONDITION CODES: [Redacted]
- DATE: 07/10/1910
- HOUR: 06:01
- SEX: F
- MS: 01

**STATEMENT COVERS**
- FROM: 07/30/2005
- THROUGH: 07/30/2005

**PAYMENT AUTHORIZATION**
- TYPE: [Redacted]

**FED. TAX NO.**
- 8N-C.D.: [Redacted]
- 9C-I.D.: [Redacted]
- 10 L-R D.: [Redacted]

**STATEMENT COVERS PERIOD**
- FROM: 07/30/2005
- THROUGH: 07/30/2005

**PATIENT ADDRESS**
- 1800 South Avenue
- Anywhere, SC 90210

**SERV. UNITS**
- 0001 000002 322

**TOTAL CHARGES**
- AMOUNT: 00

**NON-COVERED CHARGES**
- AMOUNT: 00

**MEDICAL RECORD NO.**
- [Redacted]

**billing information**
- [Redacted]

**DUE FROM PATIENT**
- [Redacted]

**DUE TO PATIENT**
- [Redacted]

**PAYER**
- Medicare A

**MEDICAL BILLING INFORMATION**
- [Redacted]

**TREATMENT AUTHORIZATION CODES**
- [Redacted]

**TREATMENT AUTHORIZATION CODES**
- [Redacted]

**EMPL. LOCATION**
- [Redacted]

**ATTENDING PHYS. ID**
- Annnnn A Good MD

**OTHER PHYS. ID**
- [Redacted]

**PRINCIPAL PROCEDURE**
- PRINCIPAL PROCEDURE: [Redacted]

**OTHER PROCEDURE**
- OTHER PROCEDURE: [Redacted]

**OTHER PHYS**
- [Redacted]

**OTHER DIAG. CODES**
- [Redacted]

**TCPC/RATES**
- HDHL1 00:00 00:00

**REMARKS**
- (RAP- SUBSEQUENT EPISODE)
**Home Health Address**

City, State, Zip

Telephone

**Patient Control No.**

000002 322

**Type of Bill**

4.7.1.5. RAP Transfer Situation UB-92

**Example**

1 Patient Name

Doe, Jane M

12 Patient Address

1800 South Avenue

Anywhere, SC 90210

14 Birthdate

07/01/2005

15 Sex

F

16 MS

B

17 Date

07/01/2005

18 HR

01

19 Type

HDHL1

20 SRC.

000002

21 D HR

07/01/2005

22 STAT

000002

23 Medical Record No.

000002

24

25

26

27

28

29

30

31 Condition Codes

32 Occurrence

33 Occurrence

34 Occurrence

35 Occurrence

36 Occurrence

37 Occurrence Span

38

39 Value Code

40 Value Codes

41 Value Codes

42 Rev. CD.

0023 Home Health Services

43 Description

0001

44 HCPCS/Rates

50 Payer

Medicare A

51 Provider No.

nnnnnn

52 INS. DEX.

nnnnnn

53 Prior Payments

54 EST. Amount Due

55

56

57

58 Insured's Name

Doe, Jane M

59 P. Rel.

01

60 Cert. - SSN - HIC. - ID No.

nnnnnnnnn

61 Group Name

nnnnnnnnnA

62 Insurance Group No.

63 Treatment Authorization Codes

07/01/200207/01/200201

64 ESC

65 Employer Name

66 Employer Location

67


51881 25011

68

69

70

71

72

73

74

75

76

77

78

80 Principal Procedure

81 Other Procedure

82 Attending Phys. ID

83 Other Phys. ID

84 Remarks

(RAP-TRANSFER SITUATION)

85 Provider Representative

DECERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART

86 Date
**Home Health Address**

**City, State, Zip**

**Telephone**

---

**Home Health Services**

**Doe, Jane M**

1800 South Avenue

Columbia, SC  90210

---

**Date of Service**: 06012005

**Type of Procedure**: Home Health Services

**Service Code**: HDHL1

---

**Attendign Phys. ID**: Annnnn

**Attending Phys. Name**: A Good MD

---

**Remarks**

(RAP-DISCHARGE/RE-ADMIT)
**Home Health Address**
City, State, Zip
Telephone

**Patient Control No.**
000002

**Type of Bill**
328

**Statement Covers**
6

**CoV.D.**
8

**N-C.D.**
9

**L-R.D.**
11

**Federated Tax No.**
06012005

**From**
06012005

**To**
06012005

**Patient Name**
Doe, Jane M

**Address**
1800 South Avenue
Anywhere, SC 90210

**Condition Codes**
31

**Admission**
07101910

**Sex**
F

**Birthdate**
06012005

**Medical Record No.**
D5

**Date**
06012005

**Type**
1

**Stat**
30

**Occurrence**
A

**Value Code**
61

**Amount**
176000

**Description**
Home Health Services HDHL1

**Procedure Dates**
06012002 06012002 01

**Principal Procedure**
51881

**Other Procedure**
51882

**Remarks**
Cancelled RAP to correct HIPPS code

**Due From Patient**

**Other Diagnosis Codes**

**Other Procedure**

**Other Phyr ID**

**Provider Representative**
Annnnn A Good MD

**Certify the Certifications on the Reverse Apply to Type Bill and Are Made A Part**
4.7.2. FC Field Descriptors

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 10, Section 40.2

<table>
<thead>
<tr>
<th>FL 1 - PROVIDER IDENTIFICATION (Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter the provider name and address. Include the following information, if not preprinted:</td>
</tr>
<tr>
<td>PROVIDER NAME</td>
</tr>
<tr>
<td>STREET NAME AND NUMBER OR</td>
</tr>
<tr>
<td>PO BOX NUMBER (OPTIONAL)</td>
</tr>
<tr>
<td>CITY, STATE, and ZIP CODE</td>
</tr>
<tr>
<td>TELEPHONE NUMBER (OPTIONAL)</td>
</tr>
<tr>
<td>FAX (OPTIONAL)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FL 3 - PATIENT ACCOUNT/CONTROL NUMBER (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter the patient account number if you use them. Palmetto GBA does not key this information when included on a hard copy claim.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FL 4 - TYPE OF BILL (Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Structure</td>
</tr>
<tr>
<td>1st Digit</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>2nd Digit</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>
This TOB should only be used when the patient is only entitled to Medicare Part A. All services will be reimbursed out of the Part A trust fund. HHAs are encouraged to submit all RAPs with a bill classification 2. (Medicare systems will determine which trust fund the claim should be paid from and change the 32x TOB to a 33x TOB as necessary.)

<table>
<thead>
<tr>
<th>3rd Digit</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Replacement of Prior Claim (Adjustment Bill)</td>
</tr>
<tr>
<td>8</td>
<td>Void/Cancel of Prior Claim</td>
</tr>
<tr>
<td>9</td>
<td>FC for HH PPS episode</td>
</tr>
</tbody>
</table>

Use this code to submit all HH PPS FCs and No-RAP-LUZA claims. The claim will be processed as a debit/credit adjustment to the RAP as appropriate.

| 0         | No payment Claim/Billing for Insurance Denial (Not Demand Bills) |

Use this code when you do not expect Medicare payment for the claim and request a Medicare denial for other payer sources. The condition code 21 must be included in FLs 24-30.

| I         | Intermediary Adjustment – No provider action required    |

**FL 5 - FEDERAL TAX NUMBER (Not Required)**

Enter the agency’s employer identification number.

**FL 6 - STATEMENT COVERS PERIOD (Required)**

These are the “from” and “through” dates of the bill. Enter the beginning and ending dates of the period covered by this bill. Report these dates in MMDDYY format.

The “from” date on the FC must match the “from” date submitted on the corresponding RAP for the episode.
If the patient discharges or transfers during the 60-day episode, report the “through” date as the date of discharge in accordance with your agency’s discharge procedures. If the patient dies during the 60-day episode, report the date of death as the “through” date.

For continuous care episodes, the “through” date must be exactly 59 days after the “from” date (or, 60-days including the “from” date).

When billing continuous care episodes, there should not be a break in service between episodes. The “from” day of the new episode should be the day immediately following the “thorough” date of the previous episode.

FCs may be submitted for payment immediately after the “through” date listed on the claim.

**FL 12 - PATIENT NAME (Required)**

Enter the patient’s last name, first name, and middle initial. Be consistent with the health insurance card.

**FL 13 - PATIENT'S ADDRESS (Required)**

Enter the patient’s full mailing address (include zip code).

**FL 14 - BIRTH DATE (Required)**

Enter the month, day, and year of birth of patient in MM-DD-CCYY format. If the correct full date is not known, leave this item blank.

**FL 15 - SEX (Required)**

Enter the sex of the patient as recorded on the date care started.

M - Male  F - Female
FL 17 - DATE OF ADMISSION/SERVICE (Required)

Enter the date the patient started home health care (MM-DD-CCYY). Report the same admission date that was submitted on the corresponding RAP for the episode. This is the same as the Start of Care (SOC) date listed on the CMS 485, field 2.

Note: Palmetto GBA will deny services if the SOC date on the CMS 485 and the admission date on the UB-92 do not match.

FL 20 – SOURCE OF ADMISSION (Required)

Enter the same source of admission code that was submitted on the corresponding RAP for that episode.

The valid Source of Admission codes are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physician Referral</td>
<td>7</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>2</td>
<td>Clinic Referral</td>
<td>8</td>
<td>Court/Law Enforcement</td>
</tr>
<tr>
<td>3</td>
<td>HMO Referral</td>
<td>9</td>
<td>Information Not Available</td>
</tr>
<tr>
<td>4</td>
<td>Transfer from a Hospital</td>
<td>A</td>
<td>Transfer from a Critical Access</td>
</tr>
<tr>
<td>5</td>
<td>Transfer from a SNF</td>
<td>B</td>
<td>Transfer from Another HHA</td>
</tr>
<tr>
<td>6</td>
<td>Transfer from Another Health Care Facility</td>
<td>C</td>
<td>Readmission to Same HHA</td>
</tr>
</tbody>
</table>

Note: For subsequent episodes of continuous care report the Source of Admission Code 1-physician referral, since the beneficiary is not a new admission but continues to receive services under a physician’s plan of care.

FL 22 - PATIENT STATUS (Required)

Enter the code that most accurately describes the patient’s status as of the “through” date of the claim.

Code Structure

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Discharged to home or self-care (routine discharge)</td>
</tr>
<tr>
<td>02</td>
<td>Discharged/transferred to another short-term general hospital for inpatient care</td>
</tr>
<tr>
<td>03</td>
<td>Discharged/transferred to SNF</td>
</tr>
</tbody>
</table>
04 Discharged/transferred to an Intermediate Care Facility (ICF)

05 Discharged/transferred to another type of institution (including distinct parts)

06 Discharged/transferred to home under care of another organized home health service organization, OR

Discharged and readmitted to the same home health agency within a 60-day episode period

Patient status code 06 should only be reported when the HHA is aware that the episode will be paid as a Partial Episode Payment (PEP). This occurs when the beneficiary is readmitted to home health care within the same 60-day episode; the beneficiary has transferred to another HHA within the 60-day episode; or readmitted to HHA within the same 60-day episode

Since this code causes an episode to be PEP adjusted, misusing the code could have significant financial implications to your agency.

07 Left against medical advice or discontinued care

20 Expired (or did not recover - Christian Science Patient)

30 Still patient

**FL 23 – MEDICAL RECORD NUMBER (Optional)**

Enter the number assigned to the patient’s health record. The number will remain on the claim through adjudication and display on the Remittance Advice (RA) or Electronic Remittance Advice (ERA).

**FLs 24 THROUGH 30 - CONDITION CODES (If applicable)**

Enter the corresponding code to describe any of the following conditions that apply to this episode/billing period.

02 Condition is Employment Related

03 Patient Covered by Insurance Not Reflected Here

04 Patient is HMO Enrollee

06 ESRD Patient in Coordination Period Covered by EGHP

07 Treatment of Non-terminal Condition for Hospice Patient
08 Beneficiary Would Not Provide Information Concerning Other Insurance Coverage

09 Neither Patient nor Spouse is Employed

10 Patient and/or Spouse is Employed but No EGHP Coverage Exists

11 Disabled Beneficiary, but No LGHP Coverage

20 Beneficiary Requested Billing (Demand Bill)

21 Billing for Denial Notice

28 Patient and/or Spouse’s EGHP is Secondary to Medicare. In response to development questions, the patient and/or spouse has indicated that one is (or both are) employed. Also, there is a group health insurance from an EGHP, other employer sponsored, or provided health insurance that covers the patient but that either (1) is a single employer plan and the employer has fewer than 20 full and part-time employees, or (2) the EGHP is a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.

29 Disabled Beneficiary and/or Family Member’s LGHP is Secondary to Medicare. In response to development questions, the patient and/or family member(s) have indicated that one is or more are employed and that there is group health insurance from an LGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and the employer has fewer than 100 full and part-time employees; or (2) the LGHP is a multi or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.

77 You Accept or Are Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as payment in full.

D0 Changes to Service Dates

D1 Changes to Charges

D2 Changes to Revenue Codes/HCPCS Codes

D5 Cancel to Correct HIC number or Provider ID*

D6 Cancel Only to Repay a Duplicate or OIG Overpayment*
D7  Change to Make Medicare the Secondary Payer
D8  Change to Make Medicare the Primary Payer
D9  Any Other Change**
E0  Change in Patient Status

* Note:  D0-D9, E0 should only be used on adjustment or cancellation claims.

* If canceling a RAP or FC (3x8 TOB), you must report one of these two condition codes. If the reason for the cancellation is not one of the reasons listed for D5 or D6, you must select one of them to report on the bill. Then indicate the real reason for the cancellation in the Remarks (FL 84) of the claim.

** If adjusting the claim (3x7 TOB) to correct a HIPPS code, report condition code D9. Indicate the reason for the HIPPS code change in Remarks (FL 84).

FLs 32A THROUGH 35B - OCCURRENCE CODES (If applicable)

Enter the appropriate codes and dates where one or more occurrences are applicable. These codes identify insurance, medical, and accident and liability situations.

01  Auto Accident
02  No-Fault Insurance Involved - Including Auto Accident/Other
03  Accident/Tort Liability
04  Accident/Employment Related
05  Other Accident
11  Onset of Symptoms/Illness (34x bills)
17  Date Outpatient Occupational Therapy Plan Established or Last Reviewed
18  Date of Retirement for the Patient/Beneficiary
19  Date of Retirement - Spouse
24  Date Insurance Denied
25  Date Benefits Terminated by Primary Payer
SECTION 4

29 Date OPT Plan Established or Last Reviewed (34x bills)
30 Date OSP Established or Last Reviewed (34x bills)
33 First Day of the First Month of the Medicare Coordination Period for ESRD Beneficiaries Covered by EGHP
35 Date Treatment Started for Physical Therapy (34x bills)
44 Date Treatment Started for Occupational Therapy (34x bills)
45 Date Treatment Started for Speech Therapy (34x bills)

**FL 36 A-B - OCCURRENCE SPAN CODE AND DATES (Not Required)**

<table>
<thead>
<tr>
<th>CODE</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>74</td>
<td>Noncovered Level of Care (period of the LOA)</td>
</tr>
</tbody>
</table>

HHAs use this code to report Leave of Absence period from the inpatient hospital stay. This code will also need to appear on the inpatient hospital claim to ensure the home health (329/339) claim can process.

**FL 37 - DOCUMENT CONTROL NUMBER (If Applicable)**

When filing an adjustment or a cancellation bill, place the document control number of the claim you are replacing in this field. (XX7 or XX8)

**FLs 39A THROUGH 41D - VALUE CODES AND AMOUNTS (If Applicable)**

Enter the corresponding code and amount.

The amount field is defined as a dollar amount field.

12 Working Aged Beneficiary/Spouse with Employer Group Health Plan
13 ESRD Beneficiary in the 30-Month Coordination Period With an Employer Group Health Plan
14 Automobile, No Fault, or Any Liability Insurance
15 Workers’ Compensation
16 Public Health Service, Other Federal Agency
Section 4

41 Department of Labor (DOL) Black Lung Program
42 Veteran’s Administration (VA)
43 Disabled Beneficiary under Age 65 with LGHP
44 Amount provider agreed to accept from primary payer when this amount is less than charges but higher than the payment received (Medicare Secondary Payment is due)

47 Any Liability Insurance. Amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment.

Note: The decimal is implied and refers to the dollar and cents delimiter.

50 Physical Therapy Visits
51 Occupational Therapy Visits
52 Speech Language Pathology Visits
58 Arterial Blood Gas (PO2/PA2)
59 Oxygen Saturation (O2 Sat/Oximetry)*

*Value code amount for codes 58 & 59 are rounded to two decimals or the nearest whole percent.

Example: 56.5 will be represented as 57

61 Metropolitan Statistical Area (MSA) (Required)

Enter value code 61 and the MSA number corresponding to the site where care was rendered, not agency location. This is required for 32x and 33x type of bills. It is not allowed on a 34x type of bill.

Enter the four-digit MSA number in the value code amount field followed by a decimal and two zeros (XXXX.00). The MSA numbers for rural areas only have two (2) digits; therefore, it is necessary to submit the MSA number with two 9s preceding the MSA number (99XX.00).

Example: 61 XXXX.00

<table>
<thead>
<tr>
<th>MSA #</th>
<th>VALUE AMOUNT</th>
<th>CODE</th>
<th>PATIENT LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0040</td>
<td>0040.00</td>
<td></td>
<td>Abilene, TX</td>
</tr>
<tr>
<td>2680</td>
<td>2680.00</td>
<td></td>
<td>Ft. Lauderdale, Fl</td>
</tr>
<tr>
<td>01</td>
<td>9901.00</td>
<td></td>
<td>Rural Alabama</td>
</tr>
</tbody>
</table>
If a beneficiary’s site of service changes from one MSA code to another during the course of the episode, HHAs should report the MSA code that corresponds to the site of service at the end of episode on the FC.

**NOTE:** In the course of processing a home health claim, Medicare systems will place two or more additional value codes on the electronic claim record. These codes may be visible to providers with Direct Data Entry (DDE) access. The value codes are:

- 17 Outlier amount, if applicable
- 62 HH visits - Part A. The number of visits paid from the Part A trust fund
- 63 HH visits - Part B. The number of visits paid from the Part B trust fund
- 64 HH reimbursement - Part A. The dollar amount paid from the Part A trust fund
- 65 HH reimbursement - Part B. The dollar amount paid from the Part B trust fund

These codes are placed on the claim by Medicare systems. Providers should never submit these codes on a claim or adjust the claim to remove these value codes.

**FL 42 - REVENUE CODE (Required)**

Enter the appropriate four-digit revenue codes to identify the type of service, supply or DME provided.

Claims must report a 0023 revenue code line that matches the one submitted on the RAP for the episode. The 0023 revenue line is used to report the HIPPS code for which the anticipated payment is based. However, a charge amount is not submitted on the 0023 revenue line.

FCs subject to SCIC adjustments will contain multiple 0023 revenue code lines and HIPPS codes. However, the claim must include a 0023 revenue code line that matches the one submitted on the corresponding RAP for the episode. The claim will reject if a matching 0023 revenue line is not found.
Unlike RAPS, final claims must report all services provided to the beneficiary within the episode. Each service must be reported as a separate line item.

Line item billing by service date is required for patients entitled to both Medicare Part A and Part B. Enter the appropriate revenue code for each visit rendered followed by the date of the visit (FL 45-Service Date) for each discipline rendered. The services submitted on the claim should fall within the statement covers period in FL 6.

Supplies should not be line item billed. One entry each supply revenue code used on the claim.

Providers bill each visit as a separate line item with the appropriate HCPC code and report the number of 15-minute increments in FL 46.

**ACCEPTABLE REVENUE CODES** *

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001</td>
<td>Total Units and/or Charges</td>
</tr>
<tr>
<td>0023</td>
<td>Home Health Services</td>
</tr>
<tr>
<td>0270</td>
<td>Medical-Surgical Supplies</td>
</tr>
<tr>
<td>0274</td>
<td>Prosthetic and Orthotic Devices</td>
</tr>
<tr>
<td>0291</td>
<td>Rental of DME</td>
</tr>
<tr>
<td>0292</td>
<td>Purchase of New DME</td>
</tr>
<tr>
<td>0293</td>
<td>Purchase of Used DME</td>
</tr>
<tr>
<td>0294</td>
<td>Infusion Therapy Supplies/Drugs</td>
</tr>
<tr>
<td>0299</td>
<td>Maintenance on DME</td>
</tr>
<tr>
<td>0421</td>
<td>Physical Therapy Visit</td>
</tr>
<tr>
<td>0431</td>
<td>Occupational Therapy Visit</td>
</tr>
<tr>
<td>0441</td>
<td>Speech Language Pathology Visit</td>
</tr>
<tr>
<td>0551</td>
<td>Skilled Nursing Visit</td>
</tr>
<tr>
<td>0561</td>
<td>Medical Social Services Visit</td>
</tr>
<tr>
<td>0571</td>
<td>Home Health Aide Visit</td>
</tr>
<tr>
<td>0600</td>
<td>Other Oxygen</td>
</tr>
<tr>
<td>0601</td>
<td>Oxygen, stationary equipment</td>
</tr>
<tr>
<td>0602</td>
<td>Oxygen equipment under 1 LPM</td>
</tr>
<tr>
<td>0603</td>
<td>Oxygen equipment over 4 LPM</td>
</tr>
<tr>
<td>0604</td>
<td>Oxygen equipment portable add-on</td>
</tr>
<tr>
<td>0623</td>
<td>Medical/Surgical Supplies*</td>
</tr>
</tbody>
</table>

*Revenue code 0623 is a new code and is an extension of 027x. HHAs may voluntarily report a separate revenue code line for charges for non-routine wound care supplies, using revenue code 0623. Use this line item to report charges for ALL non-routine wound care supplies, including but not limited to surgical dressings. Palmetto GBA encourages providers to consistently and accurately report this information under revenue code 0623 so that it can be used for future refinements of the PPS rates. CMS Manual System Reference: Publication 100-2, Medicare Benefit Policy Manual, Chapter 7, Sections 50 defines routine vs. non-routine supplies.
If also reporting non-routine wound care supplies under the revenue code 0623, do not also duplicate this information under the revenue code 0270. Providers should ensure that the charge amounts for the two revenue codes are mutually exclusive.

### FL 44 - HCPCS CODES (If applicable)

Report the appropriate HIPPS code that was produced by the Grouper in the revenue code 0023 line. On claims reflecting a SCIC adjustment(s), report each additional HIPPS codes produced by the Grouper for each OASIS assessment. The earliest dated 0023 revenue code line must contain the HIPPS that was submitted on the corresponding RAP.

For all revenue lines other than 0023, report the appropriate HCPCS code as appropriate to that revenue code.

Effective July 1, 1999, the CMS created six new HCPCS codes to report 15-minute increments. Use these six codes to report service units only on type of bills 32x and 33x. These codes do not apply to type of bill 34x. The six HCPCS codes are:

- G0151 Physical Therapy
- G0152 Occupational Therapy
- G0153 Speech Pathologist
- G0154 Skilled Nurse
- G0155 Social Worker
- G0156 Home Health Aide

<table>
<thead>
<tr>
<th>RECORD TYPE</th>
<th>REV CODE</th>
<th>HCPCS</th>
<th>DATES OF SERVICE</th>
<th>UNITS</th>
<th>TOTAL CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>042X</td>
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<td>05-05-02</td>
<td>4</td>
<td>100.00</td>
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<tr>
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<td>043X</td>
<td>G0152</td>
<td>05-29-02</td>
<td>3</td>
<td>100.00</td>
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<tr>
<td>61</td>
<td>044X</td>
<td>G0153</td>
<td>05-05-02</td>
<td>5</td>
<td>100.00</td>
</tr>
<tr>
<td>61</td>
<td>055X</td>
<td>G0154</td>
<td>05-08-02</td>
<td>6</td>
<td>100.00</td>
</tr>
<tr>
<td>61</td>
<td>056X</td>
<td>G0155</td>
<td>05-03-02</td>
<td>2</td>
<td>100.00</td>
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<tr>
<td>61</td>
<td>057X</td>
<td>G0156</td>
<td>05-01-02</td>
<td>7</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The reporting of 15-minute increments does not affect the reporting requirements for the outpatient therapies.

Report therapy CPT codes in UB-92 Field Locator (FL) 44, HCPCS/Rates. Outpatient rehabilitation services that will require HCPCS coding are outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services. Additionally, when billing
the outpatient therapies (34x type of bill), make sure that correct modifiers are used. The modifiers are used for data collection to determine who provided the modality. The modifiers are:

- GN  Speech Pathologist
- GO  Occupational Therapist
- GP  Physical Therapist

Line item date of service reporting is effective for claims with dates of service on or after October 1, 1998.

<table>
<thead>
<tr>
<th>RECORD TYPE</th>
<th>REV CODE</th>
<th>HCPCS</th>
<th>DATES OF SERVICE</th>
<th>UNITS</th>
<th>TOTAL CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
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<tr>
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<td>043X</td>
<td>97010 GO</td>
<td>05-29-02</td>
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<td>160.00</td>
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<tr>
<td>61</td>
<td>044X</td>
<td>97011 GN</td>
<td>05-05-02</td>
<td>1</td>
<td>80.00</td>
</tr>
</tbody>
</table>

Note: General Medicare Advisory 98-05 for further clarification.

**FL 45 - SERVICE DATE (Required)**

Report the dates that services were provided. For each 0023 revenue code line, record the first billable service provided under each HIPPS code. Line item billing by service date is required. Enter the date that corresponds with the visit identified by the revenue code in FL 42. The service date should correspond with the visit note to identify when the visit was rendered. **Do not enter a line item date of service for DME and supplies.**

**FL 46 - UNITS OF SERVICE (Required)**

Report the appropriate units of service for each revenue code listed. This item is not required to be completed on the 0023 revenue code line, or when billing for supplies (revenue code 0270).

Effective July 1, 1999, the fiscal intermediary shared system (FISS) was changed to accommodate the 15-minute increment reporting requirements. The units of service should no longer be reported by visit count. Providers should report their units in 15-minute increments. Use the following chart to assist in the calculation of the unit:

- 1 unit  1 minute to < 23 minutes
- 2 units  ≥ 23 minutes to < 38 minutes
- 3 units  ≥ 38 minutes to < 53 minutes
- 4 units  ≥ 53 minutes to < 68 minutes
SECTION 4

<table>
<thead>
<tr>
<th>Units</th>
<th>Time Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>$\geq 68$ minutes to $&lt; 83$ minutes</td>
</tr>
<tr>
<td>6</td>
<td>$\geq 83$ minutes to $&lt; 98$ minutes</td>
</tr>
<tr>
<td>7</td>
<td>$\geq 98$ minutes to $&lt; 113$ minutes</td>
</tr>
<tr>
<td>8</td>
<td>$\geq 113$ minutes to $&lt; 123$ minutes</td>
</tr>
</tbody>
</table>

The pattern continues for longer periods of time.

For the outpatient therapies, enter the number of therapy procedures (not visits) performed on a 34x bill type. Check the Physicians’ Current Procedural Terminology (CPT) manual for the increment of time.

**FL 47 - TOTAL CHARGES (Required)**

Enter the total charge for each revenue code.

On the 0023 revenue code line, the total charges must be reported as zero in FL 47. Sum the total charges for the billing period by revenue code (column 42) and enter them on the adjacent line in column 47. The last revenue code entered in column 42, “0001”, represents the total of all charges billed. This is the sum of column 47 on all adjacent lines.

**FL 48 – NON-COVERED CHARGES (If applicable)**

Report all non-covered charges when applicable.

For no-payment claims, submit all charges on the claim as non-covered. Report the condition code 21 and complete all other items on the claim in accordance with completing payment claims.

On the 0001 Total line, enter the sum of the non-covered charges in FL 48.

**FLs 50 A,B,C THROUGH FL 66 A,B,C — PAYER INFORMATION**

Throughout this section of the UB-92, each field locator consists of three lines, labeled A, B and C. The lines A, B and C identify the primary, secondary and tertiary payers for the claim respectively. Information listed in each line should correspond and be consistent throughout the claim. Primary payer information will always be coded on line A (a), secondary payer information on line B (b) and tertiary payer information on line C (c). Please make sure that your payer information is consistent when filling out these fields.
### FL 50 A,B,C - PAYER IDENTIFICATION (Required)

If Medicare is the primary payer, enter “Medicare” on Line A. All additional entries across the A (Items 51 - 55) supply information needed by the payer named in Item 50A.

If Medicare is the secondary or tertiary payer, identify the primary payer on line A and enter Medicare information on line B or C.

### FL 51 - A,B,C - PROVIDER NUMBER (Required)

Enter the number assigned for your agency by the payer indicated in FL 50 line A, B, or C.

### FL 52 - A,B,C - RELEASE OF INFORMATION CERTIFICATE (Required)

Enter the code to indicate whether the provider has on file a signed statement permitting the provider to release information to other organizations in order to adjudicate the claim.

**Code Structure**

- **Y** Yes. The provider has a signed written authority to release medical/billing information for the purposes of claiming insurance benefits.

- **R** Restricted or modified release. The provider has limited or restricted authority to release some medical/billing information for purposes of claiming insurance benefits.

- **N** No. The provider does not have permission to release any medical/billing information.

### FL 58 - INSURED'S NAME (Required)

On the same lettered line (A, B or C) that corresponds to the line on which Medicare payer information is shown in Item 50, enter the patient’s name as shown on his or her health insurance card.
**FL 59 - PATIENT'S RELATIONSHIP TO INSURED (If Applicable)**

If claiming a secondary or conditional payment, enter the code indicating the relationship of the patient to the identified insured.

**Code Structure**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Patient is Insured</td>
</tr>
<tr>
<td>02</td>
<td>Spouse</td>
</tr>
<tr>
<td>03</td>
<td>Natural Child/Insured Financial Responsibility</td>
</tr>
<tr>
<td>04</td>
<td>Natural Child/Insured Does Not Have Financial Responsibility</td>
</tr>
<tr>
<td>05</td>
<td>Step Child</td>
</tr>
<tr>
<td>06</td>
<td>Foster Child</td>
</tr>
<tr>
<td>08</td>
<td>Employee</td>
</tr>
<tr>
<td>09</td>
<td>Unknown</td>
</tr>
<tr>
<td>15</td>
<td>Insured Plaintiff</td>
</tr>
</tbody>
</table>

**FL 60 - CERTIFICATE NUMBER, SOCIAL SECURITY NUMBER, HEALTH INSURANCE CLAIM NUMBER, IDENTIFICATION NUMBER (Required)**

On the same lettered line (A, B or C) that corresponds to the line on which Medicare payer information was shown in Items 50 - 55, enter the patient’s Medicare health insurance number.

The HIC number must agree with the HIC number entered on all documentation.

**FL 61 - INSURED GROUP NAME (If Applicable)**

When you are claiming a payment under the circumstances described in Items 58A, B or C and there is involvement of Workers’ Compensation (WC) or an Employer Group Health Plan (EGHP), enter the name of the group or plan through which that insurance is provided.
**FL 62 - INSURANCE GROUP NUMBER (If Applicable)**

When you are claiming a payment under the circumstances described under FLs 61A, B, or C and there is involvement of WC or an EGHP, enter the identification number, control number or code assigned by each health insurance carrier to identify the group under which the insured individual is covered.

**FL 63 – TREATMENT AUTHORIZATION CODE (Required)**

Enter the eighteen digits for the OASIS Matching Key produced from the Grouper software. This links the claim record to the specific OASIS assessment that was used to produce the HIPPS code submitted in FL 44.

The code consists of the three OASIS items that contain the start of care date (M0030), the date the assessment was completed (M0090) and the reason for the assessment (M0100). The matching key must be reported on the RAP and the claim exactly as it is produced by the Grouper, and will appear in one of the following two formats:

```
MMDDCCYYMMDDCCYYXX or, 
CCYYMMDDCCYYMMDDXX
```

The OASIS Matching Key must be reported on the same line (A, B, or C) that Medicare is listed in the payer fields.

On claims that reflect a SCIC adjustment, the OASIS Matching Key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue line.

**FL 64 A,B,C - EMPLOYMENT STATUS CODE (If Applicable)**

When you are claiming a payment under the circumstances described under FLs 61A, B, or C, and there is involvement of WC or an EGHP, enter the code which defines the employment status of the individual identified on the same line in FL 65.

<table>
<thead>
<tr>
<th>Code</th>
<th>Title</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Employed Full Time</td>
<td>Individual states that he or she is employed fulltime.</td>
</tr>
</tbody>
</table>
2 Employed Part Time Individual states that he or she is employed fulltime.

**FL 65 - EMPLOYER NAME (If Applicable)**

When you are claiming a payment under the circumstances described under FLs 61A, B, or C, and there is involvement of WC or EGHP, enter the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.

**FL 66 A, B, C - EMPLOYER LOCATION (If Applicable)**

Where you are claiming a payment under the circumstances described under FLs 61A, B, or C and there is involvement of WC or EGHP, enter the specific location of the employer of the individual, identified on the same line in FL 65. A specific location is the city, plant, etc., in which the employer is located.

**FL 67 - PRINCIPAL DIAGNOSIS CODE (Required)**

The principal diagnosis should reflect the primary reason for home health services. Report the full ICD-9-CM Diagnosis code, including all five digits where applicable. The principal diagnosis code reported in FL 67 must match the primary diagnosis code reported on M0230 of the OASIS assessment, and in item 11 on the Form CMS-485 plan of care.

Generally, the principal diagnosis code will match that of the RAP. However, on claims that reflect a SCIC adjustment, the principal diagnosis code should correspond to the OASIS that produced the HIPPS code on the latest dated 0023 revenue code line.

**FLs 68 THROUGH 75 - OTHER DIAGNOSES CODES (Required)**

Enter the ICD-9-CM codes for up to eight additional diagnoses conditions co-existing according to the attending physician at the time the plan of care was established.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses), and on the Form CMS-485, form item 13 (Other Pertinent Diagnoses). Other pertinent diagnoses are all conditions that co-existed at the time the plan of care was established. In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient’s condition and to
justify the disciplines and services provided in accordance with the official ICD-9-CM Guidelines for Coding and Reporting. Surgical and V codes which are not acceptable in the other diagnosis fields M0240 on the OASIS, or on the Form CMS-485, form item 13, may be reported in FLs 68-75 on the RAP if they are reported in the narrative form item 21 of the Form CMS-485.

The sequence of codes should follow ICD-9 guidelines for reporting manifestation codes. Therefore, if a manifestation codes is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on all forms.

Generally, the other diagnosis codes will match that of the RAP. However, on claims that reflect a SCIC adjustment, the principal diagnosis code should correspond to the OASIS that produced the HIPPS code on the latest dated 0023 revenue code line.

**FL 82 - UNIQUE PHYSICIAN IDENTIFICATION NUMBER (Required)**

This field should contain information regarding the attending physician that has established the plan of care with verbal orders/signed POC.

Enter the physician’s UPIN in this field followed by his/her last name, first name and middle initial.

**EXAMPLE:** B12345 Smith John M

If the physician does not have an assigned UPIN, use one of the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>INT000</td>
<td>Intern</td>
</tr>
<tr>
<td>RES000</td>
<td>Resident</td>
</tr>
<tr>
<td>PHS000</td>
<td>Public Health Servant</td>
</tr>
<tr>
<td>VAD000</td>
<td>Veteran’s Affairs</td>
</tr>
<tr>
<td>RET000</td>
<td>Retired</td>
</tr>
<tr>
<td>OTH000</td>
<td>Other</td>
</tr>
</tbody>
</table>

**FL 84 - REMARKS (If Applicable)**

Enter any remarks needed to provide information that is not shown elsewhere on the bill but is necessary for proper payment. Remarks are necessary when adjusting or canceling a FC, to indicate the reason for the adjustment/cancellation.

**FL 85 - PROVIDER REPRESENTATIVE SIGNATURE (Not Required)**

A stamped or computer generated signature is acceptable. Enter the date the provider representative signed the form.
4.7.2.1. FC UB-92 Examples

The following are examples of Final Claim UB-92.

4.7.2.2. FC Non-Transfer Situation UB-92 Example
4.7.2.3. FC No-RAP-LUPA UB-92 Example
4.7.2.4. FC SCIC Situation UB-92 Example
4.7.2.5. FC Transfer (Transferring Agency) UB-92 Example
4.7.2.6. FC Transfer (Receiving Agency) UB-92 Example
4.7.2.7. FC Cancellation UB-92 Example
4.7.2.8. FC Adjustment UB-92 Example

*Please refer to the attachment file for the FC UB-92 Examples
**UB-92 HOME HEALTH CLAIM**

**Home Address**
City, State, Zip: Anywhere, SC 90210
Telephone: 247.2.2

**Patient Control No.**
000002

**Type of Bill**
329

**Statement Covers**
06012005
07302005

**Health Care Tax No.**
06102002
06202002
06302002
06402002
06502002
06602002
06702002
06802002
06902002
07002002

**Medical Record No.**
000002

**Patient Name**
Doe, Jane M

**Patient Address**
1800 South Avenue
Anywhere, SC 90210

**Admission Condition Codes**
31

**Admission**
07101910
06012005

**Type of Bill**
329

**Patient Control No.**
000002

**Type of Bill**
329

**Statement Covers**
06012005
07302005

**Health Care Tax No.**
06102002
06202002
06302002
06402002
06502002
06602002
06702002
06802002
06902002
07002002

**Medical Record No.**
000002

**Patient Name**
Doe, Jane M

**Patient Address**
1800 South Avenue
Anywhere, SC 90210

**Admission**
07101910
06012005

**Type of Bill**
329

**Patient Control No.**
000002

**Type of Bill**
329

**Statement Covers**
06012005
07302005

**Health Care Tax No.**
06102002
06202002
06302002
06402002
06502002
06602002
06702002
06802002
06902002
07002002

**Medical Record No.**
000002

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>HCPCS/Rates</th>
<th>Serv.Date</th>
<th>Serv.Units</th>
<th>Total Charges</th>
<th>Non-Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0023</td>
<td>Home Health Services</td>
<td>HDHL1</td>
<td>06012002</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0270</td>
<td>Medical Supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0550</td>
<td>Skilled Nurse</td>
<td>G0154</td>
<td>06012002</td>
<td>2</td>
<td>150</td>
<td>0</td>
</tr>
<tr>
<td>0570</td>
<td>HH Aide</td>
<td>G0156</td>
<td>06012002</td>
<td>3</td>
<td>75</td>
<td>0</td>
</tr>
<tr>
<td>0550</td>
<td>Skilled Nurse</td>
<td>G0154</td>
<td>06102002</td>
<td>2</td>
<td>150</td>
<td>0</td>
</tr>
<tr>
<td>0570</td>
<td>HH Aide</td>
<td>G0156</td>
<td>06102002</td>
<td>2</td>
<td>75</td>
<td>0</td>
</tr>
<tr>
<td>0550</td>
<td>Skilled Nurse</td>
<td>G0154</td>
<td>06202002</td>
<td>2</td>
<td>150</td>
<td>0</td>
</tr>
<tr>
<td>0570</td>
<td>HH Aide</td>
<td>G0156</td>
<td>06202002</td>
<td>2</td>
<td>75</td>
<td>0</td>
</tr>
<tr>
<td>0420</td>
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<td>G0151</td>
<td>06252002</td>
<td>3</td>
<td>200</td>
<td>0</td>
</tr>
<tr>
<td>0550</td>
<td>Skilled Nurse</td>
<td>G0154</td>
<td>06302002</td>
<td>2</td>
<td>150</td>
<td>0</td>
</tr>
<tr>
<td>0570</td>
<td>HH Aide</td>
<td>G0156</td>
<td>06302002</td>
<td>2</td>
<td>75</td>
<td>0</td>
</tr>
<tr>
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<td>3</td>
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<td>0</td>
</tr>
<tr>
<td>0550</td>
<td>Skilled Nurse</td>
<td>G0154</td>
<td>07202002</td>
<td>2</td>
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<td>0</td>
</tr>
<tr>
<td>0570</td>
<td>HH Aide</td>
<td>G0156</td>
<td>07202002</td>
<td>2</td>
<td>150</td>
<td>0</td>
</tr>
<tr>
<td>0420</td>
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<td>3</td>
<td>200</td>
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<tr>
<td>0550</td>
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<td>G0154</td>
<td>07292002</td>
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<td>150</td>
<td>0</td>
</tr>
<tr>
<td>0001</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Payer**
Medicare

**Provider No.**
nnnnnnn

**Prior Payments**
Y

**Due From Patient**

**Insured's Name**
Doe, Jane M

**Cert.-SSN-HIC.-ID No.**
nnnnnnnnnnn

**Group Name**

**Insurance Group No.**

63 Treatment Authorization Codes

64 ESC

65Employer Name

66 Employer Location

67

Other Diagnosis Codes

68 Code

69 Code

70 Code

71 Code

72 Code

73 Code

74 Code

75 Code

76 ADM. Diag.

77 E-Code

82 Attending Physician ID

Amnnn A Good MD

83 Other Physician ID

84 Other Physician ID

85 Provider Representative

86 Date

Certify the certifications on the reverse apply to type bill and are made a part.
**Patient Control No.**: 000002

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**12. Patient Name**: Doe, Jane M

**13. Patient Address**: 1800 South Avenue, Anywhere, SC 90210

**23. Medical Record No.**: 000002 329

**00.01 Home Health Services**: HDHL1 06012002 0 00

**0550 Skilled Nurse**: G0154 06012002 2 150 00

**0570 HH Aide**: G0156 06062002 2 75 00

**0550 Skilled Nurse**: G0154 06062002 2 150 00

**0570 HH Aide**: G0156 06062002 2 75 00

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**55. Estimate Amount Due**: 0001

**56. Due From Patient**: Doe, Jane M 01

**61. Group Name**: nnnnnnnnnA

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**63. Treatment Authorization Codes**: 0601200206012002

**64. ESC**: 65

**65. Employer Name**: nn

**66. Employer Location**: nn

**67. Other Diagnosis Codes**: 00000206012002

**78. Attending Physician**: nn

**83. Other Physician**: nn

**84. Remarks**: (Final Claim-No-Rap-Lupa)
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- **Date:** 06012002
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### Medical Supplies
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- **Amount:** 64.37

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- **Amount:** 75.00

### Skilled Nurse G0154
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### HH Aide G0156
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### Physical Therapy G0151
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- **Type:** 3
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### Skilled Nurse G0154
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### Physical Therapy G0151
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- **Type:** 3
- **Amount:** 150.00

### HH Aide G0156
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- **Type:** 3
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### Skilled Nurse G0154
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### Physical Therapy G0151
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### Medicare A
- **Due From Patient:** Y

### Doe, Jane M
- **Cert.-SSN-HIC.-ID No.:** nnnnnnnnnA

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### Other Phys. Id
- **Attending Phys. Id:** A Good MD

### Provider Representative
- **Date:** nnnnnnnnnnnn

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**Final Claim-Transfer Situation/Beneficiary to Your HHA**
# 4.7.2.7. FC Cancellation UB-92 Example

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### 12 PATIENT NAME
Doe, Jane M

### 13 PATIENT ADDRESS
1800 South Avenue
Columbia, SC  90210

### 24 BIRTHDATE
07101910

### 15 SEX
F

### 16 MS
06012005

### 17 DATE
1

### 20 SRC.
30

### 19 TYPE
D6

### 21 D HR
37

### 22 STAT
A

### 23 MEDICAL RECORD NO.
D6

### 32 OCCURRENCE
61

### 33 OCCURRENCE
1760

### 34 OCCURRENCE
00

### 35 OCCURRENCE
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### 36 OCCURRENCE SPAN
20002332340508

### 38 CODE
a

### 39 VALUE CODE
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### 40 VALUE CODE
1760

### 41 VALUE CODE
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### 42 REV.CD.
0023

### 43 DESCRIPTION
Home Health Services

### 44 HCPCS/RATES
HDHL1

### 45 SERV.DATE
06012002

### 46 SER. UNITS
0

### 47 TOTAL CHARGES
0

### 48 NON-COVERED CHARGES
0

### 50 PAYER
Medicare A

### 51 PROVIDER NO.
nnnnnnn

### 55 PRIOR PAYMENTS
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### 56 EST. AMOUNT DUE
Y

### 57 DUE FROM PATIENT

### 58 INSURED'S NAME
Doe, Jane M

### 59 P.REL
01

### 60 CERT.-SSN-HIC.-ID NO.
nnnnnnnnnA

### 61 GROUP NAME

### 62 INSURANCE GROUP NO.

### 63 TREATMENT AUTHORIZATION CODES

### 64 ESC
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### 65 EMPLOYER NAME

### 66 EMPLOYER LOCATION

### 67 OTHER DIAG. CODES

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### 76 ADM. DIAG.

### 77 E-CODE

### 78 OTHER DIAG. CODES

### 79 OTHER PROCEDURE

### 80 PRINCIPAL PROCEDURE

### 82 ATTENDING PHYS. ID
Annnnn A Good MD

### 83 OTHER PHYS. ID

### 85 PROVIDER REPRESENTATIVE

### 86 DATE
Y

---

**CANCELED CLAIM TO CORRECT HIPPS CODE**

(CANCELLATION)
**Home Health Address**
City, State, Zip
Telephone

**Patient Control No.**
000002

5 FED. TAX NO.  
6 STATEMENT COVERS  
7 COV. D.  
8 N-C D.  
9 C-I D.  
10 L-R D.  
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**Type of Bill**
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**4.7.2.8. FC Adjustment UB-92 Example**

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**Patient Name**
Doe, Jane M

13 **Patient Address**
1800 South Avenue
Columbia, SC 90210

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**Birthdate**
07/10/1910

**Sex**
F

**SSN**
0003112345

**Patient Control No.**
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**Statement Covers**
CITY, STATE, ZIP

**Telephone**
06012005 07302005

**Patient Control No.**
327

**Type of Bill**

- Medicare
- Non-Covered Charges
- Insured's Name
- Group Name
- Insurance Group No.
- Due From Patient
- Provider Representative

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<td>00</td>
</tr>
</tbody>
</table>

**Skilled Nurse**

<table>
<thead>
<tr>
<th>HCPCS/Rates</th>
<th>Serv.Date</th>
<th>Serv.Units</th>
<th>Total Charges</th>
<th>Non-Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0154</td>
<td>06/30/02</td>
<td>0</td>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td>G0156</td>
<td>06/30/02</td>
<td>0</td>
<td>00</td>
<td>00</td>
</tr>
</tbody>
</table>

**Insured's Name**
Doe, Jane M

**Provider No.**

51

85 **Provider Representative**

<table>
<thead>
<tr>
<th>Code</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>521881</td>
<td>25011</td>
</tr>
</tbody>
</table>

**Social Security Number**

<table>
<thead>
<tr>
<th>Code</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Good MD</td>
<td></td>
</tr>
</tbody>
</table>

**Other Diag. Codes**

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>531881</td>
<td>25011</td>
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</tbody>
</table>

**Other Procedure**

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>51881</td>
<td>25011</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Principal Procedure**

Adjustment line item date of service on last therapy visit-from 07/24 to 07/25/2002, and changed 15-minute increments from 3 to 4.

1 CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART.
4.8. Adjustment Claims

Adjustment bills are the most common mechanism for correcting a previously processed claim. Emphasis on timely and cost-effective adjustment processing is a priority with the CMS. As in filing any claim to Medicare, if a provider fails to include a particular item or service on its original bill or the claim processed incorrectly, an adjustment bill should be submitted within the established Medicare timeliness standard (Section 4.4).

If there have been any duplicate payments or any OIG overpayments, the Fiscal Intermediary will recoup the funds. The offsetting adjustment claim will appear on the provider’s remittance advice(s).

The following information indicates how an adjustment claim should be submitted.

4.8.1. How to file an adjustment/cancellation bill

1. The original bill must process and appear on the RA before an adjustment or cancellation can be made.

2. The third digit of the type of bill (frequency) must be changed to a “7” for an adjustment or “8” for a cancellation. For example: 327, 337, 347 or 328, 338, 348.

3. In fields 24 – 30, indicate the reason for the adjustment by entering an appropriate condition code (D0 – D4, D7 – D9, E0). For a cancellation claim, the only acceptable condition codes are D5 or D6.

4. Enter the document control number (DCN) of the original claim in field 37 of the UB-92. The DCN can be found on the remittance advice.

5. For an adjustment, make the necessary changes to the items being corrected.

6. If using DDE an Adjustment Reason Code (OT) must be entered on page 3.

7. Review all corrections (you will not make any corrections if you are canceling the claim).

8. Enter “Remarks” explaining the reason for the adjustment OR cancellation in field 84 of the UB-92 or page 4 using DDE.

9. Submit the adjustment/cancellation bills using your vendor billing software or via the DDE system.
10. In rare instances when the adjustment or cancellation bill needs to be sent hardcopy to Palmetto GBA, forward to the appropriate regions:

**For Southeast, and Southwest Regions:**
Medicare Part A, Claims Processing Dept.
Mail Code: CM-218
2300 Springdale Drive
Camden, SC  29020

**For Gulf Coast and Midwest Regions:**
Medicare Part A, Claims Processing Dept.
Mail Code: CA-103
34650 U.S. Hwy 19 N, Suite 202
Palm Harbor, FL 34684-2156

*Note:* You may not adjust a previously denied item; a written request for reconsideration must be submitted if you wish to correct a previously denied item.

### 4.9. Return to Provider (RTP) Report

**What is a Return to Provider (RTP) Report?**

An RTP report is used to notify those providers without DDE access that a specific claim is unable to be processed and requires provider action. When a claim is submitted and cannot be processed because of incorrect or incomplete information, the claim is returned with a reason code. The reason code details the error(s) on the claim and provides suggestive corrective action. A claim will not process unless it is corrected. It is the provider’s responsibility to make all necessary corrections.

It is the responsibility of the provider to correct the errors based on the reason codes identified on the RTP report. An example of an RTP report is illustrated in this manual.

Palmetto GBA encourages providers to correct the suspended claims timely to avoid having claims purge from the system. If a claim purges from the system, you must file the claim as a new claim. Verify that all corrections have been made before re-filing the claim.

**How are corrections made?**

Corrections may be made either hard copy or electronically.

**Hard copy: (2 ways)**

1. Attach any necessary documents to the RTP.
2. Use the RTP Report to make corrections.

- Locate the reason code(s) on the RTP.
- Make the corrections in red ink on the RTP report beside the claim you are correcting.
- Attach any necessary documents (i.e., Medicare Development form) to the RTP.
- Submit corrections to:
  
  **For Southeast, Southwest Regions:**
  Medicare Part A, Claims Processing Dept.
  Mail Code CM-218
  2300 Springdale Drive
  PO Box 7004
  Camden, SC 29020

  **For Midwest, Gulf Coast Regions:**
  Medicare Part A, Claims Processing Dept.
  Mail Code CA-125
  34650 US 19 North, Suite 202
  Palm Harbor, FL 34684

**Electronically**

Corrections must be made on-line via direct data entry (DDE). Please refer to the DDE manual available on our Web site, [www.palmettogba.com](http://www.palmettogba.com), for instructions.

**How long do you have to correct the errors?**

The claim will remain in an RTP status for 60-days. Following the 60th day, the claim will purge from the system. If the claim purges, it will not be detailed in a purge report. In order to have the claim processed, you must file the claim as a new claim. Verify that all corrections have been made before re-filing the claim.

*Note: It is highly recommended providers work their RTP claims regularly to avoid processing delays. Claims in an RTP status location (T B9997) will not be processed.*

**How often is the RTP Report generated?**

The RTP report is generated daily detailing the claims suspended from the previous night’s batch cycle. The RTP report is not cumulative and details only the claims suspended from the previous night’s batch run. The FISS does not generate a purged report.
Note: Effective September 1, 2005 providers enrolled in DDE will no longer receive hard copy RTP reports. Corrections must be made on-line via direct data entry.

4.9.1. RTP Report Descriptors

The following are field descriptors for the RTP report. The item numbers refer to the example included following this section. The descriptor numbers beside the item name have been added to this RTP report to aid in the education process. An actual RTP report does not include the descriptor numbers.

<table>
<thead>
<tr>
<th>ITEM 1 - RUN DATE</th>
<th>(MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The date this RTP report was generated. This is the date the claim was returned to the provider for action due to missing or incorrect information contained on the claim. It is the provider’s responsibility to correct the errors.</td>
<td></td>
</tr>
</tbody>
</table>

*Note: The RTP claim will remain in suspense for 60-days. If the claim is not corrected within 60-days, the claim will purge from our system. Once a claim purges from the system, it would need to be re-submitted as a new claim.*

<table>
<thead>
<tr>
<th>ITEM 2 - PROVIDER NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health agency’s Medicare provider number.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 3 - PROVIDER NAME &amp; ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health agency’s name and address.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 4 - HIC/CERT/SSNO</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient’s Medicare health insurance card (HIC) number.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 5 - PCN/DCN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCN:</strong> The patient’s control number as assigned by your agency for this specific patient. The PCN is the patient’s medical record number as listed on the claim in field locator 3 of the UB-92.</td>
</tr>
</tbody>
</table>

| **DCN:** The claim’s document control number. The DCN is unique to this claim. |
### ITEM 6 - TYPE OF BILL

The type of bill submitted for processing as listed on the claim in field locator 4 of the UB-92.

### ITEM 7 - PROVIDER NUMBER

Your Medicare provider number.

### ITEM 8 - NAME

Patient’s last name, first name as listed on the claim.

### ITEM 9 - ADMIT

Admit date as listed on the claim in field locator 17 of the UB-92.

### ITEM 10 - COV FM

The covered FROM date on the claim as listed in field locator 6 of the UB-92.

### ITEM 11 - COV TO

The covered TO date on the claim as listed in field locator 6 of the UB-92.

### ITEM 12 - TOTAL CHARGES

The total submitted charges as listed on the claim in field locator 42 of the UB-92.

### ITEM 13 - REASON CODE & DESCRIPTION

The specific reason the claim was returned for action. The claim was returned for missing or incorrect information. It is the provider’s responsibility to correct the information and return the claim for processing.

If more than one claim has been returned for action, the claims are listed in alphabetical order by last name.
ITEM 14- TOTAL RETURNED CLAIMS

The total number of claims returned for action and total submitted charges.
4.9.2. RTP Example

(1) PROGRAM NBR: FSNP0005
(2) Provider Number: 00-7999
RUN DATE: 06/04/02
PAGE NBR: 1

(3) HAPPY HOME HEALTH
2300 SPRINGDALE DRIVE
CAMDEN, SC 29020

(4) (5) (6) (7) (8) (9) (10) (11) (12)
HIC/CERT/SSNO PCN/DCN TYPE BILL PROVIDER NAME ADMIT COV
FM COV TO TOTAL CHGS nnnnnnnnnnnn A 123456nnnnnn 329 nnnnnnn FICIARY BENE 092401 092401
112201 3,222.75
2021510nnnnnnnn

(13) W0453 THIS CLAIM IS BEING RETURNED BECAUSE AN INVALID ICD-9 CODE HAS BEEN REPORTED FOR THE 2ND DIAGNOSIS CODE. PLEASE REFER TO THE LATEST ICD-9-CM CODING BOOK TO VALIDATE CODE AND TO ENSURE THAT THE STATEMENT COVERED DATES OF YOUR CLAIM FALL WITHIN THE EFFECTIVE DATE OF THE ICD-9 CODE YOU ARE USING. PLEASE CORRECT AND RESUBMIT/REKEY.
APPLICABLE TO TYPE BILL: 32X, 33X, AN OCCURRENCE CODE 27 IS PRESENT ON THE CLAIM; HOWEVER, THE DIFFERENCE BETWEEN THE ASSOCIATED OCCURRENCE CODE 27 DATE AND CLAIM FROM DATE IS GREATER THAN 62 DAYS; OR THE OCCURRENCE CODE 27 DATE IS GREATER THAN THE THRU DATE. YOU MUST USE THE PLAN OF TREATMENT CERTIFICATION OR RECERTIFICATION DATE THAT APPLIES TO THE DATES OF SERVICE YOU ARE BILLING ON THE CLAIM. PLEASE CORRECT AND SUBMIT/REKEY.

(13) 30720 THIS REASON CODE IS ASSIGNED FOR HOME HEALTH TYPE OF BILLS 3X2 AND 3X9. THE TREATMENT AUTHORIZATION CODE IS NOT PRESENT OR IS NOT VALID. THE VALID FORMAT FOR HOME HEALTH TYPE OF BILLS IS EIGHTEEN NUMERICs.
IF THE TYPE OF BILL IS EQUAL TO 3X2 OR 3X9, AND THE DATE OF SERVICE IS 10/01/00 OR GREATER, THEN THE ADMISSION SOURCE MUST BE 1 THRU 9, A, B, OR C.
4.10. Additional Development Request (Non-Medical)

An additional development request (ADR) is a request for documentation. There are two types of ADRs, medical and non-medical. A medical ADR is a request for medical records due to a focused medical review edit.

A non-medical ADR is a request for claims processing documentation, i.e., DME information. Providers have 30 days in which to respond to the request. The ADR shown in Section 4.10.1 is an example of a non-medical ADR.

Providers have 30 days to respond to the request for additional claim processing information. If the documentation is not received within 30 days, the claim will be reviewed based on the documentation on hand. Claims are NO LONGER returned to the provider (RTP’d) to request the records. If no documentation is received, the medical review nurses will not have the needed medical records to support the HIPPS code billed and the claim will likely be denied as not able to support medical necessity.

If the HHA disagrees with the claim denial, they will need to take the appropriate actions to file an Appeal/Reconsideration to Palmetto GBA. The process for appeal/reconsideration is shown in Section 9 of this training manual. The request must be filed within 120 days of the date of the remittance advice for the denied claim.
4.10.1. ADR Example

Non-Medical ADR

Medicare
Palmetto GBA
Part A Intermediary, Regional Home Health Intermediary
2300 Springdale Drive, Post Office Box 7004
Camden, South Carolina 29020-7004

REPORT: 001 MEDICARE PART A - 00381 PROVIDER
NUMBER: nnnnnnn DATE: 6/04/02 ADDITIONAL DEVELOPMENT REQUEST TYPE
REQUEST: NON-MEDICAL BILL TYPE: 339

HAPPY HOME HEALTH
123 MEDICARE DRIVE
ANYTOWN, SC 12345-3400

WE HAVE REVIEWED YOUR CLAIM RECORDS AND FOUND THAT ADDITIONAL DEVELOPMENT WILL BE NECESSARY BEFORE PROCESSING CAN BE FINALIZED. TO ASSIST YOU IN PROVIDING THE REQUIRED INFORMATION, WE HAVE ASSIGNED REASON CODES TO THE AFFECTED CLAIM RECORD (SEE BELOW) FOR YOUR REVIEW. PLEASE REFER TO THE ACCOMPANYING LIST FOR EXPLANATION OF THE ASSIGNED CODE, AND ENTER THE REQUIRED INFORMATION IN THE SPACE PROVIDED BELOW EACH CLAIM RECORD AND RETURN WITHIN 35 DAYS TO THE ATTENTION OF:

MEDICARE PART A CLAIMS PROCESSING
PO BOX 7004
STATION AG-230
CAMDEN SC 29020-7004

MEDICAL REC NO. PATIENT NAME/DCN HIC NUMBER FROM/TO OPR-MED TOTAL ANALYST CHARGES
1962490nnnnnnn FICIARY BENE 04/01/02 UNMYCHR
2,867.33
nnnnnnnnA 05/30/02
REASONS: 36400

NO DME RECORD IS PRESENT. PLEASE SUBMIT A DME INFORMATION RECORD FOR EACH HCPCS ON THE CLAIM. THIS REQUIREMENT CAN BE MET BY SUBMITTING ONE OF THE FOLLOWING:

1. CERTIFICATION OF MEDICAL NECESSITY (CMN) FORM.
2. DME WORKSHEET WITH THE PHYSICIAN’S WRITTEN OR VERBAL ORDERS ATTACHED.

ALL OF THE ABOVE REQUIREMENTS REQUIRE A PHYSICIAN’S SIGNATURE AND A DATE. PLEASE ATTACH ALL INFORMATION TO YOUR ADR AND MAIL TO US. DO NOT RESUBMIT THE CLAIM.
### 4.11. COMMON REASON CODE ERRORS FOR HOME HEALTH

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>CORRECTIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>W0452</td>
<td>Invalid/Missing Dx</td>
<td>Review the Diagnoses codes for the Diagnosis Code following (Fields 68-75):</td>
</tr>
<tr>
<td>W0453</td>
<td></td>
<td>The RTP Code represents the position of the error, i.e., W0452 reflects an error in Field 68.</td>
</tr>
<tr>
<td>W0454</td>
<td></td>
<td>Accuracy of coding (Refer to the ICD-9-CM Code Book).</td>
</tr>
<tr>
<td>W1463</td>
<td></td>
<td>If Diagnosis code is incorrect make the necessary corrections on the OASIS, POC and the claim</td>
</tr>
<tr>
<td>W1464</td>
<td></td>
<td>If the type of bill is equal to 3x2 or 3x9, and the date of service is 10/01/00 or greater, then the admission source must be 1 thru 9, A, B or C.</td>
</tr>
<tr>
<td>W1465</td>
<td></td>
<td>Patient status will apply for dates of service 10/01/00 and after if the type of bill is equal to 3x2 and patient status is not equal to 30. If the type of bill is equal to 3x9 and patient status is not numeric or 01 or equal to 01 thru 01, 20, 30, 50, 51, 62, 63.</td>
</tr>
<tr>
<td>W1466</td>
<td></td>
<td>Review the principle diagnosis code Diagnosis Code(Field 67).</td>
</tr>
<tr>
<td>11801</td>
<td>Invalid/Missing SOA</td>
<td>The patient’s last name and/or first initial does not match what was found on the bene record for the HICN. Please review patient’s Medicare eligibility card; correct any errors and resubmit.</td>
</tr>
<tr>
<td>12100</td>
<td>Invalid Patient Status</td>
<td>This reason code is assigned for home health type of bills 3x2 and 3x9. The Treatment Authorization Code is not present or is not valid. The valid format for home health type of bills is eighteen numerics.</td>
</tr>
<tr>
<td>30715</td>
<td>Name not match Record</td>
<td>An adjustment (XX7) or Cancellation Condition Code (XX8) bill has been submitted without an appropriate condition code (D0-D9, E0) to describe the reason for the adjustment or cancellation claim.</td>
</tr>
</tbody>
</table>
Use the appropriate condition code that describes the reason for the change. Only one “D” condition code may be used on a claim. If more than one reason exists, use D9 as the condition code and detail the reasons in the remarks field (Field 84) of the UB-92.

Refer to the billing section for valid condition codes. (Section 4.7.2, FL 24)

**Note:** *remember to reference the original DCN on XX7 and XX8 claims.*

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>CORRECTIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>31018</td>
<td>Invalid Through Date</td>
<td>Effective 10/01/00 — This reason code is assigned to home health type of bills 329 and 339. The statement Through date must not be greater than 60-days after the From date.</td>
</tr>
<tr>
<td>31755</td>
<td>Invalid/Missing line item service date</td>
<td>This reason code will be assigned if home health type of bill 3x2 or 3x9 is entered and the following criteria is not a match: the admission date, the From date and the 0023 line item service date or, revenue code 0023 is not found or, if FC, each 0023 service date must equal a visit service date.</td>
</tr>
<tr>
<td>32002</td>
<td>Admission Date Prior To</td>
<td>The patient’s SOC date (Field 17) is before the Provider Effective Date provider’s Medicare effective date. Verify the patient’s SOC. Agencies may not bill to Medicare prior to their enrollment into the Medicare Program.</td>
</tr>
<tr>
<td>31306</td>
<td>Invalid Payment Indicator</td>
<td>The claim has a source of payment indicator (Field 50) that does not match the value code (Field 39-41) for Medicare Secondary Payer claims.</td>
</tr>
<tr>
<td>38050</td>
<td>Exact Duplicate Claim</td>
<td>This claim is an exact duplicate of a previously submitted home health claim.</td>
</tr>
<tr>
<td>38055</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38107</td>
<td>No Matching RAP</td>
<td>An HH FC (329 or 339) is being processed and an HH RAP (322 or 332) does not exist. Or,</td>
</tr>
</tbody>
</table>
one of the following fields on the FC do not match the RAP:
— Statement From Date
— Admission Date
— HIPPS Code
— 0023 Line Item Date for HIPPS Code
— Provider Number

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>CORRECTIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>32902</td>
<td>Timeliness Error</td>
<td>The claim was not submitted timely.</td>
</tr>
<tr>
<td>37528</td>
<td>Cross Reference Claim Missing</td>
<td>The cross reference claim has not completely processed. Before the original claim may be adjusted or deleted, the cross reference claim must be in the final location. The original bill must appear on the remittance advice. Remember to use the appropriate condition codes to describe the reason for the change.</td>
</tr>
<tr>
<td>32400</td>
<td>HCPCS Code Required</td>
<td>According to the revenue code file, a HCPCS is required for the line item being edited; however, no HCPCS is present and the covered charges for the line item are greater than zero. Please correct and resubmit/retype. Hard copy submitters resubmit this RTP report with your corrections.</td>
</tr>
</tbody>
</table>

*Note: Work RTP claims regularly to avoid processing delays.*
4.12. Home Health Advance Beneficiary Notice (HHABN)

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 30, Section 60

4.12.1. Frequently Asked Question concerning the HHABN?

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 30, Section 60.1

- The HHABN is a written notice that home health agencies give to Medicare beneficiaries when the HHA believes that Medicare will not pay for some or all of the physician ordered services.

Why should all HHAs use a HHABN?

- Under the Medicare Provider Agreement, a provider agrees to accept the responsibility of notifying a beneficiary in writing if any services will not be covered by Medicare.

- To inform the beneficiary that you expect a Medicare payment denial for one of the following reasons:
  - services not medically reasonable and necessary
  - failure to meet homebound and/or intermittent criteria
  - due to the custodial care exclusion.

- To advise the beneficiary, orally and in writing, before home health care is initiated or continued that, in your opinion, the beneficiary will be fully and personally responsible for payment for the home health services denied by Medicare. To be “fully and personally responsible for payment” means that the beneficiary will be liable to make payment “out-of-pocket,” through other insurance coverage, or through Medicaid.

- To convey that the beneficiary has the right to seek an official Medicare determination regarding the proposed discontinuation of Medicare covered services.

To whom should the HHABN be given?

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 30, Section 60.2.5
• The HHABN is to be issued to individuals enrolled in the Medicare Fee-For-Service program, Parts A and B.

• An HHABN may be given to the Medicare beneficiary or to the beneficiary’s authorized representative.

**When should a HHABN be used?**

**Reference:** CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 30, Sections 60.3 and 60.3.2

• The HHABN must be given to the beneficiary when one of three triggering events occurs and the care is ordered by a physician, but the HHA believes that Medicare will not pay. If a triggering event occurs a new HHABN would be issued and would only be valid for one year. One year is the limit for the use of a single HHABN for an extended course of treatment; if the course of treatment extends beyond one year, a new HHABN is required for the remainder of the course of treatment. The three triggering events are:
  • Initiation of Services — whenever you advise a beneficiary prior to initiating services, that you will not accept them as a Medicare patient, because you expect Medicare will not pay for the services.
  • Reduction of Services — whenever you advise a beneficiary prior to reducing services, that you intend to reduce their home health services because you expect that Medicare will not pay for some of the services, or for any of the services at the frequency currently ordered.
  • Termination of Services — whenever you advise a beneficiary prior to stopping or discontinuing services, that you intend to terminate all of their home health services because you expect that Medicare will not continue to pay for any of the services ordered.

• The HHABN must be given to the beneficiary before reducing or terminating home health care the beneficiary is already receiving if the physician’s order for such care would still continue the care, but you expect Medicare to deny payment for the home health services.

• The notices must be issued each time, and as soon as, the provider makes the assessment that it believes that Medicare payment will not be made. HHAs are expected to notify beneficiaries no later than the end of the business day following the day on which the determination was made.

• The HHABN should not be used in situations where a physician has not ordered care, or has changed or ended the care plan.
4.12.2 Delivery of the HHABN

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 30, Sections 60.3.3, 60.3.4, and 60.3.5

- Delivery occurs when the beneficiary or authorized representative has received and can understand the notice.

- The HHA should hand-deliver the notice to the beneficiary or authorized representative whenever possible. The notice may also be mailed. However, delivery is the responsibility of the HHA and non-receipt of the notice may result in the HHA being held liable under the LOL provisions. Therefore, it is in the best interest of the HHA to hand-deliver the notice.

- In the case of extreme circumstances (severe weather, etc…) a telephone notice may be given to the beneficiary or authorized representative. However, a telephone notice is not sufficient notice for the purposes of limiting any liability, as the content of the telephone notice cannot be verified. Therefore, any telephone notice given must be immediately followed up with a mailed or hand-delivered written notice.

- Notices must be written in lay or simple language, and beneficiaries or their representatives must be able to comprehend the notice. Examples of instances where a beneficiary or his/her representative are deemed not to be able to comprehend the notice include, but are not limited to:
  - A comatose person, a confused person (i.e., someone experiencing senility, dementia, Alzheimer’s), a legally incompetent person, a person under great duress
  - A person who does not read the language in which the notice is written, a person who is not able to read at all or who is functionally illiterate to read any notice
  - A blind person or otherwise visually impaired person who cannot see the words on the page
  - A deaf person who cannot hear an oral notice being given by phone, or could not ask questions about the printed word without a translator

- An incomprehensible notice, or a notice which the beneficiary or his/her authorized representative is incapable of understanding is not sufficient notice and the beneficiary cannot be held liable where the LOL provisions apply and you may be held liable. In addition, failure to provide a comprehensible notice is a violation of the conditions of participation and may result in enforcement action.

- The HHABNs must contain detailed explanations of why services either are no longer medically necessary, or why services are believed to be non-covered.

- The HHA also must answer timely, accurately and completely any questions from the beneficiary or authorized representative who request further information and/or assistance in understanding and responding to the notice. If requested, you must
supply the basis for your determination, the beneficiary’s potential financial liability, and access to any medical record information to the extent allowed under State law. When such disclosure is prohibited under State law, you must advise the beneficiary or authorized representative how to obtain the information from the RHHI once a demand bill has been submitted to Medicare.

4.12.3. Form of HHABNs

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 30, Sections 60.1.1, 60.1.3 and 60.4

- Providers must use the OMB approved Form CMS-R-296. The HHABN must be prepared with an original and at least one patient copy. HHAs must use these one-page approved HHABN forms for services furnished on or after January 1, 2004.

- The form may be printed, copied or electronically generated, as long as it meets all of the format requirements of the approved Form CMS-R-296. NCR paper printing is permitted.

- Arial or Arial Narrow font, in the font range of 10 to 12 point, is recommended. Italics should not be used. This includes the print used to fill in blank spaces on the form.

- The precise approved format of the newly approved one-page Form CMS-R-296 is available in PDF form posted on the CMS Web site at: [http://www.cms.hhs.gov/medicare/bni/default.asp?](http://www.cms.hhs.gov/medicare/bni/default.asp?)

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 30, Sections 60.5

- General Medicare program rules regarding who may sign for a beneficiary apply to HHABNs. A beneficiary’s authorized representative may sign the notice in the place of a beneficiary who is incapable of signing the notice.

- For any given HHABN, you should make an original and two copies. Give the original to the beneficiary to sign and return to you; send one copy to the physician; and keep the other copy on file.
• If the beneficiary or his/her authorized representative refuses to sign the notice, you are not obligated to furnish services to the beneficiary because the beneficiary has not agreed to be fully and personally responsible for payment for services not covered by Medicare. In this situation, annotate your copy of the HHABN, indicating the persons and circumstance involved.

4.12.5. What should be done with a HHABN after it is completed?

• Obtain the signed original HHABN from the beneficiary as soon as possible after it is signed. Annotate the HHABN with the date of receipt from the beneficiary. The HHA must retain a copy of the signed HHABN on file and return a copy, with the date of your receipt, to the beneficiary within 30 calendar days.

4.12.6. Effectuating Beneficiary choices on the HHABN

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 30, Sections 60.4.4

• The beneficiary must select a choice, either A, B, or C to indicate their decision to:
  • Have Medicare make an initial determination on the claim
  • Not receive the services in question or,
  • Receive the services, but have no initial determination from Medicare

• Option A — If the beneficiary selects option A, the HHA must promptly (within their normal billing cycle) submit a demand bill to Medicare in accordance with official demand billing instructions. The HHA may request payment from the beneficiary or other third party payers once the demand bill has been submitted and while awaiting a decision from Medicare. If the RHHI determines that the services are covered, the HHA must refund any amounts collected from the beneficiary or other third party payers.

• Option B — If the beneficiary selects either box under option B, the beneficiary chooses to receive the services in question. The beneficiary agrees to have a claim submitted to their insurance and is responsible for any amount the insurance will not pay. No claim will be submitted to Medicare.
  • Option B1 – Beneficiary agrees to have claim submitted to their insurance and Not Medicare.
  • Option B2 – Beneficiary requests neither insurance nor Medicare be billed for services. Patient is considered to be a private-pay case. Beneficiary fully responsible for payment.

• Option C — Patient has elected Not to receive the home health services believed not to be covered by Medicare.
4.13. Demand Billing and Billing For Denial

Reference: CMS Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 10, Section 50

4.13.1. Submitting Demand Bills

Beneficiaries may request that a demand bill be sent to Palmetto GBA for an official Medicare claim determination for services that their HHA deems to be non-covered by Medicare. This is appropriate for any situation where the beneficiary is determined to not meet the Medicare Home Health eligibility criteria, or for services considered to not be medically reasonable and necessary. The beneficiary must be properly notified by the HHA with a Home Health Advanced Beneficiary Notice (HHABN) prior to rendering the services in question. Once the demand bill is sent to Palmetto GBA, the HHA may bill the beneficiary or third party payer while awaiting the official Medicare decision. If Palmetto GBA determines that some or all of the disputed services are covered, the HHA must refund the collected funds to the appropriate party. If Palmetto GBA determines that none of the disputed services may be covered by Medicare, the HHA may keep the collected funds unless further investigation proves that proper HHABN notification was not provided.

4.13.2. Billing Requirements

All PPS episodes require that a RAP and a FC be submitted for each 60-day episode. This is the same for demand billing episodes. A RAP should be submitted timely, and be followed up with the FC upon discharge or at the conclusion of the 60-day episode. The FC (329 TOB) will serve as the demand bill. RAPs (322 TOB) may NOT be submitted as demand bills.

4.13.2.1. UB-92 Requirements for Demand Bill

In addition to the information required on all PPS 329 bill types, the following must be included on the demand bill:
- FL 4, Type of bill — 329
- FL 24 – 30, Condition Codes — report the condition code “20”
- FL 42, Revenue Codes — report the 0023 revenue code along with the appropriate HIPPS code on the claim
- FL 48 , Non-covered Charges — report all disputed services as non-covered charges
- FL 63, Treatment Authorization Code — report the appropriate OASIS Matching Key

4.13.3. Billing for Denial Notices

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing Manual, Chapter 10, Sections 60.5
Sometimes HHAs may need to receive denial notices from Medicare prior to billing other payer sources. These claims are often referred to as “no-payment bills” or “denial notices”.

### 4.13.3.1. UB-92 Requirements for Denial Notice

**Do NOT submit a RAP when billing for a denial notice.** In addition to the information required on all PPS claims, the following must be included on the denial notice:

- **FL 4, Type of Bill** — 320 or 330
- **FL 24 – 30, Condition Codes** — report the condition code “21”
- **FL 42, Revenue Code** — report the 0023 revenue code along with the appropriate HIPPS code. If no OASIS assessment was completed, report the lowest weighted HIPPS code (HAEJ1) as a proxy
- **FL 48, Non-covered Charges** — report all charges as non-covered charges
- **FL 63, Treatment Authorization Code** — report the appropriate OASIS Matching Key. If no OASIS assessment was completed, report an eighteen digit string of the number “1” as the OASIS Matching Key (1111111111111111).

### 4.13.4. Simultaneous Covered and Non-covered Services

Sometimes a provider may need to receive a denial notice and receive payment for covered services during the same episode. When this situation occurs, HHAs should do the following:

- Submit a denial bill (no-payment bill) for the non-covered services according to the instructions above AND,
- Submit a RAP and FC (according to PPS billing requirements) and establish an episode for the covered services.
- If the episode for the covered services is 60-days in length, then the statement covers field (FL 6) on the denial notice (3XO TOB) should be the match the episode dates.

### 4.14 Roster Bill Claims Submission

**Reference:** CMS Manual System, Pub 100-4, Chapter 18, Section 10.3.2, and CMS Manual System, Pub 100-4, Chapter 25, Section 60

Home Health providers involved in mass immunizations of the influenza (flu) and pneumococcal (PPV) vaccines can submit roster bill claims to simplify the billing process. To qualify for roster billing, the HHA must have provided immunization for at least five beneficiaries on the same date.

The roster billing process involves use of the provider billing form, UB-92, CMS-1450 form. The HHA attaches a standard roster to a single CMS-1450 Form that contains the claims information regarding the service provided and a list of the individual beneficiaries.
The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;
- Patient’s name and address;
- Patient’s date of birth;
- Patient’s sex;
- Patient’s health insurance claim number (HICN); and
- Beneficiary signature or stamped “signature on file”.

**NOTE:** A “stamped signature on file” can be used in place of the beneficiary’s actual signature if the HHA has a signed authorization on file to bill Medicare for services rendered. In this situation, they are not required to obtain the patient signature on the roster.

Providers must retain roster bills with beneficiaries’ signatures at their permanent location for a time period consistent with Medicare regulations.

The PPV roster must contain the following information as a precaution to alert beneficiaries prior to administration of the PPV vaccine.

**WARNING:** Beneficiaries must be asked if they have been vaccinated with PPV.

- Rely on the patients’ memory to determine prior vaccination with PPV.
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine,
- If patients are certain that they have been vaccinated within the past five years, **do not vaccinate.**

The CMS-1450 Form should show information in the following field locators (FLs):

<table>
<thead>
<tr>
<th>FL 4 – TYPE OF BILL</th>
</tr>
</thead>
<tbody>
<tr>
<td>The claim is billed using a <strong>34X</strong> type of bill</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FL 22 – PATIENT STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>This should always be 01 for Roster billing claims.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FL 24 THROUGH-30 – CONDITION CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1 Code indicates the influenza virus vaccine or pneumococcal pneumonia (PPV) is being billed via the roster billing method by providers that mass immunize.</td>
</tr>
</tbody>
</table>
**FL 42 – REVENUE CODE**

0636  Vaccines  (along with the appropriate HCPC code in FL 44)
0771  Administration of the Vaccines  (along with the appropriate “G” HCPCS code in FL 44)

**FL 44 – HCPCS CODES**

90657  Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use
90658  Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use
90732  Pneumococcal vaccine
G0008  Administration of the influenza virus vaccine
G0009  Administration of the PPV vaccine

**FL 47 – TOTAL CHARGES**

Enter the total charge for each revenue code.

**FL 50 - PAYER**

“Medicare” on Line A

**FL 51 – PROVIDER NUMBER**

Enter the words “See Attached Roster”

**FL 67 – PRINCIPAL DIAGNOSIS CODE**

V04.81  For influenza virus vaccine claims (for claims with dates of service October 1, 2003 and later)

V03.82  For pneumococcal (PPV) vaccine claims
### FL 82 – UNIQUE PHYSICIAN IDENTIFICATION NUMBER

- UPIN  SLF000 is required for influenza virus vaccines
- UPIN  ID for physician ordering PPV vaccine

### FL 85 – PROVIDER REPRESENTATIVE

A stamped or computer generated signature is acceptable.

### FL 86 - DATE

Date the provider representative signed the form.
5. MEDICARE SECONDARY PAYER (MSP)

The following MSP guidelines are included in this section:

MSP Types
- Group Health Plans (GHP)
- Workers’ Compensation Plans
- Liability Insurance
- No-Fault Insurance

Determining The Primary Payer

Conditional Payments

Trauma Related Claims

MSP Claims and Billing Information
- MSP Condition Codes
- MSP Occurrence Codes
- MSP Value Codes
- MSP Payer ID Codes
- MSP Relationship Codes

MSP and HH PPS Episodes
- MSP Determinations on RAPs
- MSP Determinations on FC
- MSP Coding of FC

Coordination of Benefits (COB)
- Fact Sheet

Question/Answers

Quick MSP Tips
5.1. MSP Introduction

Reference: CMS Manual System Pub 100-5, Chapter 1

From the time that the Medicare program was instituted, providers of health care grew accustomed to billing Medicare first, in almost all cases, for services rendered to Medicare beneficiaries.

It was known that many Medicare beneficiaries were entitled to other insurance coverage, but the law allowed these private insurance policies or plans to shift most responsibility for payment of health care benefits to the Medicare program by:

- paying supplemental benefits
- paying no benefits at all

Legislative provisions during the 1980’s created changes in this method of reimbursement for health care costs and have resulted in more situations where Medicare is no longer the primary payer. As a result of these laws, the Centers for Medicare & Medicaid Services (CMS) initiated the Medicare Secondary Payer (MSP) provisions.

Part of the reason for the growth of the MSP initiative has been the concern over the long term viability of the Medicare Trust Fund. MSP is an important element of Medicare’s efforts to continue providing the nation’s elderly and disabled with a reasonable level of affordable health care.

In an effort to both safeguard program dollars as well as to ensure a proper level of coordination between private insurers and the federal government, the Medicare as a Secondary Payer program, or MSP as it has become known, was initiated in 1983. The primary function of MSP is to ensure that federal funds are not used to pay for services reimbursable under a private insurance plan. As such, it is very similar to the Coordination of Benefits (COB) activities, which have been utilized by the private insurance industry for a number of years.

5.2. Types of MSP Situations

Medicare is considered secondary to the following types of insurance coverage:

- Group Health Plan (GHP)
- Large Group Health Plan (LGHP)
- End Stage Renal Disease (ESRD/GHP)
• No-Fault Insurance
• Automobile or other Liability Insurance
• Workers’ Compensation (WC)
• Department of Labor’s Black Lung Program
• Department of Veteran’s Administration *(VA)

Medicare is considered primary in the following situations:

• Medicaid
• TRICARE
• Veteran’s Administration (VA)
• Health insurance plans for retirees or the spouses of retirees
• Beneficiary has Part B entitlement only
• Private insurance coverage which is paid for by the beneficiary
  i.e., Medigap, AARP
• Supplemental policy
• Individuals enrolled in Part A on the basis of a monthly premium

* Note: A patient eligible for VA benefits has the option of selecting either Medicare or VA as the primary payer on a claim-to-claim basis. If Medicare is billed as primary, the VA cannot be billed for secondary benefits

5.2.1. Determining the Primary Payer

In order to conform to the law and regulations, providers are required to file claims with Medicare using billing information obtained from the Medicare beneficiary. Providers that bill Medicare for services rendered to a Medicare beneficiary must determine whether Medicare is a primary or secondary payer. They are required to determine the beneficiary’s MSP status prior to submitting a bill to Medicare. Providers must accomplish this by asking the beneficiary, or their representative, about other insurance coverage. Section 20.2.1 Pub 100-5 Chapter 3 lists the type of questions providers must ask of Medicare beneficiaries for every admission, outpatient encounter, or start of care.

Situations may arise in which there may be more than one payer primary to Medicare (e.g., automobile insurer and GHP). Providers must identify all possible payers.

Verifying MSP information means confirming information previously furnished about the presence or absence of a primary payer to Medicare is correct, clear & complete, and that no changes have occurred.

The following are examples of questions to ask a beneficiary. Keep in mind that this is not considered a complete form.
• Is the patient or their spouse actively employed?

• Are the services related to an automobile or other accident, including a work related accident or illness?

• Is the patient entitled to Veteran’s Administration or Black Lung benefits?

• Is the patient entitled to Medicare as a result of End Stage Renal Disease (ESRD) and, if so, what date did their entitlement begin?
**5.2.2. MSP Chart - Over 65**

Are you/your spouse currently employed?

- **Yes**
  - How many employees does you or your spouse’s employer have?
    - More than 20 emp?
      - **Yes**
        - Are you covered under an GHP based on your or your spouse’s employment?
          - GHP is primary
            - Medicare is secondary
              - Bill to GHP first
              - Bill Medicare as secondary
                - when a balance remains and HHA is **not** obligated to accept amount as payment in full.
                - **Provide:**
                  - Name of insured
                  - Relation to patient
                  - Name and address of employer
                  - Name and address of insurer
                  - Group identification number
                  - Policy Number
                  - Amount received from primary
                  - Use appropriate value, condition and occurrence codes.
          - No
            - Follow ---
    - No
      - Follow ---

- **No**
  - Are services related to a work related injury or illness; auto or other liability accident; Veterans’ Administration?
    - **Yes**
      - Are you entitled to benefits under Workers’ Comp; VA Black Lung; or Auto or other liability insurance?
        - WC is primary
          - Medicare is secondary
            - Bill Medicare as secondary
              - when a balance remains and HHA is **not** obligated to accept amount as payment in full.
              - **Provide:**
                - Name of insured
                - Relation to patient
                - Name and address of employer
                - Name and address of insurer
                - Group identification number
                - Policy Number
                - Amount received from primary
                - Use appropriate value, condition and occurrence codes.
        - Black Lung is primary
          - Medicare is secondary
            - Bill Medicare as secondary
              - when a balance remains and HHA is **not** obligated to accept amount as payment in full.
              - **Provide:**
                - Name of insured
                - Relation to patient
                - Name and address of employer
                - Name and address of insurer
                - Group identification number
                - Policy Number
                - Amount received from primary
                - Use appropriate value, condition and occurrence codes.
        - No fault insurance
          - Medicare is secondary
            - Bill Medicare as secondary
              - when a balance remains and HHA is **not** obligated to accept amount as payment in full.
              - **Provide:**
                - Name of insured
                - Relation to patient
                - Name and address of employer
                - Name and address of insurer
                - Group identification number
                - Policy identification number
                - Amount received from primary
                - Use appropriate value, condition and occurrence codes.
    - No
      - Follow ---

- Medicare is primary
  - Bill to Medicare

---

*Palmetto GBA*

*Home Health Training Manual, 2005*
5.2.3. MSP Chart – Under 65

Are you/your spouse or responsible family member currently employed?

- No
  - Are services related to a work related injury or illness; auto or other liability accident; Veterans’ Administration?
    - No
      - Are you entitled to benefits under Workers’ Comp; VA Black Lung; or Auto or other liability insurance?
        - No
          - Medicare is primary Bill to Medicare
        - Yes
          - WC is primary Medicare is secondary
    - Yes
      - LGHP is primary Medicare is secondary
        - LGHP is primary
          - Bill to LGHP first
        - Medicare is secondary
          - Bill Medicare as secondary
            When a balance remains and HHA is not obligated to accept amount as payment in full.
            **Provide:**
            Name of insured
            Relation to patient
            Name and address of employer
            Group identification/Policy No.
            Amount received from primary

- Yes
  - How many employees does you or your spouse’s employer have?
    - More than 100
      - Are you covered under an LGHP based on your or your family member’s employment?
        - No
          - Follow ---
        - Yes
          - LGHP is primary Medicare is secondary
            Bill to LGHP first
          - Medicare is primary Bill to Medicare

5.3. Group Health Plan (GHP)

Effective May 1, 1986, Medicare became secondary to Group Health Plan (GHP) for Medicare eligible employees age 65 and older or spouses age 65 or older of employees of any age:

IMPORTANT FACTS:
- GHP is an employer that employs 20 or more employees
- Not all 20+ employees must be covered by the GHP
- Employer must offer same group health plan offered to younger employees
- Must offer same spousal group health coverage to all workers with spouses
- The employee and spouse may elect Medicare as primary; however, if Medicare is primary, then the employer cannot offer a policy that is supplemental to Medicare
- Medicare will pay primary benefits for covered Medicare services not covered by the GHP
- Claims not paid in full by the GHP may be filed to Medicare for secondary payment consideration

5.4. Large Group Health Plan (LGHP)

Effective January 1, 1987, Medicare became secondary to LGHPs for disabled beneficiaries.

IMPORTANT FACTS:
- LGHP is an employer with 100 or more employees
- Not all employees must be covered by the LGHP
- The Medicare beneficiary could be the employee or a family member of the employee
- Medicare will pay primary benefits for Medicare covered services not covered by the LGHP
- For disabled beneficiaries with ESRD, Medicare will be secondary for the 30 month coordination period, beginning with the first month of ESRD eligibility
- Claims not paid in full by the LGHP may be submitted to Medicare for secondary payment consideration
5.5. End Stage Renal Disease (ESRD)

ENTITLEMENT:

Medicare benefits begin with the fourth month after the monthly maintenance dialysis treatments begin.

Medicare coverage can begin in the first month of dialysis if:

- The beneficiary participates in a self-dialysis training program in a Medicare-approved training facility
- The beneficiary began training three months prior to dialysis beginning
- Training is expected to be completed and the beneficiary will self-dialyze thereafter

Or

- The beneficiary is admitted to an approved hospital for a kidney transplant or procedures preliminary to the transplant if the transplant is made in that month or within the following two months

Medicare is secondary for an GHP or LGHP for individuals who are entitled to Medicare solely on the basis of ESRD for a period of 30 months.

IMPORTANT FACTS:

- The 30 months Medicare is secondary is called the “coordination period”
- If an individual has more than one period of entitlement, a coordination period is determined for each period
- Effective with the BBA of 1997, a Medicare beneficiary of any age may have to serve an 30 month coordination period if certain conditions are met
5.6. Automobile Medical, No-Fault Or Any Liability Insurance

The automobile/liability provisions applicable to MSP were mandated under the Omnibus Reconciliation Act (ORA) of 1980. These provisions made Medicare secondary to automobile medical, no-fault or liability insurance if one of the following situations exist:

- the beneficiary is covered by an automobile medical, no-fault or liability insurance plan or is entitled to benefits under the plan of the party responsible for the accident, or
- the beneficiary is awarded a settlement for injuries received in an accident caused by another party.

5.7. Workers’ Compensation, Veteran’s Administration, Black Lung Coverage, Or Other Federal Agencies

Medicare is the secondary payer for items and services that are reimbursable under a Workers’ Compensation law or plan, federal agencies, governmental agencies, and the Public Health Service (PHS).

Sections 1814(c), 1835(d), 1862(a)(3), and 1862(b)(1) of the original Medicare law were enacted in 1966 and made Medicare the secondary payer in the following situations:

- Workers’ Compensation - those programs that compensate employees for injuries or diseases suffered in connection with their employment,
- Black Lung - the Department of Labor, under the Federal Black Lung Program, compensates beneficiaries for services rendered in connection with certain work related conditions,
- Veteran’s Administration - agrees to pay for authorized services due to a military service related injury or disease,
- Public Health Service and other Federal agencies - federal, state and local government entities directly and indirectly pay for services, i.e., a research grant, medical services furnished to prisoners, or restitution on the part of a prisoner to repay the Medicare Program because of injuries inflicted on a beneficiary.
5.8. Conditional Payments

Under certain circumstances, Medicare may make a primary payment if the beneficiary’s primary insurer denies payment. These Medicare payments are called Conditional Payments, because they are made on the condition that Medicare be reimbursed if the primary insurer eventually makes its usual primary payment.

Conditional payments may be made if:

- the primary insurer denies payment because a service is not covered by the plan,
- the service is subject to a pre-existing condition limitation,
- the primary plan’s deductible is not met,
- the primary plan determines the service is not medically necessary, or
- the plan’s benefits are exhausted.

Note: If the primary insurer states that all benefits are exhausted, the claim should be submitted for PRIMARY Medicare benefits, with remarks noting the date and denial reason. Conditional payment may not be made if the insurer says it is secondary to Medicare, the insurer is in receivership or is in bankruptcy, if the services are out-of-service area of the insurer, or if the provider failed to obtain a pre-certification.

If a primary insurer makes a reduced payment because of the provider’s failure to file a proper claim, the provider must inform Medicare that a reduced payment was made, and give the amount that would have been paid if a proper claim had been filed. A provider’s failure to notify Medicare of the amount that would have been paid would constitute the filing of a false claim against the United States Government.

There is a special rule in cases involving liability insurance. After a claim is submitted for conditional payment and Medicare payment is accepted by the provider, payment for the claim cannot be accepted from the liability insurer. The provider may only accept payment for Medicare coinsurance, deductible, and non-covered charges (just the same as if the claim was a regular Medicare primary claim).

Palmetto GBA can accept EMC claims requesting conditional Medicare payment. The claim should be keyed as though it is being submitted for secondary Medicare payment, but the value code (FL 39 - 41) should be entered with a zero value ($0.00). Occurrence code 24 should be used to indicate the date of denial (except for liability claims submitted after 120 days from the date of service or discharge). In addition, remarks should be entered to indicate the reason
for the primary insurer’s denial. **Claims will be returned if submitted without the required information.**

### 5.9. Trauma Related Claims

Claims resulting from trauma or trauma-related conditions must be filed with the appropriate occurrence and, if appropriate, value codes. MSP value code 47 is used to indicate liability coverage, and must be used together with occurrence code 01 or 03. Occurrence code 01 is used in auto accident situations involving insurance coverage, and occurrence code 03 is used in non-auto accident situations involving liability coverage. Value code 14 is used to indicate no-fault coverage in both auto and non-auto accidents, and must be used with occurrence code 02. Value code 15, together with occurrence code 04 is appropriate in Worker’s Compensation situations.

In **any** accident situation in which it is determined that there is no liability or no-fault insurance, the claim must be submitted as Medicare primary, with occurrence code 05. If there is no insurance, do not file with MSP value codes. Doing so will result in the creation of an inappropriate MSP record at the Common Working File (CWF). If there is, however, other insurance but benefits were denied, the claim **should** be filed for conditional payment, with appropriate MSP occurrence and value codes. Claims for conditional or secondary Medicare payment **must** include the name and address of the third party insurer.

<table>
<thead>
<tr>
<th>Situation</th>
<th>MSP</th>
<th>Value Code</th>
<th>Occurrence Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto accident - liability insurance</td>
<td>Yes</td>
<td>47</td>
<td>01</td>
</tr>
<tr>
<td>Other non-work accident - liability insurance</td>
<td>Yes</td>
<td>47</td>
<td>03</td>
</tr>
<tr>
<td>Any non-work accident - no-fault insurance</td>
<td>Yes</td>
<td>14</td>
<td>02</td>
</tr>
<tr>
<td>Work-related accident - Workers’ Compensation insurance</td>
<td>Yes</td>
<td>15</td>
<td>04</td>
</tr>
<tr>
<td>Any accident - no insurance</td>
<td>No</td>
<td>None</td>
<td>05</td>
</tr>
</tbody>
</table>
5.10. Medicare Secondary Payer Claims and Billing Information

5.10.1. MSP Condition Codes

Enter the appropriate condition code (FL 24 - 30) to describe any of the following conditions which apply during this billing period.

<table>
<thead>
<tr>
<th>Code</th>
<th>Condition Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Military service related</td>
</tr>
<tr>
<td>02</td>
<td>Condition is employment related</td>
</tr>
<tr>
<td>03</td>
<td>Patient covered by insurance not reflected here</td>
</tr>
<tr>
<td>05</td>
<td>Lien has been filed</td>
</tr>
<tr>
<td>06</td>
<td>ESRD patient in first year of entitlement covered by employer group health insurance</td>
</tr>
<tr>
<td>08</td>
<td>Beneficiary would not provide information concerning other insurance coverage.</td>
</tr>
<tr>
<td>09</td>
<td>Neither patient nor spouse is employed</td>
</tr>
<tr>
<td>10</td>
<td>Patient and/or spouse is employed but no GHP coverage exits</td>
</tr>
<tr>
<td>11</td>
<td>Disabled beneficiary but not LGHP</td>
</tr>
<tr>
<td>26</td>
<td>A VA-eligible patient has elected to receive services in a Medicare certified facility</td>
</tr>
<tr>
<td>77</td>
<td>Provider accepts or is obligated/required due to a contractual arrangement or law to accept payment by a primary payer as payment in full.</td>
</tr>
</tbody>
</table>

5.10.2. MSP Occurrence Codes

Enter the appropriate occurrence code (FL 32A - 35B) and date where one or more apply.

<table>
<thead>
<tr>
<th>Code</th>
<th>Occurrence Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Auto accident (used in conjunction with MSP Value Code 47)</td>
</tr>
<tr>
<td>02</td>
<td>Auto accident/no fault insurance (used in conjunction with MSP Value Code 14)</td>
</tr>
<tr>
<td>03</td>
<td>Accident/TORT Liability (used in conjunction with MSP Value Code 47)</td>
</tr>
<tr>
<td>04</td>
<td>Accident/Employment related (used in conjunction with Value Code 15)</td>
</tr>
<tr>
<td>05</td>
<td>Any accident - no insurance (no MSP Value Code is used)</td>
</tr>
<tr>
<td>06</td>
<td>Crime Victim</td>
</tr>
<tr>
<td>18</td>
<td>Date of patient/beneficiary retirement</td>
</tr>
<tr>
<td>19</td>
<td>Date of retirement of spouse</td>
</tr>
<tr>
<td>24</td>
<td>Date primary insurance denied</td>
</tr>
<tr>
<td>25</td>
<td>Date primary insurance benefits exhausted</td>
</tr>
<tr>
<td>33</td>
<td>First day of the first month of the Medicare coordination period for ESRD beneficiaries covered by an Group Health Plan (GHP) (used in conjunction with MSP Value Code 13)</td>
</tr>
</tbody>
</table>
5.10.3. MSP Value Codes

Enter the appropriate value code (FL 39A - 41D) and amount to indicate amount paid by the primary towards the Medicare charges.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>12</td>
<td>Working Aged with GHP (age 65 and older); Group has 20 or more employees</td>
</tr>
<tr>
<td>13</td>
<td>Beneficiary in Medicare ESRD coordination period</td>
</tr>
<tr>
<td>14</td>
<td>Automobile, no-fault insurance (used in conjunction with Occur Code 02)</td>
</tr>
<tr>
<td>15</td>
<td>Worker’s Compensation (used in conjunction with Occur Code 04)</td>
</tr>
<tr>
<td>16</td>
<td>Public Health Service/other Fed Agency</td>
</tr>
<tr>
<td>41</td>
<td>Black Lung</td>
</tr>
<tr>
<td>42</td>
<td>Veteran’s Administration</td>
</tr>
<tr>
<td>43</td>
<td>Disabled beneficiary with LGHP (under age 65); group has 100 or more employees</td>
</tr>
<tr>
<td>44</td>
<td>Contract allowance - amount the provider is required to accept as payment in full when that amount is less than total charges (must be used in conjunction with appropriate MSP Value Code 12, 13, 14, 15, 16, 41, 42, or 43).</td>
</tr>
<tr>
<td>47</td>
<td>Liability insurance including automobile liability insurance. (Use occur code 01 if automobile liability insurance; use occur 03 if accident/Tort liability insurance).</td>
</tr>
</tbody>
</table>
5.11. MSP and HH PPS Episodes

CWF will apply existing MSP edits to both RAPs and HH PPS claims, editing all RAPs, whether a MSP record is present or not, to see if the episode period service date falls within an MSP period. Though both RAPs and FCs will create episode records, only the FCs, not RAPs, payment will be affected by primary payer contributions in MSP situations. Therefore, RAPs are marked in the Medicare standard systems with a non-payment (Z) code if MPS applies, and ultimately sent to a paid status in the Medicare system, thereby processing with zero payment. First claim development is performed only on FCs, not on RAPs. RAPs should not contain any reference to MSP. Only the Final Claim should be coded as MSP, if applicable.

Claims for home health services under a plan of care (claims with types of bill 32X and 33X) for dates of service on or after October 1, 2000, are paid under HH PPS. The HH PPS does not change the principles of MSP payment established in regulation. The policy contained in regulations at 42 CFR Part 411, subparts B, C, D, E, F, G, and H continue to apply. When Medicare is secondary payer, payment is to be made on the basis of the formula contained in 42 CFR 411.33 (e).

5.11.1. MSP Determinations on RAPs

When Medicare is secondary payer and the criteria for payment on a per episode basis are met, Medicare does not make payment based on a RAP. Medicare makes secondary payment only based on a FC for the 60-day episode, which will show the primary payer’s payment if one has been made. HHAs must send all MSP claims to the primary payer first for payment before submitting claims to Medicare.

5.11.1.1. RAPs Submitted Without MSP Value Codes

Upon receipt of a RAP with no MSP value codes, CWF will apply existing edits against the MSP file to RAPs checking to see if the episode period service date falls within an MSP period. If an MSP period corresponding to the service dates exists, CWF will create a HH PPS episode record in CWF and otherwise process with the RAP with zero payment.

5.11.1.2. RAPs Submitted With MSP Value Codes

Upon receipt of a RAP with MSP value codes, Medicare’s standard systems will create a record of an MSP period. This record will create or update the CWF MSP file as appropriate, and will not calculate payment for the RAP. The RAP will create a HH PPS episode record in CWF and otherwise process with zero payment. This same process will be applied to RAPs submitted with MSP value codes which have zero dollar amounts associated with them and C in the primary payer field. Medicare does not make conditional payments based on RAPs.
5.11.2. MSP Determinations on FCs

For claims for services receiving a full episode payment or for other types of payment adjustments (e.g., when there are four visits or less in a 60-day episode) the Medicare will pay the lowest of the following calculations:

- The gross amount payable by Medicare minus the Medicare deductible
- The gross amount payable by Medicare minus the third party payment
- The HHA’s charges minus the third party payment
- The provider’s charges minus the Medicare deductible

EXAMPLES:

A) MSP payment on a full 60-day episode (at least 5 visits billed).

- A HHA furnished 30 Medicare covered visits during a 60-day episode. The agency’s total charges were $4500 (30 visits at $150 each).
- The third party payer paid $2832
- The agency is NOT obligated to accept as payment in full
- The HH PPS episode amount is $4005.60

Medicare will pay the lowest of:

- The gross amount payable by Medicare minus the Medicare deductible:
  $4005.60 - $0 = $4005.60
- The gross amount payable by Medicare minus the third party payment
  $4005.60 - $2832 = $1173.60
- The HHA’s charges minus the third party payment
  $4500 - $2832 = $1668
- The provider’s charges minus the Medicare deductible
  $4500 - $0 = $4500

Medicare’s secondary payment for this episode would be $1173.60

B) MSP payment for HH PPS when criteria for per episode payment is not met (less than 5 visits billed).

- Medicare payment will be made on a per visit basis
- MSP payment is calculated on a per visit basis
- The HHA provided 3 covered SN visits during a 60-day episode
- The HHA’s total charges were $450 (3 visits at $150 each)
• The agency is NOT obligated to accept as payment in full
• The third party payer paid $282.30 for the 3 visits ($94.40 per visit)
• The HH PPS amount per visit is $97.90

Medicare will pay the lowest of:

- The gross amount payable by Medicare minus the Medicare deductible:
  $97.90 - $0 = $97.90
- The gross amount payable by Medicare minus the third party payment
  $97.90 - $94.40 = $3.50
- The HHA’s charges minus the third party payment
  $150 - $94.40 = $55.60
- The provider charges minus the Medicare deductible
  $150 - $0 = $150

Medicare’s secondary payment for each visit would be $3.50 for a total of $10.50
(3 visits x $3.50) Note that since Medicare payment is made on a per visit basis, MSP is
calculated on a per visit basis and therefore there would be three calculations since there were
three visits.

C) MSP when the provider is obligated to accept the third party payment as payment in full
and there was a full 60-day episode (at least five visits billed).

- A HHA furnished 30 Medicare covered visits during a 60-day episode. The agency’s total
  charges were $4500 (30 visits at $150 each)
- The third party payer paid $2832
- The agency IS obligated to accept as payment in full
- The HH PPS episode amount is $4005.60

Medicare will pay the lowest of:

- The gross amount payable by Medicare minus the Medicare deductible:
  $4005.60 - $0 = $4005.60
- The gross amount payable by Medicare minus the third party payment
  $4005.60 - $2832 = $1173.60
- The amount the HHA is obligated to accept as payment in full minus the third
  party payment $2832 - $2832 = $0
- The amount the HHA is obligated to accept as payment in full minus the Medicare
deductible
  $2832 - $0 = $2832
Medicare’s secondary payment for this episode would be $0 (the lowest of the four calculations). Note that since Medicare payment is made on a per episode basis, MSP is calculated on a per episode basis, and therefore there is one calculation since there is one episode of care.

D) MSP when the provider is obligated to accept the third party payment as payment in full and the criteria for per episode payment is not met (less than 5 visits billed).

- The HHA provided 3 covered SN visits during a 60-day episode
- The HHA’s total charges were $450 (3 visits at $150 each)
- The agency is obligated to accept as payment in full
- The third party payer paid $283.20 for the 3 visits ($94.40)
- The HH PPS amount per visit is $97.90

Medicare will pay the lowest of:

- The gross amount payable by Medicare minus the Medicare deductible:
  $97.90 - $0 = $97.90
- The gross amount payable by Medicare minus the third party payment
  $97.90 - $94.40 = $3.50
- **The amount the HHA is obligated to accept as payment in full minus the third party payment** $94.40 - $94.40 = $0
- The amount the HHA is obligated to accept as payment in full minus the Medicare deductible
  $94.40 - $0 = $94.40

Medicare’s secondary payment for each visit would be $0 (the lowest of the four calculations). Note that since Medicare payment is made on a per visit basis, MSP is calculated on a per visit basis and therefore there would be three calculations since there were three visits. Medicare’s total secondary payment is $0 ($0 for each of three visits).
5.12. Coordination of Benefits (COB) Fact Sheet

The Centers for Medicare & Medicaid Services (CMS) has embarked on an important initiative to further expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program. CMS awarded the Coordination of Benefits (COB) contract to consolidate the activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries.

The awarding of the COB contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. All Medicare Secondary Payer (MSP) claims investigations are initiated from, and researched at the COB contractor. This is no longer the function of your local Medicare intermediary or carrier. Implementing this single-source development approach will greatly reduce the amount of duplicate MSP investigations. This will also offer a centralized, one-stop customer service approach, for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries that serve to protect the Medicare Trust Funds. The COB Contractor provides customer service to all callers from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers, and suppliers.

5.12.1. Information Gathering

Medicare generally uses the term Medicare Secondary Payer or "MSP" when the Medicare program is not responsible for paying a claim first. The COB contractor will use a variety of methods and programs to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. In such situations, the other health plan has the legal obligation to meet the beneficiary’s health care expenses first before Medicare. The table below describes a few of these methods and programs.

<table>
<thead>
<tr>
<th>Method/Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Enrollment Questionnaire (IEQ)</td>
<td>Beneficiaries are sent a questionnaire about other insurance coverage approximately three (3) months before they are entitled to Medicare.</td>
</tr>
<tr>
<td>IRS/SSA/CMS Data Match</td>
<td>Under the Omnibus Budget Reconciliation Act of 1989, employers are required to complete a questionnaire that requests Group Health Plan (GHP) information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary.</td>
</tr>
<tr>
<td>MSP Claims Investigation</td>
<td>This activity involves the collection of data on other health insurance that may be primary to Medicare based on information submitted on a medical claim or from other sources.</td>
</tr>
<tr>
<td>Voluntary MSP Data Match Agreements</td>
<td>Voluntary Agreements allow for the electronic data exchange of GHP eligibility and Medicare information between CMS and employers or various insurers.</td>
</tr>
</tbody>
</table>

5.12.2. Provider Requests and Questions Regarding Claims Payment

Intermediaries and carriers will continue to process claims submitted for primary or secondary payment. Claims processing will not be a function of the COB contractor. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should continue to be directed to your local intermediary or carrier. In addition, continue to return inappropriate Medicare payments to the local Medicare contractor. Checks should not be sent to the COB Contractor. Questions regarding Medicare claim or service denials and adjustments should continue to be directed to your local intermediary and carrier. If a provider submits a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the COB Contractor. This
investigation will be performed with the provider or supplier that submitted the claim. MSP investigations will no longer be a function of your local intermediary or carrier. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

5.12.3. Medicare Secondary Payer Auxiliary Records in CMS’s Database

The COB Contractor is the sole authority to ensure the accuracy and integrity of the MSP information contained in CMS’s database (i.e., Common Working File). Information received as a result of MSP gathering and investigation is stored on the CWF in an MSP auxiliary file. The MSP auxiliary file allows for the entry of several auxiliary records, where necessary. MSP data may be updated, as necessary, based on additional information received from external parties (e.g., beneficiaries, providers, attorneys, third party payers). Beneficiary, spouse and/or family member changes in employment, reporting of an accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information should be reported directly to the COB Contractor. CMS also relies on providers and suppliers to ask their Medicare patients about the presence of other primary health care coverage, and to report this information when filing claims with the Medicare program.

5.12.4. Termination and Deletion of MSP Auxiliary Records in CMS’s Database

MSP records on the CWF that are identified as invalid should be reported to the COB Contractor for investigation and deletion. Providers will need to call the Coordination of Benefits (COB) at 1-800-999-1118 to get records updated.

5.12.5. Contacting the COB Contractor

Effective January 1, 2001, refer all MSP inquiries; including, the reporting of potential MSP situations, invalid MSP auxiliary files, and general MSP questions/concerns to the COB contractor. Continue to call your local intermediary and/or carrier regarding claims-related and recovery questions. The COB Contractor’s Customer Call Center toll free number is 1-800-999-1118 or TDD/TYY 1-800-318-8782. Customer service representatives are available to assist you from 8 a.m. to 8 p.m., Monday through Friday, eastern standard time, except holidays. Clip and post this section in a handy place for access by your office and billing staff.

5.13. MSP Questions and Answers

Q. Who is considered primary if the Medicare beneficiary is retired but continues to receive health benefits from his employer?

A. The key word is “retired”. Medicare is considered secondary to GHP coverage only if the coverage is by reason of the employee’s current employment. Health insurance plans for retirees or the spouses of retirees do not meet this condition and as such are
not considered primary to Medicare, unless Medicare entitlement is due solely to ESRD. In the case of ESRD entitlement, Medicare may be secondary even if the beneficiary is no longer actively employed.

Q. If an insurance company establishes a health plan for its self-employed persons only, who is considered the primary payer?

A. Medicare is considered primary. In order for the working aged provision to apply, the health plan must be of, or contributed to, by an employer of 20 or more employees. A plan that does not have any employees as enrollees, such as in the case of self-employed persons, does not meet the definition of an GHP.

Q. If an insurance company establishes a health plan solely for its self-employed full-time life insurance agents, who is considered the primary payer?

A. As long as the health plan is of, or contributed to by, an employer of 20 or more employees, the plan will be considered primary to Medicare. A full-time life insurance agent is considered an employee for Social Security purposes; therefore, such an individual is also considered an employee under the working aged provision.

Q. Does a union plan fall under the same guidelines as an Group Health Plan?

A. Yes. A multi-employer plan or union plan falls under the same guidelines.

Q. If a multi-employer LGHP covers employees of some small employers and also covers employees of at least one employer that meets the 100 or more employees requirement, who is considered the primary payer for the employees that work for the small employee groups?

A. The group health plan is the primary payer for all of the employees enrolled in the plan, including those that work for the small employers.

Q. In the case of a multi-Group Health Plan that covers employees of some small employers and also covers employees of at least one employer that meets the 20 or more employees requirement, who is considered the primary payer for the employees that work for the small employer groups?

A. The GHP is the primary payer for only the employees of the employers that meet the 20 or more employees requirement and Medicare is the primary payer for only the employees that work for the small employers.
Q. With regard to the ESRD provision, must the group health plan be of, or contributed to by, an employer of 20 or more employees, as with the GHP provision, or 100 or more employees, as with the LGHP?

A. For the purposes of the ESRD secondary payer provision, the term “employer” is defined without regard to the number of employees. The size of the employer is irrelevant.

Q. What does the term “coordination period” mean?

A. This term is used to describe the period of time in which Medicare is secondary to the GHP or LGHP for individuals who are entitled to Medicare on the basis of ESRD. It begins with the beneficiary’s first month of entitlement to, or eligibility for, Medicare Part A.

Q. If the basis for an individual’s entitlement to Medicare changes from disability to ESRD, who is considered the primary payer and is there a coordination period?

A. Because of the changes resulting from OBRA Act 1993, the concept of “dual entitlement” has been eliminated. Medicare could be the primary or the secondary payer. If Medicare is the secondary payer, there would be a coordination period.

Q. If an ESRD patient continues to actively work after the coordination period has expired, who is the primary payer?

A. Medicare will become the primary payer after the coordination period expires regardless of whether or not the beneficiary continues to be actively employed.

Q. Who is considered the primary payer if the basis for an individual’s entitlement changes from ESRD to age 65 or disability?

A. Medicare remains the secondary payer throughout the 18 or 30 month coordination period. At the end of the coordination period, Medicare becomes the primary payer.

Q. What is the time limitation for a provider to file a claim with a group health plan?

A. While the time limitation may vary by insurer, the Federal Claims Collection Act (28 U.S.C. Sections 2415 and 2416) states that the time limitations enforced by commercial insurance companies do not apply to Medicare beneficiaries.
Q. Can a provider bill Medicare and also place a lien against a liability settlement?

A. No. A provider can either bill Medicare or place a lien against a liability settlement, but it cannot do both.

Please refer to the section in your billing manual on “AHA vs Sullivan” for additional information on this subject.


The Part A MSP staff has developed a listing of some billing tips that may be useful:

1. Avoid “conflicts” between the value and/or occurrence codes and the payer listings. If you have an MSP value code, do not list Medicare as the primary payer, even if the primary insurer paid nothing on the claim (see # 2).

Medicare primary - DO NOT USE: occurrence code 24, MSP value codes.
Medicare secondary - DO NOT USE: occurrence codes 18, 19 or 25.

2. If the “primary” insurer denies coverage because the policy has terminated, do not file the claim as MSP. File as Medicare primary, with occurrence code 18 (beneficiary) or 19 (spouse) indicating the date the coverage terminated (if the former insured is still employed, you can use occurrence code 25). Also note in the remarks that the policy has been terminated. These codes should not be used on the same claim as an MSP value code, unless the beneficiary had more than one primary policy, and only one has been terminated.

3. If you are requesting a Medicare conditional payment because an GHP or LGHP denied a claim, you must have four things on the claim before it will be processed by Medicare:

- Occurrence code 24 and the date the primary insurer denied the claim.
- An MSP value code with an amount of zero.
- The other insurer listed as the primary payer.
- The reason for the primary insurer’s denial (this can be included as a remark on an EMC claim). It is not, however, sufficient to state “EOB on file,” except for Black Lung cases.

Please complete all MSP coding, even if you are filing hardcopy and have attached the primary insurer’s explanation of benefits.
4. All claims submitted for Medicare secondary payment must have a value code indicating the amount of the primary payment. It is not sufficient to list the payment in the Prior Payments field (Item 54).

5. If a provider has agreed with the insurer to accept less than the total charges as payment in full, but the primary payment is less than this amount, the provider can file for a secondary Medicare payment. Use value code 44 to show the agreed upon amount, and the usual MSP value code to show the amount paid by the primary insurer.

If the agreed upon amount is equal to the primary insurer’s payment, do not use value code 44. Instead, use condition code 77 and the usual MSP value code.

6. If you have had a claim returned via an RTP, please do not refile it without correcting the RTP error. If you do not understand the error or how to resubmit the claim, please review your billing manual or contact Palmetto GBA.

7. If you have received an RTP with a request for the primary insurer’s explanation of benefits (EOB), do not refile the claim when you send the EOB. Our office can retrieve and reprocess the claim.

8. Instead of returning the RTP with the comment “Insurance Now Terminated”, please provide us with the retirement date and date insurance was terminated. This will allow us to make the necessary updates to our records.

9. When adjustment bills are filed hard copy, it is necessary that a copy of the Explanation of Benefits (EOB) be attached and the correct value codes are used. If the adjustment is filed electronically, all pertinent information on the UB-92 must be reported. This includes the name of the primary payer, the insured’s name and insured’s identification number.

10. Do not submit bill type XX8 (void/cancel) to MSP when requesting that Medicare become the secondary payer. These situations should always be billed as bill type XX7 (adjustment).

11. Be sure to use the correct value code. Use value code 12 in connection with a beneficiary who is over age 65 and value code 43 in connection with a beneficiary who is under age 65. Use value code 13 for beneficiaries entitled to Medicare based on ESRD.

12. Include all covered Medicare services on the bill even if some of the services are not covered by the primary insurer.
13. Do not use value code 16 to show VA payments. Value code 42 is the correct value code to use.

Each of these situations require either additional research by the MSP Department or, if we are unable to resolve it, the claim will generate an RTP. In both instances, payment to the provider is delayed unnecessarily.
6. MEDICARE COVERAGE GUIDELINES

The following Medicare coverage guidelines are included in this section:

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<td>• Physical Therapy</td>
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<td>• Speech Language Pathology</td>
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<td>• Durable Medical Equipment, Prosthetics, Orthotics, Oxygen</td>
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SECTION 6

6.1. Intermittent Skilled Nursing Services

Reference: CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Sections 30.4 and 40.1.3.

Skilled nursing services must be provided on an intermittent basis. There must be a medically predictable recurring need for skilled nursing services.

To meet the requirement for “intermittent” skilled nursing care, a beneficiary must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60-days. However, if services are furnished less frequently than once every 60-days, documentation must justify a recurring need for reasonable, necessary and medically predictable skilled nursing services.

The following are examples of infrequent, yet intermittent, skilled nursing services:

1. The patient who experiences a fecal impaction due to the normal aging process (i.e., loss of bowel tone, restrictive mobility and breakdown in good health habits) and must be manually disimpacted. Although these impactions are likely to recur, it is not possible to pinpoint a specific time frame.

2. The patient with an indwelling silicone catheter who generally needs a catheter change only at 90-day intervals.

3. The blind diabetic who self-injects insulin may have a medically predictable recurring need for a skilled nursing visit at least every 90 days. These visits, for example, would be to observe and determine the need for changes in the level and type of care which have been prescribed thus supplementing the physician’s contacts with the patient.

Where the need for intermittent skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be reimbursable. However, a one-time order, e.g., to give gamma globulin following exposure to hepatitis would not be covered.

Although most patients require services no more frequently than several times a week, Medicare will pay for part-time medically reasonable and necessary skilled nursing care daily, or more than daily, in cases involving unusual circumstances. In those cases, documentation must clearly support the need for daily visits and must indicate a predictable and finite endpoint to the daily visits. (Additional information on endpoint is discussed in the goals section of this manual).
Reimbursable skilled nursing care consists of those services reasonable and necessary for the treatment of an illness or injury which must be performed by a licensed nurse (RN, LPN, LVN), under the direct supervision of a registered nurse if the safety of the patient is to be assured and the medically desired result achieved.

In determining whether a service requires the skills of a nurse, consideration must be given to both the inherent complexity of the service and the condition of the patient.

A service is not considered a skilled nursing service merely because a nurse performs it. The fact that the skilled nursing service is taught to the patient, family or caregiver does not negate the skilled aspect of the service when performed by the nurse.

If a service is one that could be performed by the average non-medical person, the fact that a competent person is not available in the home to perform the service would not convert the service to a skilled nursing service.

The determination of skilled nursing need is based on:

- unique condition;
- individual need; and
- regardless of whether the condition is acute, chronic, terminal or expected to continue over a long period of time and in some cases if the condition is stable.

**Supervision**

Although Medicare does not specifically define the interval at which an RN should supervise the services rendered by an LPN or LVN, an RN is ensuring the appropriate level of care is being rendered. At a minimum, an RN must do the following:

- Review and co-sign all verbal orders taken by an LPN or LVN. The RN need not co-sign the verbal orders before the services are rendered as long as the RN is made aware or is notified of a verbal order before the services are rendered.

- Review the POC

**6.1.1. Skilled Nursing Services**

**Reference:** CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 40.1.
6.1.1.1. Skilled Observation and Assessment

In determining whether a service requires the skills of a nurse, consider both the inherent complexity of the service and the condition of the patient. Almost any service may be considered skilled depending on the medical condition of the patient and the complexity of the services to be performed.

Skilled nursing services would be considered reasonable and necessary when a reasonable probability exists that significant changes in the patient’s medical condition may occur. In these instances, the skills of a nurse may be required to evaluate the need for modification of the treatment plan, medication changes, the need for hospitalization, medical intervention, etc. When there has been no significant change in the patient’s condition for a reasonable period of time, nursing visits solely for observation and evaluation would not be considered reasonable and necessary.

6.1.1.2. Management and Evaluation of a Patient’s Care Plan

Skilled nursing visits for management and evaluation of the patient’s care plan are reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient’s care plan, the complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient’s recovery and medical safety in view of his/her overall condition.

The skill entails the management of a complex care plan involving unskilled services designed to provide oversight and avoid complications in the patient’s overall medical plan of care. Management and evaluation is not intended to serve as the primary mechanism for providing long-term custodial care.

Management and evaluation is a skill used when a patient’s care plan is unstable, thereby rendering the nursing services necessary to ensure the safety and effectiveness of the home health plan of care.

There are four key points in determining whether management and evaluation is appropriate for a patient.

- Is the patient at high risk for hospitalization or exacerbation of a medical condition if the POC is not implemented correctly?
• Does the patient have a complex, unskilled POC?

• Is there an unstable caregiver situation?

• Must the Registered Nurse or Registered Physical Therapist be involved in this patient’s care to ensure the safe and appropriate implementation of the plan?

Note: The last point is the most important point that separates the covered cases from those that do not meet the requirement.

The purpose of this service is to ensure that the plan is appropriately implemented to meet the patient’s medical needs, maintain safety and promote recovery. When a nurse can discontinue services without any probable jeopardy to the patient or adverse effects on implementation of the plan, management and evaluation ceases to be a skilled service.

I. Major points to consider when documenting the existence of skilled planning and management of a care plan.

A. Skilled planning and management activities are based upon a need to have the involvement of skilled nursing personnel in order to meet the patient’s medical needs, promote recovery, and ensure medical safety, even if the individual or direct nursing services provided do not require skilled expertise.

B. Skilled planning and management activities are determined from an overall assessment and association of all factors about the patient’s condition, treatment regimen, medical needs, potential for serious complications, and complexity of non-skilled services.

II. Major sources in the clinical forms for documentation that demonstrate the involvement of skilled nursing personnel to manage and evaluate the plan of care.

A. Information from the plan of care or optional CMS forms (485 and/or 487) about the patient’s medical condition and needs:

1. Medications (#10);
2. Diagnoses (#11, 13);
3. Functional Limitations (18A);
4. Activities Permitted (18B);
5. Orders for Discipline and Treatments (21); and
SECTION 6

B. Information from the optional CMS 486 form:

1. Date of Last Inpatient Stay (13)
2. Type of Facility (14);
3. Updated Information (15)
4. Functional Limitations (16)
5. Unusual Home/Social Environment (18)

C. Use all the documentation to identify the relationship between symptoms and conditions creating the level of complexity justifying the skilled management.

D. Significant Questions

1. What are the patient’s medical problems? (At present time or highly probable.)
2. What are the actions to be taken to resolve the problems?
3. What are the outcomes from the actions taken? (Evaluation of patient’s improvement or deterioration, changes to the care plan, etc.)
4. Do the goals, objectives and planned interventions require skilled expertise to manage and evaluate the plan of care?
5. Would the health and medical safety of the patient be jeopardized if licensed professionals were not planning and evaluating care?
6. Does the analysis of the answers to questions 1-5 result in a decision that trained nursing personnel are required to plan, manage, and evaluate the patient’s care to meet the patient’s medical needs, promote recovery and ensure medical safety?

E. Possible Profile of Patient Requiring Management and Evaluation of a Patient Care Plan (skilled management).

Note: The terminology (skilled management) should be in #21 of the optional CMS 485 form, under the orders.

1. Multiple medical problems impacting an overall medical condition.
2. Home health aide may be up to daily.
3. May have other skilled services.
4. Services directed to complications that are safety and high-risk concerns.

5. May have nutritional/hydration problems.

6. Will probably also have assessment and/or evaluation services.

7. May have multiple medications.

8. May have multiple or very restrictive functional limitations.

9. Mental status problems may be contributing to the complexity of the patient’s problems.

10. Multiple factors that need direction from the RN could include social concerns, personal care, a myriad of non-skilled services, other skilled services and/or community resources.

11. The frequency of skilled nursing may be as varied as daily initially or every other week as discharge approaches.

12. Presence of specific goals identifying expected outcomes.

6.1.1.3. Teaching and Training

Teaching and training activities which require the skills of a nurse to perform may be covered nursing services provided they are ordered, and reasonable and necessary for the treatment of the patient’s condition or injury.

Coverage for teaching is not dependent on what is being taught. The teaching activity itself is the skilled nursing service.

Teaching:

- Initial teaching
  - complexity of the activity
  - unique ability of the patient

- Reinforced teaching
  - retained knowledge
  - anticipated learning progress
• Reteaching significant changes in procedure
  patient’s condition
  patient’s caregiver is not appropriately carrying out the task

Also document the following:

• Reason the teaching continues
• Patient’s response to teaching

6.1.1.4. Administration of Medication

Although drugs and biologicals are excluded from coverage under the home health benefit, administration of those drugs may be considered for coverage if:

• It is ordered by a physician.
• It requires the service of a licensed nurse to safely and effectively administer the drug
• It is reasonable and necessary for the treatment of the patient’s condition or injury.

6.1.1.4.1. Diabetic Care

λ Visits to administer insulin injections or other customarily self injected medications are covered if:

  » Ordered by the physician
  » Documentation supports need
  » Patient’s inability to self-inject is documented
  » Unavailability or inability of a caregiver is documented

λ Pre-filling insulin syringes:

  » May be covered if state law requires a nurse to perform the service
  » Not a skilled nursing service
  » Not a qualifying skilled nursing service
  » Must have other qualifying skilled service being provided (SN, PT, continuing OT or SLP)

Note: Documentation would need to support that the patient is unable and the caregiver is unable or unwilling to pre-fill the syringes.
Diabetic supplies may be covered as non-routine supplies:

» syringes may be covered when the skilled nurse is:
  » teaching the patient or caregiver to administer
  » pre-filling the syringe when the patient is eligible for home care based on another service as the qualifier, or
  » administering the medication when the patient qualifies as indicated above

» finger-stick blood sugar supplies may be covered as non-routine supplies:
  » if the patient is diagnosed as a diabetic (insulin dependent or non-insulin dependent)

Note - For dates of service prior to 07-01-98, finger-stick blood sugar supplies may be covered as non-routine supplies only if:
  » if the patient’s diagnosis is of an insulin dependent diabetic, or
  » if the patient’s diagnosis is of a non-insulin dependent diabetic AND the documentation supports medical necessity or indication of an unstable diabetic condition.

A blood glucose monitor may be covered as durable medical equipment (DME) when the patient is an insulin treated diabetic (insulin dependent or insulin requiring) and the item meets the criteria for DME.

Effective 10-01-00, blood glucose strips (HCPCS A4253) and lancets (HCPCS A4259) are not bundled into the PPS episode payment. These supplies can be separately reimbursed only when billed with the appropriate HCPCS code.

Note: In order for an item (DME) to be considered for coverage, the patient must meet all eligibility criteria as established in the CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 50.4.2.
6.1.1.4.2. Vitamin B-12

Reference: CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 40.1.2.4

Visits to administer B-12 are covered when provided for the following physician certified conditions:

- Specified anemias:
  - Pernicious anemia
  - Megaloblastic anemia
  - Macrocytic anemia
  - Fish tapeworm anemia

- Specified gastrointestinal disorders:
  - Gastrectomy – total or partial
  - Malabsorption syndromes, i.e., Crohn’s Disease, Sprue, Idiopathic Steatorrhea, etc.
  - Surgical and mechanical disorders, i.e., resection of the small intestine, strictures, anastomoses and blind loop syndrome
  - Posterolateral sclerosis
  - Other neuropathies associated with pernicious anemia
  - Acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism

6.1.1.4.3. Epogen Injections

Visits to administer Epogen injections may be considered for coverage providing the following qualifying criteria are met:

- Patient is homebound.
- Patient is unable to self-inject and there is no available or willing caregiver.
- Patient is not receiving dialysis (either at home or at a clinic).
- Patient’s physician certified diagnosis is one of the following diagnoses:
  - Chronic renal failure with symptomatic anemia - patient not requiring dialysis
  - Cancer - patient currently undergoing chemotherapy
  - AIDS - patient currently taking AZT
  - Myelodysplastic Syndrome
Note: Pre-treatment creatine lab value is greater than or equal to “3” when the diagnosis of renal failure is no longer a requirement for Epogen coverage. The drug itself is not covered under the Medicare home health benefit.

6.1.1.4.4. Neupogen Injections

Visits to administer Neupogen injections may be considered for coverage providing the following qualifying criteria are met:

- Patient is homebound.
- Patient is under a physician’s home health plan of care.
- Patient’s physician certified diagnosis supports the need for neupogen.
- Patient must be unable to self-inject the drug and the caregiver must be unwilling or unable to inject the drug.

Note: The drug itself is not covered under the Medicare home health benefit.

6.1.1.4.5. Calcimar Injections

Visits to administer Calcimar injections may be considered for coverage when being provided for the treatment of one of the following diagnoses:

- Symptomatic Paget’s disease of the bone,
- Post-Menopausal Osteoporosis (female-only)
- Hypercalcemia

- May be given as often as daily (with projected decrease or endpoint)
- Must be given at least 3 times per week. In some cases, another frequency may be allowed if a physician’s statement of the medical necessity is submitted
- Calcimar is customarily a self –injected medication. If it is ordered to be administered SQ, documentation is required to support the patient’s inability to self inject, and the lack of a willing caregiver. If the Calcimar is ordered to be given IM, documentation is required to support why the patient must receive Calcimar IM vs SQ
- Dosage must meet the accepted standards of medical practice as of dates of service 01/01/2000
  a. Post-menopausal osteoporosis – 100 IU once daily, once every other day, or three times a week
  b. Paget’s disease – the initial dose of Calcimar for Paget’s disease should be 100 IU once daily, once every other day, or three times a week, in patients without serious deformity or bone involvement. This dosage may be decreased to 50 IU thereafter
c. Hypercalcemia – 4 IU/kg of body weight q 12 hours initially with increases to 8 IU/kg if necessary
   • Paget’s disease: one time serum alkaline phosphatase test
   • Post-Menopausal Osteoporosis: x-ray results indicating compression fractures, vertebral collapse, or spontaneous fractures
   • Hypercalcemia: lab results indicating unusual levels of calcium

Calcimar injections maybe considered covered at a greater or lesser frequency than the standard if a physician’s statement of medical necessity is submitted.

Note: Documentation should reflect the effectiveness of the Calcimar therapy. When billing for the drug itself with the diagnosis of postmenopausal osteoporosis, the claim to administer the Calcimar must have processed and paid prior to the drug claim (34X) being submitted for consideration. The system will RTP the drug claim (34X) if the visit claim has not completely processed and paid.

The FDA has approved the drug teriparatide (brand named Forteo) for use in treating osteoporosis. The drug should be billed using HCPCS code J3110, effective January 1, 2005.

Like the calcitonin-based osteoporosis drug, teriparatide is paid on a cost basis and is subject to deductibles and coinsurance.

The home health visit (i.e., the nurse’s visit) to administer the drug is covered under normal Medicare (Part A or Part B) home health coverage rules. This drug is considered part of the home health benefit under Part B. Therefore, Part B deductible and coinsurance apply regardless of whether home health visits for the administration of the drug are covered under Part A or Part B.

The administration of the drug is included in the charge for the skilled nursing visit billed under bill type 32X or 33X, as appropriate. The cost of the drug is billed under bill type 34X, using revenue code 0636.

These codes are paid on a reasonable cost basis, using the provider’s submitted charges to make initial payments, which are subject to annual cost settlement.

6.1.1.4.6. Oral Medications

Pre-filling a medicine box and applying topical ointments are not skilled nursing services and therefore are not billable.
6.1.1.5. IV Drug Therapy

A limited number of IV drugs may be covered under the home health benefit if certain criteria are met. A list of covered IV drugs appears in the Home Health Medicare Advisories. If the IV drug requiring administration via a pump is not one of the drugs listed in the Advisory, then that drug, the supplies, and the DME used to administer that drug are not covered. The visit to administer that non-covered drug may be considered for coverage providing the non-covered drug is reasonable and necessary in the treatment of the patient’s medical condition or injury.

6.1.1.5.1. IV Drug Therapy Supplies

Supplies used to administer a covered IV drug (see the Home Health Medicare Advisories for a list of reimbursable drugs that are covered when administered via an IV pump) and maintain the IV site must be billed with the appropriate HCPCS code (A4221, A4222).

Supplies used to administer a non-covered IV drug (that does not meet the coverage criteria for reimbursement under the home health benefit) or hydration fluids and maintain the IV site, must be billed under revenue code 0270.

Note: IV solution for hydration that does not have a drug mixed in it is billable.

6.1.1.5.2. IV Drug Therapy DME

IV pumps are only covered when the patient is receiving one of the covered IV drugs (see the Home Health Medicare Advisories). The drug must require a pump for safe, controlled administration; otherwise, the pump and associated drug are not covered. Appropriate HCPCS codes for the pumps are E0781 or E0791. Pumps are billed as DME under revenue code 0291, 0292 or 0293. The IV pole may be covered as DME when the patient is receiving covered IV drug therapy. The appropriate HCPCS code for the IV pole is E0776. The IV pole is billed as DME under revenue code 0291, 0292 or 0293.

The table below explains what may be considered for coverage provided all other qualifying criteria are met, and the services are ordered and medically reasonable and necessary in the treatment of the patient’s medical condition. This table should be used only as a quick reference tool, individual coverage guidelines apply.
<table>
<thead>
<tr>
<th>Description</th>
<th>Drug</th>
<th>Supplies</th>
<th>DME</th>
<th>Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug infused via a pump is on the list</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Drug infused via a pump is not on the list</td>
<td>No</td>
<td>Some *</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Drug administered via a drip</td>
<td>No</td>
<td>Yes</td>
<td>IV Pole only</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* The supplies directly associated with the use of the pump, for example, cassette and bags (A4222), are not billable because the pump is not covered. However, supplies that are typically used with IV therapy (for example, venosets, administration sets and tubing) are billable under revenue code 0270.

In addition, supplies used in starting and/or maintaining the IV site are considered to be covered supplies even though the solution and/or drug may or may not be covered.

*Note: Effective June 1997, starting and stopping an IV may be considered two visits as long as the service could not be performed in one visit and there was at least a two-hour break between the start and the stop.*

6.1.1.6. IV Hydration Therapy

Visits to administer hydration therapy may be covered provided all other qualifying criteria are met and the services are ordered, medically reasonable and necessary in the treatment of the patient’s medical condition or injury.

6.1.1.6.1. IV Hydration Therapy Supplies

Intravenous solutions used to hydrate the patient are billable. If the solution comes pre-mixed (crystalloids with potassium chloride, electrolytes, or dextrose) from the manufacturer, it is billable as a supply under revenue code 0270.

However, if the nurse or pharmacist adds a drug, biological, or a multi-vitamin, to the solution, then it becomes a drug or biological and is not billable. If the IV solution is used as a medium to deliver a drug or biological rather than solely as a means of hydration, the solution is then considered to be a drug or biological and is not billable.

Supplies used in starting and/or maintaining the IV site except IV flushes and tubing are considered to be covered supplies.
Note: Effective June 1997, starting and stopping an IV may be considered two visits as long as the service could not be performed in one visit and there was at least a two-hour break between the start and the stop.

6.1.1.6.2. IV Hydration Therapy DME

The IV pole may be covered as DME when the patient is receiving covered IV therapy. The appropriate HCPCS code for the IV pole is E0776. The IV pole is billed as DME under revenue code 0291, 0292 and 0293. Generally, hydration via a pump is not covered; however, there may be certain circumstances where medical necessity mandates the use of a pump for safe administration of IV fluids. Such unique situations will be considered individually based on the supporting documentation. Guidelines regarding DME (order or CMN) apply.

6.1.1.7. Enteral and Parenteral Nutrition

6.1.1.7.1. Enteral Nutrition

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing, Chapter 20, Section 30.7

Enteral nutrition may be considered for coverage under the home health benefit providing the following conditions apply. The patient must be:

- Homebound and under a POC
- Have a temporary impairment of 90 days or less
- Unable to ingest anything by mouth, i.e., ice chips, sips of water, etc.

When the patient meets the above criteria for temporary impairment, Medicare will cover:

- Visits for administration
- Nutrients
- Supplies associated with administration

6.1.1.7.2. Parenteral Nutrition

Reference: CMS Manual System Pub 100-4, Medicare Claims Processing, Chapter 20, Section 30.7

Total parenteral nutrition may be considered for coverage under the home health benefit providing the following conditions apply. The patient must be:

- Homebound and under a POC
- Have a temporary impairment of 90 days or less
When the patient meets the above criteria for temporary impairment, Medicare will cover:

- Visits for administration
- Supplies associated with administration. (The solutions/nutrients are considered drugs/biologicals and are not covered under the Home Health Benefit.)

**Note:** The documentation must indicate if the condition is expected to be permanent or temporary. If a permanent condition exists (above 90 days) and parenteral or enteral therapy is being provided, the supplies, equipment, and nutrients should be billed by a supplier as prosthetic devices under Part B on the CMS 1500 form and submitted to the appropriate durable medical equipment regional carrier (DMERC).

### 6.1.1.8. Venipunctures

According to the Balanced Budget Act of 1997 (BBA of 1997), drawing blood for laboratory tests is no longer a qualifying skilled service under the Medicare Part A home health benefit, effective February 5, 1998. However, if a patient qualifies for home health services based on another skilled service and requires a venipuncture (V/P), then the service may be considered for coverage as follows:

Drawing blood for laboratory tests may be covered as a skilled service if the following conditions are met:

- The patient qualifies for home health eligibility based on another skilled need (intermittent SN (not V/P), physical therapy, speech language pathology or continuing occupational therapy),
- The physician orders the service,
- The frequency of the blood work is:
  - consistent with accepted standards of medical practice
  - medically reasonable and necessary

**Note:** If a nurse makes a visit to draw blood and is unsuccessful, the nurse may return later to retry; both visits would be covered. Likewise, if a specimen is destroyed or rendered unusable, another skilled nursing visit to obtain a second specimen would be covered. Documentation must support the situation. Another order must be obtained from the physician for the second visit.
6.1.1.9. Wound Care Coverage

Wound care may be considered for coverage when:

λ A physician orders the service

λ Three basic skills are related to coverage:
  • Direct hands-on wound treatment
  • Teaching of the care
  • Skilled observation and assessment of the wound

λ Documentation should include:
  • Size/Depth
  • Nature of drainage (color, odor, quantity, and consistency)
  • Condition and appearance of surrounding skin

λ The Plan of Care must contain specific instructions for the treatment of the wound.

Note: Independent Wound Care Clinics are not subjected to consolidated billing.

6.1.1.10. Psychiatric Nursing Criteria

λ Patient must be homebound

λ Homebound criteria applied to psychiatric patients:
  • Illness is manifested by a refusal to leave the home, i.e., severe depression, paranoia, agoraphobia
  • Due to illness it would be unsafe for the patient to leave the home, i.e., hallucinations, violent outbursts
  • These psychiatric patients may have no physical limitations

λ Effective May 24, 1996, (CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 40.1.2.15) psychiatric services may be ordered by a psychiatrist or physician

λ Under the Conditions of Participation, an agency may not be primarily providing psychiatric care

λ Services are medically reasonable and necessary
Services provided by the psychiatric nurse may include:

- evaluating
- teaching
- psychotherapy
- other medically skilled services

Psychiatric nurse credentials must be approved by Palmetto GBA prior to the nurse rendering psychiatric services as of dates of service 06/01/00. Also, the nurse should sign all documentation in the medical records with his/her legal name. When a provider receives an ADR (Additional Documentation Request) on a claim involving psychiatric nursing services, a copy of the approval letter from Palmetto GBA of the nurse’s psychiatric credentials should be included with the medical records.

Note: It does not require the skills of a psychiatric nurse to administer or assess psychotropic medications.

6.1.10.1. Psychiatric Nurse Qualifications

A psychiatric nurse has training and/or experience beyond the standards for a RN and must meet one of the following qualifications:

- A registered nurse with a master’s degree in psychiatric or mental health nursing.
- A registered nurse with a bachelor’s degree in nursing with one year of experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic.
- A registered nurse with a diploma or associate’s degree with two years experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic.
- On an individual basis, other combinations of education and experience may be considered.

Home Health Agencies must submit the resume of any RN that will be providing psychiatric services under the Home Health Medicare benefit. Providers need to send the resume to the following address:
The resume will be reviewed and the agency will be notified if the RN meets the requirements or not within 30 days. NOTE: This notification should be in the provider files prior to the RN rendering psychiatric services.

6.1.1.10.2 Reference: CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 40.1.2.15

6.1.1.11. End Stage Renal Disease

_CODE OF FEDERAL REGULATIONS, SECTION 409.49 (e), DATED DECEMBER 20, 1994_, specifically excludes services which must be provided by an End Stage Renal Disease (ESRD) facility. “Services that are covered under the ESRD program and are contained in the composite rate reimbursement methodology, including any service that is directly related to that individual’s dialysis, are excluded from coverage under the Medicare home health benefit.”

Dialysis related services are **not** covered under the home health benefit.

- Any and all dialysis-related services are the responsibility of an ESRD facility.
- Dialysis-related services that are not covered:
  - Treatment of an infected shunt site
  - Epogen injections
  - Venipuncture for dialysis-related labs
  - CAPD/PD
  - Hemodialysis
- Renal-related services that may be covered include:
  - Treating an abandoned shunt site
  - Medical treatment not related to the dialysis, i.e., decubitus wound care
  - Teaching the administration of non-dialysis related medications
6.2. Therapy Services Criteria

6.2.1. Reference

CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 40.2

6.2.2. General Therapy Information

Therapy services under the Medicare home health benefit may include the following disciplines:

- Physical Therapy (PT)
- Speech Language Pathology (SLP)
- Occupational Therapy (OT) - OT may not be a qualifying skilled service, but must be started under another discipline. However, when a qualifying discipline (PT, SN, or SLP) establishes the need for Medicare home health services (initiating a POC) OT services may be provided. Once OT has been initiated under another POC, then it may become a qualifying service.

λ Patient must be homebound

Note: Patients receiving Medicare home health outpatient therapy services under Part B need not be homebound to qualify for outpatient therapy. Refer to CMS Manual System, Pub 100 -2, Medicare Benefit Policy, Chapter 7, Section 90 for more information regarding outpatient therapy services. These outpatient therapy services are billed on a 34X bill type. Coinsurance and deductible apply. If the patient is receiving home health services under PPS, the outpatient therapy services would need to be billed on a 32X or 33X bill type due to consolidated billing and the patient would need to be homebound.

λ Therapy services must be ordered by physician

λ Therapy services may be covered because:

- Of the inherent complexity of the service
- It must be performed by a skilled therapist
- It must be performed under the supervision of a skilled therapist

λ Diagnosis or prognosis is never the sole factor in deciding if a service is skilled or not skilled:

- Consider the patient’s medical condition (history)
- The treatment must require a skilled therapist
A service ordinarily considered non-skilled may be considered skilled when there are medical complications that require skilled rehabilitation personnel to perform or supervise the service or to observe the patient.

Services must be reasonable and necessary for the treatment of the beneficiary’s particular medical needs

- Amount, frequency, and duration must be reasonable
- Services must be consistent with the nature and severity of the patient's illness or injury
- Services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the patient’s condition
- Services must be provided with the expectation that:
  - the condition of the patient will improve materially in a reasonable and predictable period of time, or
  - the services are necessary to establish a safe and effective maintenance program.
  - evaluation and re-evaluation must be reasonable and necessary to be covered.

Services of skilled therapists to teach the patient or non-agency caregivers necessary techniques, exercises, or precautions are covered to the extent they are reasonable and necessary to treat the illness or injury.

- Therapies (physical therapy, occupational therapy, and speech-language pathology services) are covered home health services that are subject to consolidated billing requirements.

6.2.2.1. Medical History

- Information that is pertinent to or influences the treatment rendered
- Date of onset and/or exacerbation
- Functional status prior to current treatment episode
- History of treatment and outcomes from previous providers, i.e., type of surgery, date, discharge status
- Identify the date of change or deterioration if non-specific onset or chronic dysfunction exists
- History of previous therapy for the same problem and outcome
6.2.2. Progress Notes

- Patient’s prior level of functioning before the therapy treatment began
- Patient’s current level of functioning
- Patient’s expected improvement (goals)
- Changes in the plan of treatment

6.2.2.3. Therapy Plan of Treatment

The plan of treatment must include specific functional goals and a reasonable estimate of when they will be met. It must include:

- **Type of modality/procedures:** should describe the specific nature of the therapy to be provided such as, diathermy, ultrasound, hot packs, whirlpool, and/or gait training.
- **Frequency of visits:** the frequency of treatment to be rendered. Example: 3wk2 (3 x per week for 2 weeks)
- **Duration:** length of time over which the services are to be rendered. May be expressed in days, weeks, or months.
- **Diagnosis:** should include the physical therapy diagnosis if different from the medical diagnosis. **Example:** The medical diagnosis might be “rheumatoid arthritis”; however, the shoulder might be the only area being treated, so the physical therapy diagnosis might be “frozen shoulder” (limited movement due to pain).
- **Functional Goals:** should reflect the physical therapist’s and/or physician’s description of what the patient is expected to achieve as a result of therapy.
- **Rehabilitation Potential:** The therapist’s and/or physician’s expectation concerning the patient’s ability to meet the goals at initiation of treatment.

*Note: Plans of care for home health outpatient claims (34x bill type) must be reviewed every 30 days; the CMS 700 Form may be used for the plan of care.*

6.2.3. Therapy

The individuals authorized to provide therapy services are registered physical therapists, registered occupational therapists, registered speech language pathologists, or individuals working under the supervision of a registered therapist.

6.2.3.1. Restorative Therapy

To constitute physical therapy, a service must be reasonable and necessary for the treatment of the patient’s illness or injury. Documentation must show acute changes in the patient’s condition and/or no history of prior physical therapy services for the illness or injury currently being
treated. Documentation from the physical therapist must support the medical necessity for such services and indicate progress or lack of progress, e.g., patient has progressed from ambulating 15 feet in one walk to 25 feet; or patient has progressed from standing with assistance to walking with an assistive device.

In addition, it must be expected that the patient’s condition will improve significantly in a reasonable and generally predictable period of time. If at any point in the treatment of an illness, it is determined that the expectations will not be met, the services will no longer be considered reasonable and necessary.

### 6.2.3.2. Maintenance Program

Repetitive maintenance exercises are non-covered if the skills of a therapist are not needed. However, therapeutic exercises may be skilled due either to the type or complexity of the exercise or the patient’s condition. Repetitive maintenance exercises, on an exception basis, may require the skills of a therapist because of the level of the procedures or because of complications. Even if significant recovery or improvement is not possible, a beneficiary may require skilled therapy to maintain his or her current functioning. Medicare will, during the medical review process, evaluate the patient’s individual needs and conditions to determine whether the beneficiary requires skilled therapy.

Medicare recognizes three basic situations in which a beneficiary, who is at a maintenance level, may require skilled therapy:

- If the repetitive services designed to maintain function involve the use of complex and sophisticated procedures that may only be performed by a skilled therapist.
- If special medical complications exist which necessitate a skilled therapist to perform or supervise the service or to observe the beneficiary.
- If a skilled therapist is needed to manage and periodically re-evaluate the appropriateness of a maintenance program because of an identified danger to the patient.

Certain conditions/situations may require a maintenance program established by a qualified physical therapist. A patient who has not been under a restorative physical therapy program, or who has suffered an acute exacerbation, can be eligible for physical therapy services. However, when a beneficiary is receiving restorative therapy, the maintenance program should be planned while a patient is receiving the restorative physical therapy. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable or necessary and would be excluded from coverage.
6.2.3.3. Non-Skilled Maintenance Therapy

When the patient is not a candidate for restorative therapy, physical therapy services may be indicated to establish a maintenance program in the home. Such a program for a patient who has not received restorative therapy, or who has suffered an acute exacerbation, may be considered for coverage. Short-term therapy may be indicated to instruct in transfer training, range of motion exercises, use of adaptive equipment, etc.

EXAMPLE 1. Recent CVA with no restorative potential. Caregiver needs instruction in the use of a hoyer lift, range of motion exercises, and safe transfers.

EXAMPLE 2. Recent exacerbation of MS renders patient wheelchair bound. The disease process has limited the patient’s restorative potential. Physical therapy would be indicated for short term instruction in wheelchair mobility and use of other adaptive equipment.

6.3. Supportive Services

There are two disciplines that have been defined as supportive disciplines. They are medical social work and home health aide services. In order for a patient to receive medically reasonable and necessary supportive services, he or she must meet the eligibility criteria established for the Medicare home health benefit. A brief review of the eligibility criteria is as follows:

- Patient must be homebound,
- Patient must be under the care of a physician and
- Patient must require skilled care, i.e., intermittent skilled nursing, physical therapy, speech language pathology or a continuing need for occupational therapy.

Note: Patient must meet all the criteria defined in the CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 30.

The following sections explain the supportive disciplines covered under the Medicare home health benefit.

6.3.1. Medical Social Work Services

6.3.1.1. Reference

CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 50.3
6.3.1.2. Medical Social Work Coverage Criteria

- Patient must be homebound
- Medical social work (MSW) services must be rendered concurrently with one or more skilled services (SN, PT, SLP, or continuing OT)
- MSW services must be reasonable and necessary
  - must contribute meaningfully to the treatment of the patient’s condition
  - resolve social or emotional problems which are, or are expected to be an impediment of the patient’s medical condition

The POC must indicate that the services require the skills of a MSW or social work assistant under the supervision of a MSW.

- Types of services provided:
  - assessment of social and emotional factors related to the patient’s illness
  - assessment of the patient’s home situation, financial resources, and/or community resources available
  - appropriate action in resolving any associated problems
  - counseling required by the patient

Counseling furnished to family members is covered on a short term basis (2 - 3 visits) if it can be demonstrated that the service is necessary to resolve a clear and direct impediment to the treatment of the patient’s medical condition or rate of recovery. The MSW may evaluate the support system, physical environment, and economic condition.

- Support system should be a person who is:
  » Willing
  » Able
  » Capable
  » Accessible

- Environment assessment includes:
  » Safety issues
  » Risk factors
  » Abuse/neglect

- Economic assessment includes:
  » Financial resources
  » Community resources
Non-covered MSW services include:

- Assistance with Medicaid application
- Assistance with living wills
- Assistance with Meals on Wheels

6.3.1.3. Medical Social Work Documentation

- Indicate what services are provided by a MSW and why the services require the skills of a qualified MSW
- Document the link between services rendered and the patient’s medical condition or rate of recovery

  » MSW will evaluate
  - Physical
  - Mental
  - Emotional
  - Social
  
  documentation must demonstrate how the MSW services link to the patient’s medical condition

- Clarify terminology and abbreviations
- Present a clear picture of the patient
- Physician’s orders
  
  • Specify frequency and duration
  • Identify services to be rendered
  • Length of time services covered depends on the patient’s needs

6.3.2. Home Health Aide Services

The services of a home health aide are supportive in nature and cannot stand alone. Patient’s receiving aide services under the Medicare home health benefit must meet the eligibility criteria detailed in the CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 50.2.

6.3.2.1. Reference

CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 50.2.
6.3.2.2. Aide Coverage Criteria

- Patient must meet the home health eligibility criteria defined in CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 30.
- Services must be provided under a qualifying discipline (intermittent SN, PT, SLP, or continuing OT).
- Services must be ordered by a physician.
- Services must be reasonable and necessary for the treatment of a patient’s condition or injury.

6.3.2.3. Types of Home Health Aide Services

Home health aide services are personal care services that are required to maintain the patient’s health or facilitate treatment of their illness or injury, such as:

- Bathing, dressing, grooming, caring for hair, nails, and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the patient’s health
- Feeding, assistance with elimination, ambulating or transfers
- Simple dressing changes which do not require the skills of a licensed nurse *
- Assistance with medications which are ordinarily self-administered and which do not require the skills of a licensed nurse to be provided safely and effectively (Example: Prefilling of insulin syringes or administering insulin) *
- Assistance with activities which are directly supportive of skilled therapy services and do not require the skills of a therapist
- Routine care of prosthetic and orthotic devices
- A doctors order to assist the patient if the ADL score is not acceptable

* Under Medicare guidelines, an aide may provide these services. Please refer to your state licensure agency for guidelines regarding these services being provided by an aide. If your state does not allow an aide to provide these services, you must abide by the more stringent rule.

Services, which are incidental to the care being provided as described above and in the CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 50.2, allowed as long as those incidental services do not significantly add to the time spent in the home. The primary reason for aide services in the home should not be to provide incidental services, as they are non-covered under the home health benefit. Incidental services may be services such as light house cleaning, meal preparation, shopping, and garbage removal.
6.3.2.4. Home Health Aide Supervision

An RN or qualified therapist must provide a supervisory visit at least every two weeks. This supervisory visit is considered an administrative visit and is not billable. However, if the RN or qualified therapist renders an ordered, covered, and medically reasonable and necessary service in addition to the supervisory visit, it becomes billable.

The supervisory visits must be made on-site, but the aide is not required to be present.

6.4. Other Medical Services

6.4.1. Outpatient Home Health Therapy Coverage Guidelines

Reference: CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 90.

Physical, speech, and occupational therapy services can be provided to outpatients by a home health agency. There is no special state certification required for a home health agency to provide outpatient services if it is certified to provide therapy services in the home.

Outpatient therapy services are covered as medical and other health services under Part B of the Medicare Program and are billed on the CMS-1450 (UB92) as bill type 34x.

Note: If a patient is homebound and receiving services under a Home Health plan of care, outpatient services are allowed and billable (consolidated billing) on the Home Health bill as indicated in CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 40.2.

There are two occurrence codes and one value code that must always be used when outpatient therapy is being billed.

<table>
<thead>
<tr>
<th>Value Code</th>
<th>Discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 and 35</td>
<td>50 Physical Therapy</td>
</tr>
<tr>
<td>11 and 44</td>
<td>51 Occupational Therapy</td>
</tr>
<tr>
<td>11 and 45</td>
<td>52 Speech Therapy</td>
</tr>
</tbody>
</table>
Billling Requirements

• Part B services may not be billed more often than every 30 days

• Effective April 1, 1998, outpatient therapy services require HCPCS codes and number of units based on the service provided. In field 44 of the UB-92, enter the appropriate HCPCS code. In field 44, enter the number of units based on the procedure or service e.g., based on the HCPCS code reported instead of the revenue code.

◊ Example: A beneficiary received outpatient occupational therapy (HCPCS code 97530 which is defined in 15-minute intervals) for a total of 60 minutes. The provider would report revenue code 0431 in field 42, HCPCS code 97530 in field 44, “four” units in field 46, and “one” visit in value code 51 field 39.

• Effective October 1, 1998, outpatient therapy service must be line item by dates of service per revenue code and HCPCS code.
• Additionally, when billing the outpatient therapies (34X TOB), make sure that correct modifiers are used. The modifiers are used for data collection to determine who provided the modality. The modifiers are:

  GN  Speech Pathologist
  GO  Occupational Therapist
  GP  Physical Therapist

 Please refer to the Medicare Advisory 98-02 for a listing of HCPCS codes.

Coverage Requirements

An individual is not required to be confined to his or her home to be eligible for these outpatient home health therapy services.

To be reimbursable under the medical and other health service provision, outpatient physical therapy, speech language pathology, or occupational therapy must meet all of the following conditions.

• Services must be reasonable and necessary for the treatment of the patient’s condition

• Services must be specific and effective treatment for the patient’s condition

• Services must be of such a level of complexity and sophistication, or the condition of the patient such, that these services can only be safely and effectively performed by a qualified physical, occupational, or speech language pathologist or under his/her supervision
• There must be an expectation that the condition will improve significantly in a reasonable time period

• The patient must be under the care of a physician

• The need for the service is certified by the physician and put into writing before the services are rendered

• When services are continued over a period of time under the same plan of treatment, the physician must recertify at intervals of at least once every 30 days

6.4.2. Outpatient Physical Therapy, Occupational Therapy, and Speech Language Pathology Services

Reference: CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 15, Section 220.

Outpatient physical therapy, occupational therapy, and speech language pathology services are covered when furnished by a provider to its outpatients, i.e., to patients in their homes, to patients who come to the facility’s outpatient department, or to inpatients of other institutions. In addition, coverage includes physical therapy, occupational therapy and speech language pathology services furnished by participating hospitals and skilled nursing facilities to those of their inpatients who have exhausted their Part A inpatient benefits or who are otherwise not eligible for Part A benefits.

Outpatient physical therapy, occupational therapy, or speech-language pathology services furnished to a beneficiary by a participating provider are payable only when furnished in accordance with the following conditions:

• Physician’s or non-physician practitioner’s certification and recertification;

• Outpatient must be under the care of a physician or non-physician practitioner;

• Outpatient physical therapy, occupational therapy or speech-language pathology services furnished under a plan; and

• Services must be furnished on an outpatient basis.

Outpatient physical therapy, occupational and speech-language pathology services must meet all of the conditions set forth in the CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 1, Sections 100 and 220.
Certification

A physician or non-physician practitioner must certify that:

- The services are or were required by the patient.
- A plan for furnishing such services is or was established and periodically reviewed by the physician or non-physician practitioner.
- Either the physician or non-physician practitioner or the qualified physical therapist providing such services establishes a plan of treatment for outpatient physical therapy services.
- Either the physician or non-physician practitioner or the qualified occupational therapist providing such services establishes a plan of treatment for outpatient occupational therapy services.
- Either the physician or non-physician practitioner or the speech-language pathologist providing such services establishes a plan of treatment for outpatient speech-language pathology services. However, a physician or non-physician practitioner must periodically review a plan established by a speech-language pathologist, occupational therapist or physical therapist.
- The outpatient physical therapy, occupational therapy or speech-language pathology services are or were furnished while the patient was under the care of a physician or non-physician practitioner.

Since the certification is closely associated with the plan of treatment, the same physician or non-physician practitioner who established or reviews the plan of treatment must certify the necessity for services. The plan must be written and developed by the physician or non-physician practitioner caring for the patient. The carrier will obtain certification at the time the plan of treatment is established or as soon thereafter as possible.

Physician means a doctor of medicine, osteopathy (including an osteopathic practitioner), podiatric medicine legally authorized to practice by the State in which they perform the services and optometrist (for low vision only). In addition, physician certifications and recertifications by doctors of podiatric medicine or optometry must be consistent with the scope of the professional services provided by a doctor of podiatric medicine or optometry as authorized by applicable State law.

Recertification

When outpatient physical therapy, occupational therapy or speech-language pathology services are continued under the same plan of treatment for a period of time, a recertification must be obtained:
• The physician or non-physician practitioner must recertify at intervals of at least once every 30 days from the date last seen by the referring physician or non-physician practitioner that there is a continuing need for such services and estimate how long services are needed.

• Obtain the recertification at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan.

• The form of the recertification and the manner of obtaining timely recertification is up to the individual facility and/or practitioner.

6.5. Durable Medical Equipment, Prosthetics, Orthotics, Oxygen

6.5.1 Reference: CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 50.4.2

6.5.2. DME General Information

A participating provider of services may be reimbursed under the Medicare Program for durable medical equipment (DME), prosthetics, orthotics, oxygen, and oxygen equipment that it rents or sells to a patient for home use if the requirements are met.

DME is specifically excluded from the 60-day episode rate and consolidated billing requirements. DME continues to be paid on the fee schedule outside of the PPS rate.

Payment also may be made under this provision for repairs, maintenance and delivery of equipment, as well as expendable and non-reusable items essential to the effective use of the equipment subject to the conditions in Section 220.4.

Section 4062 of PO 100-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA), requires that payment for DME furnished under the Part A home health benefit and Part B DME, prosthetic and orthotic devices, be made on the basis of a fee schedule. The lesser of fee schedule reimbursement or charges will be applied to such items included on claims for services rendered on or after January 1, 1989.

HCPCS coding is required. If HCPCS codes are not included when billing for DME, prosthetic and orthotic devices, (billed under revenue code 274) oxygen and oxygen equipment, the claim will be returned. (See addendum E of CMS Pub No. 11 for a current listing of HCPCS codes and definitions.) The HCPCS code should be included on the UB-92 in form locator 44. Revenue codes may be listed more than once, but any given HCPCS code may be listed only once.

Use the following rules for determining payment and patient liability for DME:
• **Payment to an HHA Other Than Nominal Charge**
  To determine the Part B payment to you, the intermediary subtracts any unmet part B deductible from the lower of the actual charge or the fee schedule amount for the item or service and multiplies the remainder by 80%. This is the final payment.

  If the item or service is covered under the Plan of Treatment, the payment is determined in the same way except that no deductible is applicable.

• **Payment to a Nominal Charge HHA**
  To determine the Part B payment to you, the intermediary subtracts any unmet deductible from the fee schedule and multiplies the remainder by 80%. This is the final payment.

  If the item or service is furnished by a nominal charge HHA and is covered under the Plan of Treatment, the payment is determined in the same way except that no deductible is applicable.

• **Patient Liability to a HHA**
  To determine the patient liability to you under Part B (nominal charge or regular HHA), subtract any unmet deductible from the lower of the actual charge or fee schedule amount and multiply the remainder by 20%. The result obtained plus the unmet deductible is the patient’s liability.

  If the item or service is covered under the Plan of Treatment, the deductible does not apply.

### 6.5.3 DME Equipment Class

**Reference:** CMS Manual System Pub 100-4 Medicare Claims Process, Chapter 20, Section 30

There are six (6) classes of equipment for DME:

- Prosthetic and orthotic devices
- Inexpensive or other routinely purchased DME
- Items requiring frequent and substantial servicing
- Customized items
- Capped rental items
- Oxygen and oxygen equipment
6.5.4. Prosthetic and Orthotic Devices

These items consist of all prosthetic and orthotic devices, excluding items in the classes of certain customized items and items requiring frequent and substantial servicing, transcutaneous electrical nerve stimulators (TENS), parenteral/enteral nutritional supplies, and intraocular lenses. Other than these exceptions, payment for prosthetic and orthotic devices is made on a lump-sum-purchase basis, using the lesser of the fee schedule amount or the actual purchase charge.

Prosthetic and orthotic devices should be billed using revenue code 0274. Items with HCPCS codes A4214 through A4440, which include catheter supplies, ostomy bags, ostomy care supplies, are excluded from the fee schedule when providers bill the regional home health intermediary.

6.5.5. Inexpensive or Other Routinely Purchased DME

This is equipment with a purchase price not exceeding $150 or equipment that is acquired by purchase at least 75% of the time. Payment is either through rental or purchase, but the total payment amount for a particular item may not exceed the actual charge or fee for purchase. Payment is possible for maintaining and servicing purchased equipment.

This class of equipment should be billed using one of the following revenue codes:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>0291</td>
<td>DME Rental</td>
</tr>
<tr>
<td>0292</td>
<td>DME Purchase - New</td>
</tr>
<tr>
<td>0293</td>
<td>DME Purchase - Used</td>
</tr>
</tbody>
</table>

Any item billed under these revenue codes must be accompanied by the appropriate HCPCS code.

An order or certification proving Medical Necessity (CMN) is required for all DME regardless of whether it is rented or purchased.
6.5.6. Items Requiring Frequent and Substantial Servicing

These are items such as ventilators, aspirators, IPPB machines, and nebulizers. Payment is made on a rental basis based on monthly fee schedule amounts until the medical necessity ends. Payment is not made for equipment purchased June 1, 1989 and later.

Bill this equipment under the appropriate revenue code:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>0291</td>
<td>DME Rental</td>
</tr>
<tr>
<td>0292</td>
<td>DME Purchase - New</td>
</tr>
<tr>
<td>0293</td>
<td>DME Purchase - Used</td>
</tr>
</tbody>
</table>

Note: A customized item may only be purchased, it may not be rented.

There are only three HCPCS codes for customized items:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1220</td>
<td>Security constructed wheelchair</td>
</tr>
<tr>
<td>E1399</td>
<td>DME, Not Otherwise Classified</td>
</tr>
<tr>
<td>L8499</td>
<td>Miscellaneous Prosthetic and Orthotics</td>
</tr>
</tbody>
</table>

An order or CMN is always required when billing for a customized item.

6.5.7. Capped Rental Items

These are DME items not covered by the above categories. For these items, payment is on a rental basis not to exceed a period of 15 continuous months. Payment is not made for equipment purchased on June 1, 1989, and later.

Bill this class of equipment under the appropriate revenue code:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>0291</td>
<td>DME Rental</td>
</tr>
</tbody>
</table>

Effective June 1, 1989 Medicare does not pay for the purchase of capped rental items.
When billing revenue code 0291, bill the appropriate monthly rental amount.

Any item billed under this revenue code must be accompanied by the appropriate HCPCS code.

An order or CMN is always required when billing for a capped rental item.

6.5.8. Oxygen and Oxygen Equipment

Payment is on a monthly basis using a monthly payment rate per beneficiary. Payment is not made for purchased equipment. Payment may be made for maintenance and servicing of this equipment under revenue code 0299, with the appropriate HCPCS code representing the equipment. The billed amount is paid if reasonable.

Oxygen and oxygen equipment should be billed using the appropriate revenue codes:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>0291</td>
<td>DME Rental</td>
</tr>
<tr>
<td>0600</td>
<td>Other Oxygen</td>
</tr>
<tr>
<td>0602</td>
<td>Monthly Oxygen, less than 1 LPM</td>
</tr>
<tr>
<td>0603</td>
<td>Monthly Oxygen, all inclusive rate, greater than 4 LPM</td>
</tr>
<tr>
<td>0604</td>
<td>Monthly Oxygen, all inclusive rate, greater than 4 LPM and Portable Oxygen</td>
</tr>
</tbody>
</table>

Any items billed under these revenue codes must be accompanied by the appropriate HCPCS code.

An order or CMN is always required for rented oxygen equipment. On the first and fourth month rental test results are required:

<table>
<thead>
<tr>
<th>Condition Codes</th>
<th>Test Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>ABG</td>
</tr>
<tr>
<td>59</td>
<td>O2 Sat</td>
</tr>
</tbody>
</table>

Please refer to CMS Manual System, Pub 100-4, Medicare Claims Processing, Chapter 20, Section 100.2.3
6.5.9. Maintenance and Servicing

- Bill for maintenance and servicing of DME under revenue code 0299. Any item billed under this revenue code must be accompanied by HCPCS code #1350. See Section 463 of CMS Pub. 11 for more information.

- An order or CMN is always required for maintenance and servicing of DME.

The following section provides examples for completing the UB-92 claim form when billing for DME.

Medicare Billing - DME Home Health Claim

This example represents a home health agency billing for DME charges. The patient is homebound, has an established home health plan of treatment, and has Part A benefits. Physician orders indicate the patient requires use of a walker throughout the treatment plan. The physician established plan of treatment on August 1, 1996 and the agency started care on August 1, 1996. The agency is submitting a final bill for the month of October.

The initial SOC was August 1, 1996 and the physician’s recertification for this claim is October 1, 1996.

In this example, the fee schedule reimbursement for this walker is $20.

Medicare Billing - DME Home Health Claim

This example represents a home health agency billing for DME charges. The patient is homebound, has an established home health plan of treatment, and has Part B benefits. Physician orders indicate the patient requires use of a walker throughout the treatment plan. The physician established a plan of treatment on August 1, 1996 and the agency started care on August 1, 1996. The agency is submitting a final bill for the month of October.

The initial SOC was August 1, 1996 and the physician’s recertification for this claim is October 1, 1996.

In this example, the fee schedule reimbursement for this walker is $20.
Medicare Billing - DME Home Health Claim

This example represents a home health agency billing for DME charges. The patient is homebound, is under a home health plan of treatment, and has Part A benefits. The physician established a plan of treatment on August 1, 1996 and the agency started care on August 1, 1996. The agency is submitting a final bill for the month of October. The initial SOC was August 1, 1996 and the physician’s recertification for this claim is October 1, 1996.

Physician orders indicate the patient will require use of a cane for the rest of her life. Therefore, the patient purchases a used quad cane.

The fee schedule reimbursement for this cane is $65.
7. HOME HEALTH DOCUMENTATION

The Documentation Section will discuss the documentation requirements for all home health agencies. The following information is included in this section:

- Plan of Care Requirements
- Verbal Orders
- Plan of Care
- OASIS Completion Reminders
- Wound Care Summary Sheet
- Wound Care Flow sheet
- Optional CMS 485 Form, Plan of Care Field Descriptions
- Optional CMS 486 Form, Medical Update and Patient Information Field Descriptions
- Optional CMS 487 Form, Addendum to the Plan of Care/Medical Update
7.1. Plan of Care Requirements

Reference: CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 30.2.1 - Content of the Plan of Care

The plan of care must contain all pertinent diagnoses:

- Enter a valid ICD-9-CM code which best describes the primary reason for home health services.

- If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered.

- Enter the date of onset or exacerbation in six-digit format (MMDDYY). Indicate if the diagnosis is a new onset ("O") or an exacerbation ("E") of a pre-existing or chronic condition by placing an “O” after the diagnosis date to denote a new onset, or an “E” for an exacerbation. It is vital that the date of exacerbation be entered when the primary diagnosis is pre-existing or chronic. When there is no date of onset or exacerbation documented, the need for initiation or continuation of home health services may be in doubt. Although documenting the Os and Es are not a CMS mandate, Palmetto GBA suggests Os and Es be used to help paint a clear clinical picture. If the clinical notes document the date of onset or the exacerbation of the patient’s condition, then it is not necessary to include the O and E beside the diagnosis and date.

  O = onset of a new diagnosis
  E = exacerbation or a flare-up of a condition (requiring a change in the current plan of care)

- The HHA enters the ICD-9-CM code or the primary diagnosis. This code must be the full ICD-9-CM diagnosis code, including all five digits where applicable. When the proper code has fewer than five digits, it is not zero filled. It may or may not relate to the patient’s most recent hospital stay, but it must relate to the services the agency is rendering.

- The ICD-9-CM code and primary diagnosis reported in field 67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis) and on the Plan of Care form, unless a SCIC (significant change in condition) has occurred.
• “V” codes are acceptable as both primary and secondary diagnoses. However, “V” codes should only be used if they better describe the condition of the patient and the focus of the home health care. Do not use the “V” code when the acute diagnosis code is more specific to the exact nature of the patient’s condition. Refer to CMS Manual System, Pub 100-8, Medicare Program Integrity, Exhibit 29, Number 11.

The plan of care must also contain:

• The patient's mental status;
• The types of services, supplies, and equipment required;
• The frequency of the visits to be made;
• Prognosis;
• Rehabilitation potential;
• Functional limitations;
• Activities permitted;
• Nutritional requirements;
• All medications and treatments;
• Safety measures to protect against injury;
• Instructions for timely discharge or referral; and any additional items the HHA or physician choose to include.

The patient’s mental status: appropriate documentation could be oriented, comatose, forgetful, depressed, disoriented, lethargic, agitated, or other, please explain.

The types of services, supplies, and equipment required: list all services, supplies, and durable medical equipment (DME) to be used during the billing period. Enter all non-routine supplies to be billed.

• List all supplies necessary and include in Plan of Care.

  Example: dressing supplies, catheter kits, IV supplies.

• If no DME or supplies -- enter “N/A”.

  Note: If providing and billing for DME, remember to submit a hard copy certificate of medical necessity or order for the DME item (use HCPCS).

The frequency of the visits made: List frequency and duration for each discipline ordered by the physician. (Refer to CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 30.2.2 for information regarding specificity of orders)
• Include both a frequency and duration for each modality when billing for PT, SLP and continuing OT.

• Frequency denotes number of visits (not modalities) and should be stated in days, weeks, or months.

• Ranges are acceptable for frequency; however, they must be small. If a range is given, the upper limit is the frequency (e.g., SN 1-3 wk 9 – this allows a maximum number of 3 skilled nurse visits each week for 9 weeks).

• Orders must include all disciplines and services/treatments to be rendered even if they are not billable to Medicare.

• PRN orders must be qualified and quantified (e.g., 1 PRN SN visit per month for complication of Foley catheter). Open-ended PRN orders are not acceptable.

• The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency and duration of the services.

• **Medicare reviews orders as follows unless otherwise instructed by the provider:**
  
  - Sunday to Saturday
  - Calendar month *

  *Note: A calendar month always begins on the first day of the month. If a certification begins after the first day of the month, all orders will be reviewed for each four-week period.*

• The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

**EXAMPLE**

SN x 7/wk x 1 wk; 3/wk x 4 wk; 2/wk x 3 wk, (skilled nursing visits 7 times per week for 1 week; 3 times per week for 4 weeks; and 2 times per week for 3 weeks) for skilled observation and evaluation of the surgical site, for teaching sterile dressing changes and to perform sterile dressing changes. The sterile dressing change consists of (detail of procedure). Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided during the 60-day episode to home health patients. When a range of visits is ordered, the upper limit of the range is considered the specific frequency.
Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.

The following chart lists examples of acceptable frequency and duration of physician orders.

### Daily Orders

<table>
<thead>
<tr>
<th>Daily x _____ days</th>
<th>1DA31</th>
<th>Once per day for 31 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>BID x _____ days</td>
<td>2DA60</td>
<td>Twice a day for 60 days</td>
</tr>
<tr>
<td>TID x _____ days</td>
<td>3DA21</td>
<td>Three times a day for 21 days</td>
</tr>
<tr>
<td>QID x _____ days</td>
<td>4DA14</td>
<td>Four times a day for 14 days</td>
</tr>
</tbody>
</table>

**Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.**

### Weekly Orders

<table>
<thead>
<tr>
<th>____ times a week x ___ weeks</th>
<th>1WK9</th>
<th>Once a week for 9 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2WK9</td>
<td>Two times a week for 9 weeks</td>
</tr>
<tr>
<td></td>
<td>3WK9</td>
<td>Three times a week for 9 weeks</td>
</tr>
</tbody>
</table>

**Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.**

### Monthly Orders

<table>
<thead>
<tr>
<th>__ times a month x ___ months</th>
<th>1MO3</th>
<th>Once a month for 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2MO2</td>
<td>Twice a month for 2 months</td>
</tr>
<tr>
<td></td>
<td>3MO2</td>
<td>Three times a month for 2 months</td>
</tr>
</tbody>
</table>

**Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.**

### PRN Orders

<table>
<thead>
<tr>
<th>PRN Visits</th>
<th>1PRN</th>
<th>One PRN visit for foley change due to leaking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2PRN</td>
<td>Two PRN visits for disimpaction</td>
</tr>
</tbody>
</table>

**Note: PRN Orders must be qualified and quantified.**

### Range Orders

<table>
<thead>
<tr>
<th>____ times a week for __ weeks</th>
<th>1-3WK9</th>
<th>One to three times per week for 9 wks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2-4WK9</td>
<td>Two to four times per week for 9 wks</td>
</tr>
<tr>
<td></td>
<td>3-5WK9</td>
<td>Three to five times per week for 9 wks</td>
</tr>
</tbody>
</table>

**Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.**

### Note: The upper limit of the range is considered the frequency.
Prognosis: Some appropriate responses may be poor, guarded, fair, good, excellent

Rehabilitation Potential: Enter the physician’s description of achievable goals and the patient’s ability to meet these goals.

- Document the discharge plans for care after discharge.
- Rehabilitation potential should include patient’s ability to achieve goals and estimated time needed to achieve. Stay away from “Fair” or “Poor”. Use descriptors.
- Endpoint to daily skilled nursing visits may be documented here or in a nursing note.

Endpoint criteria are as follows:

- When skilled nursing is the qualifying skill, and
- Services are being provided on a daily basis (effective October 1, 1997, daily is defined as 7 days per week) and
- The visits are expected to last more than a short period of time (CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 40.1.3 defines short duration as 2-3 weeks), then
- There must be a finite and predictable endpoint to the daily skilled nursing visits.
- This endpoint must be documented in the medical record. The suggested place to document endpoint is in the “Goals” field (22) of the optional 485 form. However, it may be documented in a nursing note or in the summary of the optional 486 form.
- The endpoint may be stated in days, weeks, months, or a specific date. The endpoint to daily skilled nursing visits may extend past the certification period, if necessary. Endpoint is different from orders. Orders only cover the current certification period, while endpoint refers to when the daily skilled nursing visits are expected to be reduced to less than daily and therefore may extend past the certification period. Documentation should substantiate the endpoint.
- Upon admission, many times the stated endpoint is the physicians’ and the nurses’ “best guess” of when the skilled nursing services will be reduced to less than daily. This endpoint should be adjusted if, after care is started, it becomes evident that the original endpoint is not realistic. Adjustment of the endpoint should not wait until the next certification period,
but rather, adjusted immediately in either a nurse’s note or the medical record. In either case, substantiate the new endpoint and what precipitated that change. Bear in mind, continual extensions of endpoint for daily skilled nursing visits may be viewed as not finite and predictable.

- If it is evident, or becomes evident that there is not a finite and predictable endpoint to daily skilled nursing visits, then the patient no longer qualifies for Medicare home health coverage. *This is a technical issue and not a medical necessity issue.* The Medicare Home Health Benefit was not established to provide daily skilled nursing services, but rather, to provide intermittent skilled nursing services.

**Note:** *The one and only one exception to this rule is a patient who requires and qualifies for skilled nursing services to perform daily insulin injections.*

**Functional limitations:** Current limitations as assessed by physician or home health agency. Examples: amputation, bowel-bladder incontinence, contracture, hearing, paralysis, endurance ambulation, speech, legally blind, other

**Activities permitted:** Indicate all activities allowed by physician: i.e. bed rest, up as tolerated, transfer bed/chair, exercise prescribed, partial weight bearing, independent at home, crutches, cane, wheelchair, walker, no restrictions, other.

**Nutritional requirements:** Enter physician’s orders or diet including:

- Therapeutic diets
- Specific dietary requirements
- Fluid restrictions or requirements
- Parenteral or enteral requirements should be included

**All medications and treatments:** Enter all medications including over-the-counter drugs.

- Enter dosage, frequency and route.
- New or Changed Medication.
- New within last 30 days (N).
- Changed within last 60-days (C).
- It is very important that you indicate new or changed medications. New and/or changed medications indicate and support changes or exacerbations in the patient’s condition, which may warrant additional or continuing home health services. **These indicators must be updated with each re-certification.**

**Safety measures to protect against injury:** Enter physician’s instructions for safety measures or those identified by the home health agency. Example: Bed confined, oxygen precaution.
Instructions for timely discharge or referral: list discharge plans

Any additional items the HHA or physician choose to include.

7.2 Verbal Orders

Reference: CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 30

When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies. The following individuals responsible for furnishing or supervising the ordered services may take and co-sign verbal orders:

- Registered Nurse
- Qualified Therapist
- Registered Physical Therapist
- Registered Speech Language Pathologist
- Registered Occupational Therapist
- Masters Medical Social Worker

The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician before HHA bills Medicare for services.

When a change occurs in the patient’s condition requiring a change in the POC, a verbal order or supplemental order updates the current POC. Verbal orders supersede orders on the POC and previous verbal orders. They are only valid for the duration listed in the order, or until the end of the plan of care, whichever comes first. Remember, all verbal orders must be signed by the physician prior to billing the fiscal intermediary. If the verbal orders are intended to continue into the next certification period, the order must reference the plan of care for which the order is intended.

Note:

- Verbal orders are considered complete when they include the discipline, frequency and duration of services and treatment or service to be provided.
- Agencies need to ensure compliance with State Licensure Guidelines on signature of verbal orders.
- Orders taken by LVN, LPN, or BSW must be co-signed by a qualified individual listed above.
7.3 Who Signs the Plan of Care

The plan of care must be signed and dated by a physician who meets the certification and recertification requirements of 42 CFR 424.22 and before the final claim for each episode for services is submitted for payment. Any changes in the plan of care must be signed and dated by a physician.

7.3.1 Frequency of Review of the Plan of Care

The plan of care must be reviewed and signed by the physician who established the plan of care every 60 days, in consultation with HHA professional personnel. Each review of a patient's plan of care must contain the signature of the physician and the date of review.

7.3.2 Facsimile Signatures

The plan of care or oral order may be transmitted by facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

7.3.3 Alternative Signatures

HHAs that maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown.

7.3.4 Physician Certification

Reference: CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 30.5

The HHA must be acting upon a physician certification that is part of the plan of care (Form CMS-485 may be used, but is optional) and meets the requirements of this section for HHA services to be covered.
The physician must certify that:

- The home health services are or were needed because the patient is or was confined to the home;

- The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased;

- A plan of care has been established and is periodically reviewed by a physician; and

- The services are/or were furnished while the patient is or was under the care of a physician.

### 7.3.5 Periodic Recertification

**Reference:** CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 30.5.2

At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode. An eligible beneficiary who qualifies for a subsequent 60-day episode would start the subsequent 60-day episode on day 61. Under HH PPS, the plan of care must be reviewed and signed by the physician every 60 days unless one of the following occurs:

- A beneficiary transfers to another HHA;
- A SCIC (significant change in condition) resulting in a change in the assigned case-mix; or
- A discharge and return to the same HHA during the 60-day episode.

Medicare does not limit the number of continuous episode recertifications for beneficiaries who continue to be eligible for the home health benefit. The physician certification may cover a period less than but not greater than 60 days.

### 7.4 OASIS Completion Reminders

The OASIS Implementation Manual (revised December 2002) is the OASIS instruction manual for the home health agency, which is provided by CMS. This information is located on the CMS web site at [www.cms.hhs.gov/oasis/usermanu.asp](http://www.cms.hhs.gov/oasis/usermanu.asp).

The following M0 items represent a HHRG (Home Health Resource Group), which is identified on the claim by a HIPPS code. The responses to these M0 items total each of the three (Clinical, Functional, Service Utilization) Domain scores.
7.4.1 Clinical Severity Domain

M0230: Primary Diagnosis for which the Patient is Receiving Home Care

- The primary diagnosis on M0230 should be the primary reason for providing home care. List the ICD codes according to their severity. The M0230 response for a Beneficiary with cholelithiasis resulting in cholecystectomy would be the diagnosis of cholelithiasis.
- Trauma codes are reserved for injuries from accidents or intentional violence. Supportive documentation is necessary for identification of the trauma.
- Refer to the CMS web site at: [www.cms.hhs.gov/providers/hhapps/hhdiaig.pdf](http://www.cms.hhs.gov/providers/hhapps/hhdiaig.pdf) for correct diagnosis coding for Medicare Home Health under PPS.

M0240: Other Diagnoses for which the Patient is Receiving Home Care

- If the primary homecare diagnosis is coded as a combination of an etiology and a manifestation code, the etiology code should be entered in M0230 (a) and the manifestation code should be entered in M0240 (b). The ICD-9-CM manual clearly shows the instances where manifestation coding is required.
  
  A common example of manifestation coding in home care is diabetic ulcers. The alphabetic index lists diabetic ulcers under “diabetes, ulcer (skin)”. This entry shows codes, as follows: 250.8x [707.9]. The first code is for the diagnosis “diabetes with other specified manifestations”. (The “x” means a fifth digit is required. The tabular list explains how to determine the fifth digit.) The second code is for the diagnosis “chronic ulcer of unspecified site”. Placed in brackets, the second code is a manifestation of the disease diabetes.
- Refer to the CMS Web site: [www.cms.hhs.gov/providers/hhapps/hhdiaig.pdf](http://www.cms.hhs.gov/providers/hhapps/hhdiaig.pdf) for correct diagnosis coding for Medicare Home Health under PPS.

M0245: Payment Diagnoses (optional)

- Effective October 1, 2003
- Complete M0245 only if a V code has been reported in place of a case mix diagnosis in M0230.

*Note – A case mix diagnosis is a primary diagnosis that assigns the patient with selected conditions to an orthopedic, diabetic, neurological or burn/trauma group for Medicare PPS case mix adjustment. A case mix diagnosis may involve manifestation coding.*

- If the patient’s primary home care diagnosis is coded as a combination of an etiology and a manifestation code, the etiology code should be entered in M0245 (a) and the manifestation code should be entered in M0245 (b).
M0250: IV/Infusion/Parenteral/Enteral Therapies
• Documentation should clarify the role of the HHA in the provision of these therapies.
• This M0 item does not include therapies a patient receives in outpatient facilities.

M0390: Vision
• Identifies the patient’s ability to see within his/her environment.

M0420: Pain
• Identifies the frequency with which pain interferes with activities/function.

M0440: Does the Patient have a Skin Lesion or an Open Wound?
• Identifies any open skin lesion or wound, excluding ostomies.
• Type of wound, description, location, status, and drainage size should be included in provider documentation.
• Wound associated with burn/trauma requires documentation of the type trauma sustained and the appropriate ICD-9 code in M0230.

Note: Refer to the following:
1. Wound Summary spreadsheet sheet included, Section 7.5.
2. Wound Care Flowsheet, Section 7.5.2.

M0450: Current Number of Pressure Ulcers at Each Stage
• Identifies the number of Stage 3 and 4 pressure areas (support with documentation).
• Definitions of pressure ulcer stages are derived from the National Pressure Ulcer Advisory Panel. Refer to the Web site at www.npuap.org for additional clarification and/or resources.
• Reverse staging of granulating pressure ulcers is NOT acceptable clinical practice
• Muscle flaps to surgically replace a pressure ulcer are considered surgical wounds and no longer pressure ulcers
• A pressure ulcer that has been surgically debrided remains a pressure ulcer.

M0460: Stage of Most Problematic (Observable) Pressure Ulcer
• “Most Problematic” is defined as the largest, most advanced stage and most difficult to treat depending on the specific situation.
• Wound must be visible to determine the stage of the ulcer. Wounds covered with necrotic tissue cannot be staged until the necrotic tissue is removed.
• Definitions of the pressure ulcer stages are derived from the National Pressure Ulcer Advisory Panel. Refer to the Web site at www.npuap.org for additional clarification and/or resources.

M0476: Status of Most Problematic (Observable) Stasis Ulcer
• Stasis Ulcers are caused by inadequate venous circulation.
• Stasis Ulcers do not include arterial circulatory lesions or arterial ulcers.
• Documentation should differentiate stasis ulcers from other types of skin lesions such as diabetic or pressure ulcers.
• Refer to Wound, Ostomy, and Continence Nurses Society (WOCN) at www.wocn.org for additional clarification.

M0488: Status Most Problematic (Observable) Surgical Wound
• If more than one wound exists, determine the most problematic.
• Examples of surgical wound may include: orthopedic pin sites, central line sites, stapled or sutured incisions, debrided graft sites, wounds with drains, Medi-port sites and other implanted infusion devices or venous access devices.
• A PICC line is not considered a surgical wound due to peripheral insertion.
• Refer to Wound, Ostomy, and Continence Nurses Society (WOCN) at www.wocn.org for additional clarification.

M0490: When is the Patient Dyspneic or Noticeably Short of Breath?
• Identifies the patient’s level shortness of breath: if the patient uses oxygen continuously, mark the response that best describes the patient’s shortness of breath while using the oxygen. If oxygen is used intermittently, mark the response that best describes the patient’s shortness of breath.

M0530: When does Urinary Incontinence Occur?
• Identifies the time of day when the urinary incontinence occurs.

Note: The responses to M0520 and M0530 should be consistent or M0530 will be invalid.

M0540: Bowel Incontinence Frequency
• Identifies how often the patient experiences bowel incontinence.

M0550: Ostomy for Bowel Elimination
• Identifies whether the patient has an ostomy for bowel elimination.

M0610: Behaviors Demonstrated at Least Once a Week
• Identifies specific behaviors exhibited by patient.
• The frequency of interfering behaviors must be at least once weekly.

7.4.2 Functional Status Domain

M0650 Ability to Dress Upper Body
M0660 Ability to Dress Lower Body
M0670 Bathing: Ability to Wash Entire Body
M0680 Toileting
These MO items assess the patient’s current ability to perform the specific activity. If the ability varies, the OASIS response should describe the ability noted more than 50% of the time.

### 7.4.3 Service Utilization Domain

**M0175: Health Service Utilization Preceding this Medicare Home Health Admission**

- All descriptive categories must be marked.

Note: Emergency room visits do not constitute inpatient hospitalization and should be coded as “other”. All “other” responses should be accompanied by comment. Assisted living is not considered an inpatient facility.


**M0825: Therapy Threshold**

- Therapies include physical, occupational and speech-language pathology.
- Therapy threshold is defined as 10 or more therapy visits provided under the home health plan of care.
- Wound care provided by the physical therapist (within the auspice of the State Practice Acts) counts toward therapy threshold.

### 7.5 Wound Summary Sheet Information

The following spreadsheet is a summary of information regarding various types of wounds including pressure ulcers (also known as decubitus ulcers, bedsores, or plaster ulcers), diabetic ulcers, stasis ulcers, burns, traumatic wounds, atherosclerotic wounds, and surgical wounds. The information includes associated ICD-9-CM coding, staging, definitions, descriptions and associated OASIS items. For more information, refer to the following Web sites:

[www.npuap.org](http://www.npuap.org)
[www.wocn.org](http://www.wocn.org)
7.5.1 Wound Summary Sheet

Wound Summary Sheet begins on the next page
<table>
<thead>
<tr>
<th>Type of Wound</th>
<th>ICD-9 Code</th>
<th>Staged</th>
<th>Definition</th>
<th>Description</th>
<th>OASIS</th>
</tr>
</thead>
</table>
| Pressure Ulcer    | 707.0 (Decubitus Ulcer) *Bedsore *Decubitus Ulcer (Any site) *Plaster Ulcer *Pressure Ulcer | Stage 1: Nonblanchable erythema of skin; the heralding ulceration of skin ulceration. In darker pigmented skin, warmth, edema, hardness or discolored skin may be indicators. Stage 2: Partial thickness skin loss involving epidermis and/or dermis. Ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous fat tissue which may extend down to, but not through, underlying fascia. Ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. Stage 4: Full-thickness loss with extensive destruction, tissue necrosis, or damage to tendon, muscle, bone, or supporting structure (e.g.: joint capsule, etc.). ***The ulcer bed must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar, it cannot be staged until the necrotic tissue is removed. The correct OASIS response must include "E" ***Reverse staging of granulating pressure ulcers is not acceptable clinical practice according to the National Pressure Ulcer Advisory Panel. If a pressure ulcer is assessed to be a Stage 3 and is granulating at the time of the OASIS assessment, it remains a Stage 3 ulcer. | Pressure Ulcer can take as little as one to two hours to form. In the early stages, pressure ulcers may appear as nothing more than a redness of the skin. But over time, the redness may progress to a deep opening in the skin. The areas most associated with pressure ulcers are the tailbone, heels, elbows, shoulder blades, knees, ankles, the back of the head, and the spine. ***A muscle flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer. ***A pressure ulcer that has been surgically debrided remains a pressure ulcer. It does not become a surgical wound. | M0 445  
M0 450  
M0 460  
M0 464 |
<table>
<thead>
<tr>
<th>Type of Wound</th>
<th>ICD-9 Code</th>
<th>Staged</th>
<th>Definition</th>
<th>Description</th>
<th>OASIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Ulcer</td>
<td>Code first any associated underlying condition: Diabetes Mellitus, 250.80-250.83</td>
<td>N/A</td>
<td>Diabetes affects circulation as well as the nerve endings in the feet. As a result, many diabetics suffer reduced circulation and loss of sensation in their feet. The loss of sensation is dangerous, because they are unable to feel rubbing, pinching, or other pain that could cause a wound to develop on the foot. Risk factors for developing a diabetic ulcer include loss of sensation or peripheral neuropathy, structural deformity, infection, and decreased circulation.</td>
<td>The arterial occlusion typically involves the tibial and peroneal arteries but spares the dorsalis pedis artery. Signs and symptoms may include claudication, pain occurring in the arch or forefoot at rest or during the night, absent popliteal or posterior tibial pulses, thinned or shiny skin, absence of hair on the lower leg or foot, thinned nails, redness of the affected area when the legs are dependent, or dangled, and pallor when the foot is elevated. Foot deformities, which are common in diabetic patients, lead to focal areas of high pressure. Most diabetic foot ulcers form over areas of bony prominences, especially bunion, calluses, or hammer toe formations lead to abnormally prominent bony points. Foot deformities are believed to be more common in diabetic patients due to atrophy of the intrinsic musculature responsible for stabilizing the toes. In the diabetic foot, autonomic neuropathy has several common manifestations. First, denervation of dermal structures leads to decreased sweating. This causes dry skin and fissure formation, which predispose the skin to infection.</td>
<td>*Points can only be taken for M0230 Diabetic ulcer if the ICD-9-CM Codes are appropriately paired. Primary Diagnosis: 250.80-250.83 (in M0230) Secondary Diagnosis: 707.1-707.9 (in M0240, line b.)</td>
</tr>
<tr>
<td></td>
<td>Secondary Diagnosis, 707.1 (Ulcer of lower limbs, except decubitus) Ulcer, chronic: neurogenic, tropic of lower limb. 707.10 Ulcer of lower limb, unspecified 707.11 Ulcer of thigh 707.12 Ulcer of calf 707.13 Ulcer of ankle 707.14 Ulcer of heel and midfoot 707.15 Ulcer of other part of foot 707.19 Ulcer of other part of lower limb 707.8 Chronic ulcer of other specified site. 707.9 Chronic ulcer of unspecified site.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Palmetto GBA
Home Health Training Manual, 2005*
<table>
<thead>
<tr>
<th>Type of Wound</th>
<th>ICD-9 Code</th>
<th>Staged</th>
<th>Definition</th>
<th>Description</th>
<th>OASIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Ulcer</td>
<td>Code first any associated underlying condition: Diabetes Mellitus, 250.80-250.83 Secondary Diagnosis, 707.1 (Ulcer of lower limbs, except decubitus) Ulcer, chronic: neurogenic, tropic of lower limb. 707.10 Ulcer of lower limb, unspecified 707.11 Ulcer of thigh 707.12 Ulcer of calf 707.13 Ulcer of ankle 707.14 Ulcer of heel and midfoot 707.15 Ulcer of other part of foot 707.19 Ulcer of other part of lower limb. 707.8 Chronic ulcer of other specified site. 707.9 Chronic ulcer of unspecified site.</td>
<td>N/A</td>
<td>Diabetes affects circulation as well as the nerve endings in the feet. As a result, many diabetics suffer reduced circulation and loss of sensation in their feet. The loss of sensation is dangerous, because they are unable to feel rubbing, pinching, or other pain that could cause a wound to develop on the foot. Risk factors for developing a diabetic ulcer include loss of sensation or peripheral neuropathy, structural deformity, infection, and decreased circulation.</td>
<td>Neurpathy, a major etiologic component of most diabetic ulcerations. This lack of protective sensation, combined with unaccomodated foot deformities, exposes patients to undue sudden or repetitive stress that leads to eventual ulcer formation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Points can only be taken for M0230 Diabetic ulcer if the ICD-9-CM Codes are appropriately paired.</td>
<td>Primary Diagnosis: 250.80-250.83 (in M0230) Secondary Diagnosis: 707.1-707.9 (in M0240, line b.)</td>
<td></td>
</tr>
<tr>
<td>Type of Wound</td>
<td>ICD-9 Code</td>
<td>Staged</td>
<td>Definition</td>
<td>Description</td>
<td>OASIS</td>
</tr>
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<td>---------</td>
</tr>
<tr>
<td>Stasis Ulcer</td>
<td>459.81 Venous (peripheral insufficiency, unspecified chronic venous insufficiency NOS) Use additional code for any associated ulceration (707.10-707.9)</td>
<td>N/A</td>
<td>Venous leg ulcers are related to chronic venous insufficiency, a condition in which the veins in the leg are inadequate at pumping blood back towards the heart. As a result, fluid and blood products leak through the vessel walls into the surrounding tissue.</td>
<td>Venous leg ulcers are shallow, irregular shaped ulcers that often appear beefy and red. Typically, they are located below the knee, usually inside the legs just above the ankles. However, they can occur almost anywhere on the lower leg.</td>
<td>M0 468</td>
</tr>
<tr>
<td></td>
<td>459.89 Other Collateral Circulation (venous), any site Phlebosclerosis Venofibrosis</td>
<td></td>
<td>*Stasis ulcers are sometimes referred to as venous ulcers or ulcers related to peripheral vascular disease (PVD). Stasis ulcers do not include arterial circulatory lesions or arterial ulcers. (PVD can occur in the arteries or veins.)</td>
<td>*Fully granulating: Wound granulating tissue to the level of the surrounding skin or new epithelium; no dead space, no vascular tissue; no signs or symptoms of infection; wound edges open.</td>
<td>M0 470</td>
</tr>
<tr>
<td></td>
<td>454.0 Stasis ulcer with varicose veins.</td>
<td></td>
<td></td>
<td>*Early/partial granulation: &gt;25% of wound bed is covered with granulation tissue; minimal avascular tissue (i.e., &lt;25% of the wound bed is covered with avascular tissue); may have dead space; no signs or symptoms of infection; wound edges open.</td>
<td>M0 474</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Non-healing: Wound with &gt;25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.</td>
<td>M0 476</td>
</tr>
<tr>
<td>Type of Wound</td>
<td>ICD-9 Code</td>
<td>Rated, not staged</td>
<td>Definition</td>
<td>Description</td>
<td>OASIS</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Burn</td>
<td>941 Burn of head/face/neck</td>
<td>First-degree burns appear red or pink in color and may be mildly swollen. The skin feels raw and tender. Sunburn is the most common kind of first-degree burn. Second-degree burns turn the skin bright red. The skin can also appear blistered, swollen, and moist in appearance. Blisters are the distinguishing characteristic of second-degree burns. The following types of burns can result in first or second-degree burns: *Thermal burns-burns caused by heat or flames. *Contact burns-Burns caused by a hot surface like an iron, light bulb, or muffler tail pipe. *Scald-a burn caused by hot water, grease, or radiator fluid. *Sunburn Third-degree burns destroy the epidermis and dermis. The third degree burns are dry, leathery, and appear dark brown, black, or a dry white.</td>
<td>Burn is defined as any injury caused by heat, electricity, chemicals, radiation, or gases. Burns are rated according to how many layers of skin are damaged. First-degree burns occur when the top layer of skin, called the epidermis, is burned. Second-degree burns, or partial thickness burns, occur when the burn penetrates beyond the superficial epidermis and burns through the dermis. Third-degree burns, or full thickness burns, burns completely through the dermis, and may burn throughout the underlying flesh and bones.</td>
<td>M0230 (Primary medical diagnosis) and M0440 (marked &quot;yes&quot;)</td>
<td></td>
</tr>
<tr>
<td>Type of Wound</td>
<td>ICD-9 Code</td>
<td>Staged</td>
<td>Definition</td>
<td>Description</td>
<td>OASIS</td>
</tr>
<tr>
<td>---------------</td>
<td>------------</td>
<td>--------</td>
<td>------------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>Trauma</td>
<td>870 Ocular Adnexa Open wound 872 Open wound of ear 873 Other open wound of head 874 Open wound of neck 875 Open wound of chest 876 Open wound of back 877 Open wound buttocks 878 Open wound genital organ 879 Open wound site NEC 880 Open wound shoulder/upper arm 881 Open wound of lower arm 882 Open wound of hand 883 Open wound of finger 884 Open wound arm mult/NOS 885 Trauma Amputation thumb 886 Trauma Amputation finger 890 Open wound of hip/thigh 891 Open wound of knee/leg/ankle 892 Open wound of foot 893 Open wound of toe 894 Open wound of leg 895 Traumatic amputation toe</td>
<td>N/A</td>
<td>Traumatic wound is one that results from an unintentional injury or accident. Traumatic wounds are acute wounds, as opposed to diabetic foot ulcers and venous leg ulcers, which are chronic wounds.</td>
<td>A number of wounds are considered traumatic wounds, including lacerations, cuts, scrapes, and skin tears associated with an accident or trauma to the body, as opposed to surgery or a chronic wound.</td>
<td>M0230 (primary medical diagnosis) and M0440 (marked &quot;yes&quot;)</td>
</tr>
<tr>
<td>Type of Wound</td>
<td>ICD-9 Code</td>
<td>Staged</td>
<td>Definition</td>
<td>Description</td>
<td>OASIS</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Ulcer associated with atherosclerosis due to diabetes</td>
<td>Primary Diagnosis: 440.23 (440.21-440.23) Secondary Diagnosis: 707.1-707.9 See description of IC9 codes under Diabetic Ulcer (secondary diagnosis).</td>
<td>N/A</td>
<td>Artherosclerosis is characterized by the deposition of fatty substances in &amp; fibrosis of the inner layer of the arteries. In diabetes, occlusion of the smaller vessels is more frequent.</td>
<td>Ulcers are likely to be moist and infected. Healing, if it occurs at all, may be very slow and healed areas may break down easily.</td>
<td>No points for MO items.</td>
</tr>
<tr>
<td>Type of Wound</td>
<td>ICD-9 Code</td>
<td>Staged</td>
<td>Definition</td>
<td>Description</td>
<td>OASIS</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Surgical Wound</td>
<td>Refer to ICD-9 book for appropriate ICD-9 Code.</td>
<td>N/A</td>
<td>According to ROVER Manual 4-15, Identifies the degree of healing visible in the most problematic surgical wound. Orthopedic pin sites, central line sites, stapled or sutured incisions, debrided graft sites and wounds with drains are all considered surgical wounds, as are Medi-port sites and other implanted infusion devices or venous access devices. A PICC line is not a surgical wound, as it is peripherally inserted. *The &quot;most problematic&quot; wound is one that may be complicated by the presence of infection, location of wound, large size, difficult management of drainage, or slow healing. *A surgical incision with approximated edges and a scab (i.e., crust) from dried blood or tissue fluid is considered a current surgical wound. &quot;Old&quot; surgical wounds which have resulted in scar or keloid formation are not considered current surgical wounds. *Established Medi-ports and similar sites would be coded as &quot;1&quot;-fully granulating.</td>
<td>*Fully granulating/healing-incision well approximated with complete epithelialization of incision; no signs or symptoms of infection, healing ridge well defined. *Early/partial granulation-incision well approximated but not completely epithelialized; no signs or symptoms of infection; healing ridge palpable but poorly defined. *Non-healing-incisional separation OR incisional necrosis OR signs or symptoms of infection OR no palpable healing ridge. *Description/classification of wounds healing by secondary intention (i.e., healing of dehisced wound by granulation, contraction, and epithelialization) *Fully granulating- Wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue, no signs or symptoms of infection; wound edges are open. *Early/partial granulation-&gt;255 of the wound bed is covered with granulation tissue; there is minimal avascular tissue (i.e., &lt;25% of the wound bed is covered with avascular tissue); may have dead space, no signs or symptoms of infection, wound edges are open. *Non-healing-Wound with &gt;25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite comprehensive appropriate wound management.</td>
<td>M0482 M0484 M0486 M0488</td>
</tr>
</tbody>
</table>
### 7.5.2 Wound Care Flow Sheet

#### Wound Care Flow Sheet

<table>
<thead>
<tr>
<th>Date of Assessment: ____________________</th>
<th>Wound Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name: _________________________</td>
<td>Primary Diagnosis: ______________________</td>
</tr>
<tr>
<td>HICN: _______________________________</td>
<td>Secondary Diagnosis: ______________________</td>
</tr>
</tbody>
</table>

#### Wound Etiology:
- [ ] Trauma
- [ ] Diabetic
- [ ] Venous Stasis
- [ ] Other ___________
- [ ] Burn
- [ ] Pressure
- [ ] Surgery

#### Wound Type:
- [ ] Trauma Wound
  - report cause: ______________________________
- [ ] Burn
- [ ] Pressure Ulcer
  - report stage: [ ] I [ ] II [ ] III [ ] IV [ ] Unobservable
- [ ] Surgical Wound
  - surgery date: ________ type: ___________
- [ ] Diabetic Ulcer
- [ ] Venous Stasis Ulcer
- [ ] Arterial Ulcer
- [ ] Other: ________________________________

#### Wound Type Definitions:
- **Trauma**: A wound that resulted from an unintentional injury or accident.
- **Burn**: Any injury caused by heat, electricity, chemicals, radiation, or gases. Burns are rated according to how many layers of skin are damaged.
- **Pressure Ulcer**: Any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers are usually over bony prominences and are staged to classify the degree of tissue damage observed.
- **Surgical Wound**: A wound caused by a surgical intervention. Orthopedic pin sites, central lines (excluding PICCS), stapled or sutured incisions, debrided graft sites and wounds with drains are all considered surgical wounds.
- **Diabetic Ulcer**: A chronic wound of the foot that occurs in patients with diabetes. It is caused by loss of sensation and feeling in the lower extremities.
- **Venous Stasis Ulcer**: An ulcer caused by inadequate venous circulation, usually lower legs. Lesions usually weeping and with irregular wound edges.
- **Arterial Ulcer**: An ulcer caused by inadequate arterial circulation, usually located distally small, dry lesions with well defined borders (punch-out lesions).
## Wound Description:

| Location: ______________________________ |
| Width ______ | Length ______ | Depth ______ |

- Tunneling
- Undermining
- Unobservable

Due to:
- Eschar
- Cast
- Nonremovable Dressing

Type of Dressing: ____________________________

- Other: ____________________________

Please Explain:

Drainage (amount and color): ______________

Wound Color: ____________________________

Odor: _________________________________

Surrounding Tissue: ____________________________

Granulation Tissue:
- Fully Granulating
- Early/Partial Granulation
- Not Healing

## 7.6 CMS 485----Optional Form

Please see the above section 7.1 through 7.1.6 for the requirements for plan of care. Please note that home health agencies are not required to use the CMS Form 485, however, we have left instructions in this training manual as some providers may choose to use the CMS 485 Form for the Plan of Care.

Proper completion of the CMS 485 form is of fundamental importance. This form must be completed in its entirety and no field may be left blank. Documentation of the CMS 485 form must be accurate, clear and concise. If your agency uses a plain paper CMS 485, all fields must be present including field locators 26 and 28. Each CMS 485 form must stand alone since prior certifications and/or recertifications are not used in the review of claims which fall under a new certification period.

The optional CMS 485 form should be completed as soon as possible after the patient’s start of care.

- CMS 486 (Optional Form)
The CMS 486 may be completed when a claim is selected for medical review and medical records are requested via the Additional Development Request (ADR). The agency has the option of completing the CMS 486 or submitting discipline notes in response to the medical ADR request.

- **CMS 487 (Optional Form)**

  The CMS 487 may be used as an addendum to either the CMS 485 or CMS 486. The agency has the option of completing the CMS 487 addendum or using a blank sheet of paper to list the continued sections.

When your agency uses an addendum to the CMS 485, blank paper may be used with the name and health insurance number of the specific beneficiary listed across the top. Also, remember to number the pages (i.e., page 1 of 2, etc.). When responding with updated clinical information it is not necessary to photocopy the medical record; the agency may wish to provide the requested updated clinical information in summary format on a blank sheet of paper with the name and health insurance number of the specific beneficiary listed across the top. This is not to say Palmetto GBA will no longer accept medical records. Either format is acceptable to us, as well as the continued use of optional CMS 486 and optional CMS 487 forms at your expense. Directions for completion of the CMS 485, 486, and 487 forms follow.

### 7.6.1 CMS - 485, Plan of Care Field Descriptions

<table>
<thead>
<tr>
<th>FIELD 1 - PATIENT’S HIC NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Must be the same on all documentation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FIELD 2 - START OF CARE DATE (SOC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- First Medicare billable service.</td>
</tr>
<tr>
<td>- Assessment visit is an administrative visit and thus not billable. However, if the RN performs an ordered, medically reasonable and necessary skilled service during that assessment visit, then that visit becomes the first Medicare billable visit.</td>
</tr>
</tbody>
</table>

**EXAMPLE 1: Verbal** order from physician for home health care received by the agency on 040196, yet the first Medicare billable visit is not made until 040596. Since 040596 is your first Medicare billable visit, this will be your start of care date.

**EXAMPLE 2: Skilled** visits ordered one time a month to begin on 041596 and durable medical equipment ordered to go into the home on 040596 (agency is also billing
Medicare for the DME). 040596 will be your first Medicare billable service; therefore, 040596 will also be your start of care date.

- The SOC date will remain the same until the patient is discharged.

- The SOC date will be the FROM date (FL 3) on the initial POC. The SOC will also be the admission date as listed on the UB-92 FL 4.

- If a patient is in the hospital at the time the recertification is due, the patient may either be discharged and re-admitted with a new SOC date or may be placed on hold for a period no longer than 60-days from the date of hospitalization.

### FIELD 3 - CERTIFICATION PERIOD

- This identifies the period covered by the physician’s plan of care. Enter the six-digit month, day and year.

- **From Date**
  - The first day this POC covers includes this day.
  - On the initial certification, the “from date” must be the same as start of care.

- **To Date (for dates of service beginning 10/01/00)**
  - The “TO” date should be the end of the certification. Services delivered on the “TO” date are covered in the present certification date.
  - The “TO” date should be up to and including the stated date, but not exceeding 60-days.
  - The subsequent recertification “FROM” date should be the next date after the previous certification’s “TO” date. For example:

    Initial certification:

    ```
    “FROM”: 100100
    “TO”: 112900
    ```

    Recertification:

    ```
    “FROM”: 113000
    “TO”: 012801
    ```

Note: The 60-day episode dates should match the 60-day plan of care.
FIELD 4 - MEDICAL RECORD NUMBER

- Optional at the agency level. May enter the patient’s chart number, if applicable. If your agency does not assign medical record numbers, enter “N/A” (not applicable) in this field.

FIELD 5 - PROVIDER NUMBER

- Enter the provider number assigned by Medicare. This number is comprised of six digits.

- The first two digits identify the state, the third digit indicates a home health agency, the last three digits specify a particular agency, i.e., ss-7nnn.

FIELD 6 - PATIENT’S NAME AND ADDRESS

- Enter the patient’s last name, first name, and middle initial as shown on the patient’s health insurance card, followed by the street, city, and state where care is being rendered.

Note: It is extremely important that the name and the patient HIC number is as reported on the CWF. Otherwise, the claim will be returned for correction or denied.

- List the address where care is being rendered.

FIELD 7 - PROVIDER’S NAME AND ADDRESS

- Enter your agency’s name and address. Also include the agency’s most current phone number in the event questions arise during the course of medical review.

FIELD 8 - DATE OF BIRTH

- MMDDYYYY (Must be correct and in six-digit format).
FIELD 9 - SEX

- Check the appropriate box.

M - Male  F - Female

FIELD 10 - MEDICATIONS

- Enter all medications including over-the-counter drugs.

- Enter dosage, frequency and route.

- Place an “N” next to new medications and a “C” for changed medications, if appropriate.

- N = New within last 30 days.
  C = Changed within last 60-days.

It is very important you indicate any new or changed medications. New or changed medications indicate and support changes or exacerbations in the patient’s condition, which may warrant additional or continuing home health services. These indicators must be updated with each recertification.

FIELD 11 - PRINCIPAL DIAGNOSIS

- Enter a valid ICD-9-CM code which best describes the principal reason for home health services.

- If more than one diagnosis exists, enter the most acute.

- Enter the date of onset or exacerbation in six-digit format (MMDDYY). Indicate if the diagnosis is a new onset (“O”) or an exacerbation (“E”) of a pre-existing or chronic condition by placing an “O” after the diagnosis date to denote a new onset, or an “E” for an exacerbation. It is vital the date of exacerbation be entered when the primary diagnosis is pre-existing or chronic. When there is no date of onset or exacerbation documented, the need for initiation or continuation of home health services would be in doubt. Although documenting the Os and Es are not a CMS mandate, Palmetto GBA suggests Os and Es be used to help paint a clinical picture. If the clinical notes document the date of onset or the exacerbation of the patient’s condition, then it is not necessary
to include the O and E beside the diagnosis and date. However, Palmetto GBA suggests agencies use Os and Es beside the diagnosis and date.

O = onset of a new diagnosis  
E = exacerbation or a flare-up of a condition (requiring a change in the current plan of care)

- The HHA enters the ICD-9-CM code for the principal diagnosis. This code must be the full ICD-9-CM diagnosis code, including all five digits where applicable. When the proper code has fewer than five digits, it is not zero filled. It may or may not relate to the patient’s most recent hospital stay, but it must relate to the services the agency is rendering. If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.

The ICD-9-CM code and principle diagnosis reported in filed 67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis), and on the Plan of Care form, unless a SCIC (significant change in condition) has occurred.

- “V” codes are acceptable as both primary and secondary diagnoses. However, “V” codes should only be used if they better describe the condition of the patient and the focus of the home health care. Do not use the “V” code when the acute diagnosis code is more specific to the exact nature of the patient’s condition. Refer to CMS Manual System, Pub 100-8, Medicare Program Integrity, Exhibit 29, Number 11.

FIELD 12 - SURGICAL PROCEDURE/DATE

- Enter a “valid” ICD-9-CM surgical code.

- Only necessary if relevant to services being rendered or if the surgical procedure was within the last six months. If a surgical procedure was not performed or is not relevant to the POC, do not leave the field blank. Enter N/A.

- Enter the exact date of the surgical procedure in six-digit format (MMDDYY). At a minimum, the month and the year of the surgery must be entered. You may use “00” for the day if unknown. However, ensure all investigative resources have been exhausted before the “00” is used for the day; month and year dates must be accurate. Please note most computers cannot accept 00 as a valid date.
FIELD 13 - OTHER PERTINENT DIAGNOSES

- Enter all pertinent diagnoses. Place in order of seriousness to justify the discipline and services being rendered.

- Enter date of diagnosis in MMDDYY format followed by O or E as appropriate to indicate onset (o) or exacerbation (e).

  O = onset of a new diagnosis
  E = exacerbation or flare-up of a condition

- If the exact date is unknown, you **must** indicate the year and place “00” for the month and day.

- These diagnoses are those that co-exist at the time the POC is established or develop subsequently.

- Exclude those diagnoses that have no bearing on treatment.

- The HHA enters the full ICD-9CM codes for up to eight additional conditions if they coexisted at the time of the establishment of the plan of care. None of these other diagnosis may duplicate the principal diagnosis listed as an additional or secondary diagnosis.

- For other diagnosis, the diagnosis and ICD-9-CM codes reported on the OASIS, form item M0240 (other diagnosis), and on the plan of care form. Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established. In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient’s condition and to justify the discipline and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. Surgical and V codes, which are not acceptable in the other diagnosis fields, may be reported in narrative field. The sequence of codes should follow ICD-9-CM guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence, on all three forms (claim, plan of care, and OASIS) unless a SCIC (significant change in condition) has occurred. Beyond these guidelines, Medicare does not require that the sequence of the codes on the three forms must be identical.
FIELD 14 - DME AND SUPPLIES

- Enter all non-routine supplies to be billed.
- List all supplies necessary and include in POC, but not exact usage.

Example: dressing supplies, catheter kits, IV supplies.
- If no DME or supplies -- enter “N/A”.

Note: If providing and billing for DME, remember to submit a hard copy certificate of medical necessity or order for the DME item (use HCPCS).

FIELD 15 - SAFETY MEASURES

- Enter physician’s instructions for safety measures or those identified by home health agency.

Example: Bed confined, oxygen precaution

FIELD 16 - NUTRITIONAL REQUIREMENTS

- Enter physician’s orders or diet including:
  - Therapeutic diets
  - Specific dietary requirements
  - Fluid restrictions or requirements
- Parenteral or enteral requirements should be included in this field.

FIELD 17 - ALLERGIES

- Enter medicine allergies or other allergies or “NKA”.

Palmetto GBA
Home Health Training Manual, 2005
FIELD 18A - FUNCTIONAL LIMITATIONS

- Current limitations as assessed by physician or home health agency. If “other” is checked, provide detail below other or in an addendum to the POC.

FIELD 18B - ACTIVITIES PERMITTED

- Indicate all activities allowed by physician.

FIELD 19 - MENTAL STATUS

- Check most appropriate blocks. If other, explain on an addendum to the POC.

FIELD 20 - PROGNOSIS

- Check box most appropriate for the patient’s plan of care.

FIELD 21 - ORDERS FOR DISCIPLINE AND TREATMENTS

- List frequency and duration for each discipline ordered by physician.

- Include both a frequency and duration for each modality when billing for PT, SLP, and OT.

- Frequency denotes number of visits (not modalities) and should be stated in days, weeks, or months.

- Ranges are allowed; however, they must be small. If a range is given, the upper limit is the frequency (SN 1-3 wk 9).

- Orders must include all disciplines and services/treatments to be rendered even if they are not billable to Medicare.

- PRN orders must be qualified and quantified. Open-ended PRN orders are not acceptable (1 PRN SN per month for complication of Foley catheter).
FIELD 22 - GOALS/REHABILITATION POTENTIAL/DISCHARGE PLANS

- Enter the physician’s description of achievable goals and the patient’s ability to meet these goals.

- Document the discharge plans for care after discharge.

- Rehabilitation potential should include patient’s ability to achieve goals and estimate of time needed to achieve. Stay away from “Fair” or “Poor”. Use descriptors.

- Endpoint to daily skilled nursing visits should be documented here or in a nursing note.

- Endpoint criteria are as follows:

ENDPOINT CRITERIA

• When skilled nursing is the qualifying skill, and

• services are being provided on a daily basis (effective October 1, 1997, daily is defined as 7 days per week), and

• the visits are expected to last more than a short period of time (CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 7, Section 40.1.3 defines short duration as 2-3 weeks), then

• There must be a finite and predictable endpoint to the daily skilled nursing visits.

• This endpoint must be documented in the medical record. The best place to document endpoint is in the “Goals” field (22) of the optional CMS 485. However, it may be documented in a nursing note or in the summary of the optional CMS 486.

• The endpoint may be stated in days, weeks, months, or a specific date. The endpoint to daily skilled nursing visits may extend past the certification period, if necessary. Endpoint is different from orders. Orders only cover the current certification period, while endpoint refers to when the daily skilled nursing visits are expected to be reduced to less than daily, and therefore may extend past the certification period. Documentation should substantiate the endpoint.
• Upon admission, many times the stated endpoint is the physicians’ and the nurses’ “best guess” of when the skilled nursing services will be reduced to less than daily. This endpoint should be adjusted if, after care is started, it becomes evident that the original endpoint is not realistic. Adjustment of the endpoint should not wait until the next certification period, but rather, adjusted immediately in either a nurse’s note or the medical record. In either case, substantiate the new endpoint and what precipitated that change. Bear in mind, continual extensions of endpoint for daily skilled nursing visits may be viewed as not finite and predictable.

• If it is evident, or becomes evident that there is not a finite and predictable endpoint to daily skilled nursing visits, then the patient no longer qualifies for Medicare home health coverage. *This is a technical issue and not a medical necessity issue.* The Medicare Home Health Benefit was not established to provide daily skilled nursing services, but rather, to provide intermittent skilled nursing services.

*Note: The one and only one exception to this rule is a patient who requires and qualifies for skilled nursing services to perform daily insulin injections.*

<table>
<thead>
<tr>
<th>FIELD 23 - VERBAL START OF CARE AND NURSE’S SIGNATURE AND DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The RN or qualified therapist would indicate the date the verbal order was received and/or the date the POC was reviewed and signed by the RN.</td>
</tr>
</tbody>
</table>

*Note: This field may be used as the verbal order to either begin services or to recertify services and will cover the services being rendered until the physician signs the POC.*

<table>
<thead>
<tr>
<th>FIELD 24 - PHYSICIAN’S NAME AND ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Enter the name and address of the physician that established the Plan of Care. The referring physician must not have a significant financial relationship with the agency.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FIELD 25 - DATE HHA RECEIVED POC</th>
</tr>
</thead>
</table>
| - Enter the date the agency received the signed but not dated POC.  
Enter “N/A” if field 27 is completed. |
- It is recommended that agencies date stamp every POC upon return from the physician.

**FIELD 26 - PHYSICIAN CERTIFICATION STATEMENT**

- Physician must indicate whether he/she is certifying or recertifying.

**FIELD 27 - ATTENDING PHYSICIAN’S SIGNATURE AND DATE**

- The POC must be signed prior to claim submission.
- Faxed signatures are acceptable when followed by an original to be retained by the HHA and made available upon request.
- Electronic signatures are acceptable as long as certain conditions are met.
- A Physician Assistant or a Nurse Practitioner may not sign the plan of care.
- May be signed by another physician if authorized to do so by attending physician, i.e., partnership agreement.
- Do not pre-date or write the date in this field. If physician does not date his/her signature, leave it blank and document in field 25.
- Retain copy in HHA files.
- When more than one physician gives the HHA orders, a supplementary POC may be documented in field 18 of the 486.

**FIELD 28 - ANTI-FRAUD STATEMENT**

- “Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable federal laws.”
7.7 Optional Form CMS - 486, Medical Update and Patient Information

Field Descriptions

The CMS 486 form is optional, but if used, it should contain data and medical information needed by the fiscal intermediary to make coverage determinations. The CMS 486 form can be either retrospective, prospective, or both, depending upon the time of completion.

The agency has the option of completing the CMS 486 or submitting discipline notes in response to an ADR request.

If your agency uses the 486, this form should be completed in its entirety. Field 15 may be left blank. There are some fields where “N/A” (not applicable) may be acceptable. In these fields, look for: “note: N/A may be an appropriate response for this field.”

If additional space is needed to complete a field on the CMS 486 form, the Addendum (CMS 487 form) may be used. Write “See 487” in the specific field to denote the use of the addendum. Remember to paginate the addendum, “Page 1 of 2”, “Page 2 of 2”.

Field 1 - Patient’s HIC Number

- Must be the same on all documents.

Field 2 - Start of Care Date (SOC)

- This date should match the SOC date as shown on the plan of care or 485 and should match the FROM date on the initial certification. The first Medicare billable service.

Field 3 - Certification Period

- Enter the “From” and “To” dates of service covered by the certification/recertification. Should match the certification/recertification period on the plan of care--485.

Field 4 - Medical Record Number

- Optional at the agency level. Enter your medical record number if used.

Field 5 - Provider Number

- Enter your six-digit Medicare assigned number.
FIELD 6 - PATIENT’S NAME
- Enter last, first and middle initial.

FIELD 7 - PROVIDER’S NAME
- Enter your agency’s name and address.

FIELD 8 - MEDICARE COVERED
- Check yes or no.

FIELD 9 - DATE PHYSICIAN LAST SAW PATIENT
- If unknown, enter “unknown”. If unknown, may cause claim to be reviewed.

FIELD 10 - DATE PHYSICIAN LAST CONTACTED
- Enter most recent physician contact (verbal or written within last 60 - 62 days) concerning the patient. State purpose of contact in field 15.

FIELD 11 - IS PATIENT IN SNF OR EQUIVALENT
- Enter yes or no. If yes, not covered by Medicare.

FIELD 12 - CERTIFICATION/RECERTIFICATION
- Check whether this is a certification or recertification.

FIELD 13 - INPATIENT STAY
- Enter admit and discharge dates. If no inpatient stay within last six months, enter “N/A”.

FIELD 14 - TYPE OF FACILITY
- If completed field 14 - enter type of facility. Otherwise, enter “N/A”.

FIELD 15 - UPDATED INFORMATION
- New orders/treatments/clinical facts/summary should be entered for each discipline identifying the services actually performed. This information should not just be a restatement of the orders.
- Document any new orders, treatments, or changes with the associated dates since the optional CMS 485 was completed.
- Copies of verbal or supplemental orders should be included with the ADR response.
- Document all significant clinical findings for each discipline including symptoms and changes in the patient’s condition during the last 60-days. Document any progress or non-progress for each discipline.
- Document any PRN visits made during this billing period with the date and reason for the visit.
- Paint a clinical picture for the Medical Review staff.

FIELD 16 - FUNCTIONAL LIMITATIONS/REASON HOMEBOUND/PRIOR FUNCTIONAL STATUS
- Give narrative description of the patient’s functional status, current limitations and activities permitted. Elaborate on the information provided in fields 18a and 18b of the CMS 485.

FIELD 17 - SUPPLEMENTARY PLANS OF CARE ON FILE FROM PHYSICIAN OTHER THAN REFERRING PHYSICIAN
- This field should be completed if more than one Plan of Care is being used to record ordered services.

FIELD 18 - UNUSUAL HOME/SOCIAL ENVIRONMENT
- Enter any or all limitations which relate to the home environment that may affect the patient care.
FIELD 19 - UNTITLED

- Indicate any time when the home health agency made a visit and the patient was not home and reason why.

FIELD 20 - UNTITLED

- Specify any known medical and/or non-medical reasons the patient regularly leaves home and frequency of occurrence.

FIELD 21 - UNTITLED

- Signature of nurse or therapist completing or reviewing the forms.

7.8 CMS – 487--Optional Form-- Addendum to the Plan of Treatment/Medical Update

The addendum is used when additional space is required for additional information and/or data carries over from the CMS 485 form or CMS 486 form.

The agency has the option of completing the CMS 487 as an addendum to either CMS 485 or CMS 486 or use a blank sheet to list the continued sections.

The agency must identify whether this is an addendum to the CMS 485 (Plan of Care) or an addendum to the CMS 486 (Medical Update and Patient Information) by checking the appropriate box.

The agency may use a separate CMS 487 form (addendum) to the Plan of Care and a separate CMS 487 form (addendum) to the Medical Update. One form may not be an addendum to both CMS 485, Plan of Care, and the CMS 486 Medical Update.

If the addendum is used to document items on the CMS 485 form (Plan of Care), the CMS 487 (addendum) must be sent with the CMS 485 form to the physician for signature.

Remember to paginate, “Page 1 of 2”, “Page 2 of 2”.
8. Medical Review Activities

This section is dedicated to all aspects of medical review. The following information is included in this section:

- Progressive Corrective Action (PCA)
- Additional Development Request (ADR)
- Request for Reopening
- Medicare Summary Notice
General Information

Palmetto GBA is responsible for paying benefits within the provisions of the law. The medical review department must make determinations that the services provided are covered by Medicare. These decisions are based on careful examination of the patient’s medical records. Unless there is documented medical justification for the level of care and the necessity of services rendered, benefits may be denied.

Medical Review of PPS Episode Claims

Coverage requirements under the Medicare Home Health benefit have not changed as a result of PPS. However, an additional step has been incorporated into the medical review process: validation of the HIPPS code billed on the claim. All documentation submitted by the provider is used to substantiate the information on the OASIS (Outcome Assessment Information Set) form. The OASIS consists of 23 items and responses on which the HIPPS code is based. If the documentation in the medical records does not support the responses given on the OASIS, the HIPPS code may be reduced to a lower case mix level resulting in a decreased reimbursement rate.

8.1. Progressive Corrective Action

Reference: CMS Manual System, Pub 100-8, Medicare Program Integrity, Chapter 3, Section 3.11.

Progressive Corrective Action (PCA) is simply a way of targeting and directing medical review efforts on claims where there exists the greatest risk of inappropriate program payment(s). This step is a continuation of the claims process and has not changed from previous practice.

PCA is the term used to identify and implement the processes performed by medical review. This is a comprehensive term that includes the following:

1. Data analysis
2. Method by which claims are selected for medical review, and
3. Education of providers on the requirements for payment under the Medicare program.

When claims for home health services are submitted by the agency, it is essential that the claims and required supporting documentation are accurate and submitted on a timely basis. PCA targets and directs medical review efforts where there is the greatest risk of inappropriate program payment.

Data analysis is the first step in the PCA process. It includes reviewing claim submissions locally, regionally and nationally for patterns/trends or aberrancies that may present a potential problem.
Data analysis may be performed based on general surveillance or referrals for specific complaints. These referrals may be initiated from provider or beneficiary sources, fraud alerts, Centers for Medicare and Medicaid Services (CMS) reports, other contractors and/or other government and non-governmental agencies.

If it is determined that further review of claims is necessary, a prepay edit is put in place to suspend a sample of those claims that match the edit criteria. The areas of focus will vary depending on the results of both the analysis and the review. The edit will stay in place only as long as there continues to be evidence of inappropriate program payment.

The intent and goals of PCA are:

- To decrease the receipt of claims for non-covered or unnecessary services
- To educate providers on appropriate practices
- To help improve quality of care for beneficiaries
- To avoid inconvenience to providers who adhere to program requirements

If a claim is suspended for medical review, the provider will receive a request for medical records for that specific claim. Although a claim was selected for medical review based on a specific edit, all items billed on the claim will be reviewed for medical necessity.

Medical Review:
The medical review process entails performing probe reviews by service or provider. To determine whether a service-specific or provider-specific review should be performed, several things are taken into consideration, such as

- The number of potential claims billed in error,
- The amount of dollars that could be involved, and
- The likelihood of the error occurring repeatedly for an extended period of time.

- A service-specific probe edit usually includes a 100-claim sample based on a specific service (e.g. revenue code, procedure code, diagnosis, HHRG, HCPCS, RUG, etc.). The claims are selected randomly among all providers billing the service in question. Providers are notified that a service specific edit is being initiated and the results of the edit via an article in our Medicare Advisory posted on the Palmetto GBA web site.

- A provider-specific probe edit usually includes a 20-40-claim sample of claims from a particular provider. The claims selected may be specific to a particular issue and the provider will be notified in writing of the initiation of the review as well as the outcome.
Service-specific probe and provider-specific probe edits are implemented by requesting additional documentation from the provider billing the service. This information must be submitted within 30 days of the documentation request. Failure to submit the information will result in a denial. Once the appropriate numbers of claims have been reviewed, a charge denial rate (CDR) is calculated. The CDR is determined by dividing the total charges for the claims reviewed and processed into the total denied charges for the claims reviewed and processed. The results are multiplied by 100 and reported as a percentage.

This calculation is used to determine the following:
- Percentage of claims that have been billed in error,
- To what extent this error is occurring, and
- To guide additional activities that may be initiated.

Based on the results of the CDR, several actions may occur, such as
- No further action necessary,
- Additional medical review is warranted,
- Referrals to additional activities that may be initiated.

An integral part of the PCA process is education regarding the issues identified via the medical review process. Educational opportunities and activities may include, but not limited to, the following:
- Articles posted on the Palmetto GBA web site,
- Teaching and Instruction to Providers (TIP) letters mailed to providers,
- Education conference calls, and/or
- Individual letters with the results of provider-specific reviews.

### 8.1.1. PCA Decision Tree

Medicare Intermediaries’ approach to Progressive Corrective Action is governed by CMS guidelines. Palmetto GBA has developed a “decision tree” that correlates with the guidelines. Palmetto GBA has made the PALMETTO GBA MEDICARE PART A PCA DECISION TREE available on the Palmetto GBA website to educate the provider community on the PCA process. Providers currently under corrective action plans and/or undergoing medical review should refer to the decision tree in order to understand and anticipate the series of events that will unfold as the PCA process progresses.
8.2. Additional Development Request (ADR)

An additional development request (ADR) is a request for documentation. There are two types of ADRs, medical and non-medical. A medical ADR is a request for medical records due to a Progressive Corrective Action (PCA) edit. A non-medical ADR is a request for claims processing documentation, i.e., DME information. Providers have 30 days in which to respond to the request, either medical records or claims processing information as indicated on the ADR. (Non-medical ADR information is included in the billing section of this manual).

8.2.1. What is a Medical ADR?

A medical additional development request (ADR) notifies the provider that a specific claim has been selected for medical review. Claims are selected for review based on established edit criteria. If the submitted claim(s) match the edit criteria, then the claim will be suspended for medical review and subsequently a medical ADR is generated and mailed to the provider.

The medical ADR specifically details the claim(s) selected for medical review. In addition, the medical ADR identifies the edit code, which describes the reason for review. The medical ADR is mailed to the provider in a bright yellow envelope with the words “ADR REQUESTS TIME SENSITIVE” stamped on the front of the envelope. It is suggested that the provider have a process in place to ensure these request for medical records are responded to in a timely manner. Submit responses to the appropriate address on the ADR and be sure to include the mail code with the address.

Providers have 30 days to respond to the medical record request. If the medical records are not received within the allowable time, a medical review decision will be based on the available documentation at the time of medical review. A denial for non-receipt of records is considered a medical denial. If the provider’s remittance advice indicates a denial for this reason, submit the records with a copy of the ADR to the address on the ADR in a timely manner.

For those providers with access to the Direct Data entry (DDE) system at Palmetto GBA, you can monitor any ADRs through these instructions.

To see the total number of claims in ADR status:

- At the main menu select 01 for inquiry
- Next select 56 for Claims count Summary
- Status/location SB6001 will show the total number of claims in ADR status

To view individual claims in the ADR status:

- At the Main Menu select 01 for inquiry
• Next select 12 for the claims sub-menu
• Tab to the S/LOC field and enter SB6001
• To see/print the ADR letter, select the claim and press enter
• The ADR letter follows claim page 6
• Do not use the <F9> key while in these claims; it causes a new ADR to generate

Providers who monitor claims through the DDE system may print the ADR letter as above, attach it to the medical records and submit the requested records prior to receipt of the yellow envelope.

*Claims for which documentation has been requested will no longer return to the provider (RTP) when medical records are not received.

8.2.2. Medical ADR Example

Medical ADR

**Medicare**
*Palmetto Government Benefits Administrators*
Part A Intermediary, Regional Home Health Intermediary
2300 Springdale Drive, Post Office Box 7004
Camden, South Carolina  29020-7004

REPORT:  001 MEDICARE PART A - 00381 PROVIDER NUMBER:  nnnnnnn
DATE:  6/09/02 ADDITIONAL DEVELOPMENT REQUEST TYPE REQUEST:  MEDICAL
BILL TYPE:  329

HAPPY HOME HEALTH
123 MEDICARE DRIVE
ANYTOWN, SC  12345-3400

WE HAVE REVIEWED YOUR CLAIM RECORDS AND FOUND THAT ADDITIONAL DEVELOPMENT WILL BE NECESSARY BEFORE PROCESSING CAN BE FINALIZED. TO ASSIST YOU IN PROVIDING THE REQUIRED INFORMATION, WE HAVE ASSIGNED REASON CODES TO THE AFFECTED CLAIM RECORD (SEE BELOW) FOR YOUR REVIEW. PLEASE REFER TO THE ACCOMPANYING LIST FOR EXPLANATION OF THE ASSIGNED CODE, AND ENTER THE REQUIRED INFORMATION IN THE SPACE PROVIDED BELOW EACH CLAIM RECORD AND RETURN WITHIN 35 DAYS TO THE ATTENTION OF:

MEDICARE PART A MEDICAL REVIEW
PO BOX 7004
STATION AB-315
CAMDEN SC  29020-7004

<table>
<thead>
<tr>
<th>MEDICAL REC NO.</th>
<th>PATIENT NAME/</th>
<th>FROM/TO</th>
<th>OPR-MED</th>
<th>TOTAL</th>
</tr>
</thead>
</table>

*Palmetto GBA*
*Home Health Training Manual, 2005*
8.2.3. Helpful Hints for Responding to a Medical ADR

Plan of Care or CMS 485 Form:
- Plan of Care /485 must be signed and dated by the physician prior to billing Medicare for services.
- Ensure the plan of care submitted is for the dates of service requested
- Plan of care must cover the entire billing period
- Additional orders, not included on the plan of care, to cover all services billed should be submitted.

OASIS Documentation
- Submit all OASIS documentation used to generate the HIPPS code(s) billed to include SCIC OASIS, if applicable.

Documentation of services rendered should include:
- Adequate documentation to substantiate the medical necessity of all the services billed.
- Visit notes and/or 486 summarizing the services.
- If intermittency is in question, documentation must include the in/out times for the nurse and the aide visits, as well as the finite and predictable endpoint to daily nursing visits.
- Include any other pertinent documentation that may be needed to support medical necessity, i.e., dates of hospitalization, medication changes, lab values.

Itemized supply list (if supplies are billed)
- Include item name, quantity, unit cost, and total unit cost. Remember the total on the itemized supply list should equal the total billed under revenue code 0270.
- Signed and dated orders to cover all supplies.
When Responding to ADR requests:

- Ensure the medical records to support each claim are being attached to an ADR.
- If responding to multiple requests on the same patient for various dates of service, respond to each request separately. Bundling multiple requests under the same ADR may cause substantial delays in processing.
- Multiple responses may be mailed in the same envelope, just not stapled together as one record.
- Place one staple in the upper left hand corner to attach all the documents for one record.
- Mail to the appropriate address and mail code as indicated on the ADR request.
- Palmetto GBA does not accept C.O.D.
- If billing corrections are needed, submit a hardcopy UB-92 with a 337 or 327 bill type with the medical records.

Required Documentation

The key to Medicare coverage is adherence to the home health benefit guidelines through documentation. The provider must “paint a picture” for the nurses/therapists that are reviewing your claims. Because many things influence the beneficiary’s response to treatment and length of recovery time, it is important to paint an accurate picture through your documentation. The length of time services are covered is determined by the needs of each individual beneficiary.

The beneficiary’s health status and medical needs should be reflected in the plan of care, OASIS and clinical documentation. There should be no contradictions between the information on the plan of care, OASIS and clinical documentation. The documentation in the medical records should address the beneficiary’s medical condition, treatment interventions, response to treatment, support system, functional limitations, mental status, and anything else that might have an influence on the care of the beneficiary.

Documentation Requirements for Therapists

Therapy services documented in checklist form do not give the reviewer a good picture of the patient’s progress. The patient’s progress or reaction to treatment should be documented in the notes in measurable terms. This will allow the reviewer a better understanding of progress made by patients. The form CMS-700-701 can be used for outpatient rehabilitation. This form is the physician’s legal orders and must be signed/dated just as with the CMS-485 form used for Part A home health. This form will be accepted as a Plan of Care/Assessment for Outpatient Part B Home Health for Therapists. Documentation should reflect the exact care and treatment of the patient as well as the patient’s response to the care plan and any changes in orders during the interim of care. If there are any questions, please call the Provider Contact Center. Denials occur when the medical reviewer cannot determine the patient’s treatment or response to treatment.
Documentation is the key to a comprehensive review. The following questions are significant to each home health claim review:

1. Are there physician orders for the services being provided?
2. Is the patient confined to the home?
3. Are the services being provided reasonable and necessary to the treatment of the patient’s illness or injury?
4. Does the documentation support that the services are actually being provided?

This is a concise checklist to follow prior to sending in medical records.

**Note:** The documentation submitted by the provider is the only picture we have of the beneficiary. Unclear or incomplete documentation could result in an unnecessary denial.

At a minimum, the following documentation must be submitted when responding to a Medical Additional Development Request (ADR):

- Plan of Care or optional CMS 485 form
- Visit notes for all disciplines billed or optional CMS 486 form summarizing all services / visits
- All OASIS documentation used to generate the HIPPS code(s) for services billed

**Note:** An agency may choose to submit either the optional CMS 486 form or the notes; or a combination of both.

- Verbal or supplemental orders covering this period
- Itemized supply list detailing items, quantities, unit cost, and total cost

**Note:** Total cost shown on the supply list should equal the amount submitted under revenue code 0270.

### 8.3 Request for Reopening

If a provider believes that the information that was submitted with the Additional Development Request (ADR) was not considered in the initial determination process, the provider should request a reopen because the claim was denied for a technical reason. A provider’s failure to submit the information with the ADR request does not meet the criteria to allow Palmetto GBA to reopen a claim.
This is not an opportunity for the provider to submit additional documentation. A provider’s failure to submit the information with the original ADR request does not meet the criteria to allow Palmetto GBA to reopen a claim.

The CMS policy is to reopen a claim only after the appeal rights are exhausted. Since the provider does not have the right to appeal technical denials, the provider should request a reopening. A reopening of a Palmetto GBA claim decision is conducted at the discretion of the Department of Health and Human Services secretary’s agents (Intermediaries, hearing officers, ALJs and the Appeals Council).

Good cause for reopening exists where:

- “New and material evidence” not readily available at the time of the determination is furnished
- There is an error on the face of the evidence on which such determination or the decision is based.
- There is a clerical or computational error in the claim file. (Example: The Intermediary makes a mathematical error or there is a misapplication of reasonable charge profiles.)

**NOTE:** Information that the provider has or should have had at the time the claim was filed is not considered “new and material evidence.”

If the information submitted with the ADR does meet the criteria to request a reopening, please mail the information to the following address:

Medicare Part A Reopening Request, AG-230
Palmetto GBA
2300 Springdale Drive, Building One
P.O. Box 7004
Camden, SC 29020-7004
9. THE REDETERMINATION AND RECONSIDERATION PROCESS

The following information is included in this section:

- The Redetermination and Reconsideration Process
- Appeals Request Form
- Assurance of Payment (AOP) Form
- Sample Medicare Summary Notice
9.1 Provider Redetermination

**Reference:** CMS Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 29, Sections 20, 30.2.2, and 40.1.3

Medicare providers have a limited right through the appeals process to appeal coverage decisions on issues affecting the overpayment or underpayment of a claim. Beneficiaries may appeal coverage decisions on any issues affecting the overpayment or underpayment of a claim. The request for an appeal must be made in writing.

Providers may request a redetermination from the Appeals Department within 120 days of receiving the remittance advice. The Appeals Department will render a decision within 60 days of receipt of the written request.

- The redetermination letter issued by the Appeals Department is called the Medicare Redetermination Notice (MRN) and it will contain all the information necessary to request the next level of appeal.

- The Appeals Department will send the QIC reconsideration request form with the appeals determination letter. Providers are strongly encouraged to use this form.

- Providers can appeal all types of denials, and are no longer required to use a SSA 1696(U4) form for a “technical” denial.

Providers may request a Qualified Independent Contractor (QIC) appeal within 180 days of the appeals determination. The QIC decision will be called a reconsideration. The QIC will render a decision within 60 days of receipt of the request.

- Providers can now request a QIC review of an Appeal Department dismissal. If dismissed by the QIC, then no further appeal is possible.

- The two QICs are:
  
  East QIC - Maximus
  West QIC - First Coast Service Options
9.1.1 Redetermination Department Address

All information concerning appeals, reconsiderations and hearings must be sent to:

Medicare Part A Redetermination AG-630
Palmetto GBA
2300 Springdale Drive
P.O. Box 7004
Camden, SC 29020-7004

9.1.2 Provider Acting As Beneficiary Representative

Reference: CMS Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 29, Section 60.5

A beneficiary or his/her representative may ask the provider to act as the beneficiary’s representative. In this situation, the following requirements must be met:

- A specific individual must be identified. The representative may be an employee of the agency, but the agency itself may not be appointed as the representative. If the provider accepts this appointment, a provider representative should sign the appointment of representative form (SSA 1696 U-4) in the appropriate areas.

- If someone other than the beneficiary signs the Appointment of Representative forms, (SSA 1696 U-4), for the beneficiary appointing the provider to act as a representative, the person who signs must indicate his/her relationship to the beneficiary, and also why the beneficiary cannot sign the form. If the beneficiary signs the form with an ‘X,’ two people who know the beneficiary must also sign as witnesses.

- If the appointment of representative form is signed by someone other than a relative, a copy of a power of attorney or guardianship should be attached.

- If the beneficiary is deceased at the time the appeal is filed, the legal representative of the estate may appoint the provider as the representative. If the person signing the appointment of representative form is the legal representative of the estate, proof should be attached.

- If there is no legal representative of the estate, then whoever has assumed responsibility for settling the estate is the person who may appoint the provider to act as the representative. It should be indicated if this is the case.
• The provider representative must indicate in writing that the provider will not charge the beneficiary for the services, which were paid under the waiver of liability provision. (This requirement only pertains when the denied services are paid per the waiver of liability provision.)

The appointee and the beneficiary should sign and date the Appointment of Representative form simultaneously. The individual requesting the appeal and the individual appointed as the representative on the U4 form must be the same person.

Once an appointment form meets the standards required, it remains valid for any subsequent appeal on the claim in question unless the beneficiary specifically withdraws the representative’s authority. If an appeal is filed more than one year after the beneficiary signed the appointment of representative form, a new form is required. While the Appointment of Representative is valid for one year, the representative must include a copy with each appeal filed.

9.1.3 Assurance of Payment (AOP)

The Centers for Medicare and Medicaid Services (CMS) requires that Palmetto GBA determine if a provider has received payment from any other source prior to making any payment as a result of reconsideration for a previously denied claim or a determination by an Administrative Law Judge Hearing. An Assurance of Payment (AOP) Form is sent with the determination letter when a favorable reconsideration/ALJ decision is made. This form must be completed and returned to the Appeals Department before the claim can be forwarded to the Claims Department for payment. The AOP Form is printed on blue paper and sent to the provider in an envelope with a time sensitive stamp. In the event that the original form is misplaced, the AOP Form is also available on the Palmetto GBA Web site. From our home page under Providers select Regional Home & Hospice Intermediary (RHHI) and then select Forms. A sample letter can also be seen in Section 6.1.9.2 of this manual.

9.1.4 Request Forms

You may obtain the CMS 2649, Request for Reconsideration of Part A Health Insurance Benefit form, the CMS 5011A, Request for Medicare Part A Hearing, and the SSA 1696 U-4 form, Appointment of Representative form at your local Social Security office.

• The CMS 2649 form is also available at the following web address: http://cms.hhs.gov/forms/csm2649.pdf
• The CMS 5011A form may also be obtained from the following web address: http://cms.hhs.gov/forms/cms5011aeng.pdf
• The SSA 1696 U-4 form is available at the following web address: http://www/ssa/gov/online/forms.html
9.1.5 MEDICARE PART A APPEAL REQUEST FORM

Beneficiary Information:

Name of Medicare Beneficiary:____________________________________________

Medicare Number:  _______________________________________________________

Dates of Service: _________________________________________________________

Explain why you would like an appeal on this claim:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Provider Information:

Provider Name:  _________________________________________________________

Provider Number:  _______________   Telephone Number:  ______________________

Provider Address:  _________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

___________________________________   _______________________
Signature      Date

Please Print Name

Attachments: Please attach all documentation that you would like considered in this appeal.
*Please fill out form completely to ensure a valid reconsideration request.

Mail to:
Palmetto GBA, Medicare Part A Appeals Department
Mail code:  AG-630
2300 Springdale Drive, Building One
Post Office Box 7004
Camden, South Carolina 29020-7004
9.1.6 Assurance of Payment Medicare Part A Appeals Sample Letter

Provider:
Provider No:

Regarding:
Beneficiary:
HIC:
Dates of Service:
Case ID:
Date:

The Centers for Medicare and Medicaid Services (CMS) has directed that Palmetto GBA, prior to making any payment because of a hearing decision by an Administrative Law Judge, must determine if you have received payment from the beneficiary or other source(s). To assist Palmetto GBA with processing the claim, please complete the following and return to us as soon as possible.

A. Assurance of Payment:

  ____ We have not been paid by the beneficiary or anyone else acting on their behalf for the services other than applicable deductible and/or coinsurance.

  ____ We have refunded payment other than the applicable deductible and coinsurance received from the beneficiary or any one else acting on the beneficiary’s behalf. (This includes any payments for private insurance.)

  Date of Refund: _______________________

B. Replacement Bill: (If a replacement bill has been requested, indicate if it is attached.)

  ____ Replacement Bill attached to this form

  ____ Replacement bill not attached to this form

Submitted By:

Name: ________________________________ (Please Print)

Signature: ____________________________ Date: _____________

Title: _______________________________________________________________________

Please return form to:

Medicare Part A Appeals, AG-630
2300 Springdale Drive, Building One
P.O. Box 7004
Camden, SC 29020
9.1.7 MEDICARE SUMMARY NOTICE SAMPLE

The following letter is an example of a Medicare Summary Notice (MSN). This statement notifies beneficiaries of all services rendered under the Medicare benefit. The MSN replaces the Notice of Utilization (NOU), the Explanation of Medicare Benefits (EOMB), and the Benefit Denial Letter (BDL).

**Medicare Summary Notice**
January 31, 2002

**Customer Service Information**

Your Medicare Number: NNN-NN-
NNNNA

If you have questions, write or call:
Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Phone Number: (XXX) XXX-XXXX
1-800-XXX-XXXX
TTY for Hearing Impaired: 1-800-XXX-XXXX

This is a summary of claims processed on 01/05/2002.

**HOME HEALTH CARE**

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Benefits</th>
<th>Non-Covered Charges</th>
<th>Deductible and Coinsurance</th>
<th>You May Be Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Days Used</td>
<td>Amount Charged</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Control number: 12345-84956-84556

Home Health Agency Name
Street Address
City, State, Zip Code

Referred by: Dr. Feelgood

10/13/01 - 11/06/01 Med-Surg Supplies $181.56 $0.00 $0.00 $0.00
8 Skilled Nursing $800.00 $0.00 $0.00 $0.00
Claim Total $981.56 $0.00 $0.00 $0.00
Field Description

The Date the MSN was sent.

Refer to the Customer Service Information box if you have questions about your MSN. For all inquiries, include your Medicare number, the date of the notice, and the specific date of service you have questions about.

Your Medicare Number should match the number on your Medicare card.

If Your Name and Address is incorrect on your MSN, please contact both the Medicare intermediary shown on your MSN and the Social Security Administration immediately.

Read the Help Stop Fraud message for information on ways to protect yourself and Medicare against fraud and abuse.

Home Health Claims: The Home Health services provided by the home health agency.

Dates of Service shows when services were provided.

Each claim is assigned a Claim Number, which you may be asked to provide when calling regarding you MSN.

Benefit Days Used shows the number of days used in the benefit period. See the back of your MSN for an explanation of benefit periods.

NOTE: For Part B Medical Insurance - Outpatient Facility Claims (not shown here), the column will be titled Services Provided and will give a brief description of the service or supply provided.

Non-covered Charges shows the charges for services denied or excluded by the Medicare program for which you may be billed.

The amount applied to your Deductible and Coinsurance.

You May Be Billed. This is the total amount the provider is allowed to bill you. It combines the deductible, the coinsurance and any non-covered charges. If you have supplement insurance, it may pay all or part of this amount.

See Notes Section. If a letter appears in this column, refer to the Notes Section.
Provider’s Name and Address shows the name of the facility where you received services. The referring doctor’s name will also be shown. The address shown is the billing address may be different from where you received the service(s).

General Information:

As requested, this is a duplicate copy of your Medicare Summary Notice.

If you change your address, please contact the Social Security Administration by calling 1-800-772-1213.

Circle the item(s) you disagree with and explain why you disagree.

Send this notice, or a copy, to the address in the “Customer Service Information” box on Page 1.

Sign here_______________________________ Phone Number (_______)__________________________

THIS IS NOT A BILL – Keep this notice for your records.

The Notes Section gives more detailed information about your claim.

The Deductible Information section shows how much of your Part A and/or Part B deductible has been met.

The General Information section provides important Medicare news and information.

Appeals Information, such as how and when to request an appeal, is shown here. See the back of your MSN for more information and how to get help with appeal requests.
10. PROVIDER AUDIT AND REIMBURSEMENT

The following Provider audit and reimbursement information is contained in this section:

- General Provider Audit and Reimbursement Information
- Miscellaneous Reimbursement Topics
- Credit Balance Reporting
- Remittance Advice
- Cost Report Activities
10.1. Overview of Provider Audit and Reimbursement

The Provider Audit and Reimbursement Department (PARD) is responsible for setting-up new providers in the systems, collecting overpayments, auditing Medicare cost reports and making final settlement determinations for all Part A providers. PARD has four distinct areas of responsibility:

- Reimbursement
- Audit
- Settlement
- Appeals

Reimbursement

The primary goal of the reimbursement staff is to compute tentative cost report settlements of Medicare home health cost reports submitted by providers. The reimbursement area is also responsible for FISS claims testing and maintaining the national Provider Statistical and Reimbursement (PS&R) system.

Audit

The audit staff performs desk reviews and/or field reviews of Medicare cost reports submitted by providers. The auditors perform an in-depth review of providers’ financial accounting data to ensure the allowability of claimed Medicare costs.

Settlement

After the audit staff completes their analysis, the settlement staff incorporates the proposed audit adjustments to produce a final settled Medicare cost report. The allowable cost determined after audit is compared to interim payments to determine a final settlement amount due to either the provider or Medicare.

Appeals

If after a final settlement is made, a provider disagrees with our determination, it may choose to appeal the determination. Our appeals staff reviews the provider’s appeal and performs any necessary research related to the issue being appealed. Because the appeals process can be very lengthy, the PARD appeals staff encourages settlements that can be reached before a hearing is necessary.
10.1.1. PARD Contact Listing

PROVIDER AUDIT & REIMBURSEMENT CONTACTS

<table>
<thead>
<tr>
<th>Office Location</th>
<th>Mailing Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Columbia, SC</td>
<td>Palmetto GBA</td>
<td>Main Number:  (803) 735-1034</td>
</tr>
<tr>
<td></td>
<td>AG-330 Provider Audit &amp; Reimbursement</td>
<td>Reimb. Fax: (803) 935-0227</td>
</tr>
<tr>
<td></td>
<td>2300 Springdale Dr, Bldg. One</td>
<td>Audit Fax: (803) 935-0226</td>
</tr>
<tr>
<td></td>
<td>Camden, 0SC 29020</td>
<td>Fax for Credit Balance reports (803) 763-7777</td>
</tr>
<tr>
<td>Palm Harbor, FL</td>
<td>Palmetto GBA (CA –106)</td>
<td>Main Number: (727) 773-9225</td>
</tr>
<tr>
<td></td>
<td>Provider Audit &amp; Reimbursement</td>
<td>Fax Number: (727) 771-7838</td>
</tr>
<tr>
<td></td>
<td>34650 U.S. Highway 19 N., Suite 202</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palm Harbor, FL 34684-2156</td>
<td></td>
</tr>
<tr>
<td>Springfield, IL</td>
<td>Palmetto GBA</td>
<td>Main Number: (217) 726-6240</td>
</tr>
<tr>
<td></td>
<td>Provider Audit</td>
<td>Fax Number: (217) 726-7853</td>
</tr>
<tr>
<td></td>
<td>3021 Montvale Drive, Suite C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Springfield, IL 62704</td>
<td></td>
</tr>
</tbody>
</table>

PROVIDER REIMBURSEMENT DEPARTMENT CONTACTS:

- Overpayment Supervisor: Virginia Jordan (803) 382-6235
- Overpayment Manager: Kay Lydon (803) 382-6229
- Reimbursement Manager, Palm Harbor: Clay Hatfield (727) 773-9225
- Reimbursement Supervisor, Columbia: Sallie Noble (803) 382-6217

PROVIDER AUDIT DEPARTMENT CONTACTS:

- Audit Manager, Columbia: Linda Eubanks (803) 382-6272
- Audit Manager, Columbia: Pat Anderson (803) 382-6276
- Audit Manager, Columbia: Scott Neely (803) 763-5526
- Audit Manager, Palm Harbor: Lynda Hebbeln (727) 773-9225
- Audit Manager, Springfield: Sara Hays (217) 726-6240

OTHER PARD AREAS

- PS&R: Louis Overbey (727) 773-9225
- Cost Report Filing: Dinah McFadden (803) 382-6189
- Credit Balance Reporting: Michael Madison (803) 382-6219
10.2. Miscellaneous Reimbursement Activities

10.2.1 Provider Enrollment – General Information Revised Form CMS-855A

CMS recently revised the enrollment process. One change to the process is Part A providers will initially contact the intermediary to obtain an enrollment application. Also, new enrollment applications were issued. There are now unique enrollment forms for Part A providers (Home Health Agencies).

The application Part A providers complete is labeled CMS 855A. It has a green cover. This form was approved for use beginning November 1, 2001. Form CMS-855A will be used in a number of situations, including:

1. Enrolling as a new provider
2. Enrolling when there has been a change of ownership
3. Reporting changes of information, such as address changes, representative changes, etc.

In addition to a new form, there are other changes in the enrollment process. These are noted below and addressed in this section.

- The intermediary (Palmetto GBA) is now the initial point of contact for enrollment information.
- Request forms from Palmetto GBA
- Change in procedures
  - Change of Ownership
  - Electronic Funds Transfer requests
- New information requirements
  - Authorized Signatures (affects all providers)
- Processing Changes

10.2.1.1. Initial Point of Contact

The revised instructions changed the initial point of contact for providers from the state agency to the Medicare Part A Intermediary. As of November 1, 2001, Palmetto GBA is the initial point of contact for obtaining an application and obtaining information about the enrollment process. The application can be obtained by calling our office at the number noted in the following section. As well, our web site, www.palmettogba.com contains the name and phone number of associates who can address questions and assist in the process of completing the form. After opening the web site, make the following selections Providers / Regional Home Health & Hospice Intermediary / Provider Enrollment. Under the provider enrollment section are several articles, including:
10.2.1.2 Requesting Forms

To request a form, call (803) 382-6167. As well, forms may be obtained from the web site as referenced above.

10.2.1.3. Procedural Changes

Change of Ownership

A separate CMS-855A is now required from the old (outgoing-selling) owner as well as from the new (incoming-purchasing) owner. Two copies of the sales or other asset transfer agreement, in its current form, MUST be submitted with this application filing. Also, a copy of the FINAL agreement MUST be submitted once the sale is executed.

Acquisitions

If the change of ownership will result in an acquisition, additional sections of the CMS-855A applications are required from the acquiring provider and the provider being acquired.

Consolidations

If the change of ownership will result in a consolidation, additional sections of the CMS-855A applications are required from the consolidating provider(s) as well as the newly created provider.

Electronic Funds Transfers (EFT)

The Medicare Authorization Agreement for EFT (CMS-588) and the Letter of Credit of Advancing Funds forms will be mailed with each CMS-855A form. These forms should be completed in their entirety and submitted with the CMS-855A if EFT is desired.
10.2.1.4. New Information Requirements

Authorized Official Signatures

All 855A forms MUST be signed and dated by the authorized official of the provider. The authorized official may have up to three (3) delegated officials. The delegated officials would be able to sign CMS-855A submissions for changes and updates only. The signature of an authorized or delegated official is required to update any information on the provider, specifically:

- Changes of address
- Changes to contact persons
- Changes to Electronic Funds Transfer (EFT) agreements

10.2.1.5. Processing Changes

Enrollment applications will no longer be returned to the provider unless the application is not signed or is signed by an “unauthorized” official.

A phone call will be made to the contact person and any problems each of the submissions will be discussed. Problems/errors requiring written corrections will be documented in a developmental letter, which will be forwarded to the contact person.

Applications for all provider-based Home Health Agencies (HHA) and Hospice provider types should be submitted to the audit intermediary (intermediary of the parent provider) effective November 1, 2001.

Applications for free-standing Home Health Agencies and Hospice provider types should continue to be submitted to the appropriate regional intermediary.

10.2.2 Provider Enrollment – Submitting Changes of Information

CMS has issued a revised provider enrollment application (CMS 855A). This form is to be used not only for new providers to enroll in the Medicare program, but also for current providers to change information. A change of information is a change of address, phone number, contact person, etc.

Although the CMS 855A appears to be thick, most of the pages are instructions and only the sections requiring an update need to be completed.

Please note:

- Section 1.A. “General Application Information” and section 15. “Certification Statement” must be completed for all changes.
In addition to sections 1.A. and 15, complete only the sections of the CMS 855A related to the information that is changing – see the guide below.

The instructions are presented on the page prior to the section.

Remove the sections completed from the booklet and submit them to Palmetto GBA.

Do not fax the completed form. The form must be mailed; an original signature of an authorized official is required.

Address is noted below.

Palmetto GBA
Provider Enrollment (AG-330)
2300 Springdale Dr., Bldg. One
PO box 7004
Camden, SC  29020 – 7004

If you have questions using the 855A for changes of information, please call one of the contacts as noted on our web site.

The following is a guide to using the application.

<table>
<thead>
<tr>
<th>Type of Change</th>
<th>Page</th>
<th>Section</th>
<th>Section Heading</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Changes</td>
<td>7</td>
<td>1. A. 1.</td>
<td>General Application Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>✓ Change of Information and ✓ the sections (1 – 16) that are being updated</td>
</tr>
<tr>
<td>All Changes</td>
<td>7</td>
<td>1. A. 2.</td>
<td>Indicate Tax Identification Number</td>
</tr>
<tr>
<td>All Changes</td>
<td>7</td>
<td>1. A. 3.</td>
<td>Indicate Medicare provider number</td>
</tr>
<tr>
<td>All Changes</td>
<td>51</td>
<td>15</td>
<td>Certification Statement (Must be an original signature of the current authorized official.)</td>
</tr>
<tr>
<td>Agency Name Change</td>
<td>15</td>
<td>2. B. 1.</td>
<td>Provider Identification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. B. 2.</td>
<td></td>
</tr>
<tr>
<td>Type of Change</td>
<td>Page</td>
<td>Section</td>
<td>Section Heading</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Fiscal Year End Date</td>
<td>15</td>
<td>2. b. 4.</td>
<td>Medicare Year-End Cost Report Date</td>
</tr>
</tbody>
</table>

If all correspondence is to be sent to a single address, only complete one section 2.C. However, if correspondence should be sent to unique addresses for:

- Medicare Secondary Payer
- Medical Review
- Audit & Reimbursement

Complete multiple sections 2.C. and note the type of correspondence at the bottom of the page.

<table>
<thead>
<tr>
<th>Type of Change</th>
<th>Page</th>
<th>Section</th>
<th>Section Heading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number / Fax Number</td>
<td>17</td>
<td>2. C.</td>
<td>Correspondence address</td>
</tr>
<tr>
<td>Physical Location</td>
<td>23</td>
<td>4. A.</td>
<td>Practice Location Information</td>
</tr>
<tr>
<td>“Pay To” Address</td>
<td>25</td>
<td>4. F.</td>
<td>Medicare Payment “Pay To” Address</td>
</tr>
<tr>
<td>Stock Transfer Information</td>
<td>31</td>
<td>5. B.</td>
<td>Ownership Interest or Managing Control Information</td>
</tr>
<tr>
<td>Personnel Changes – Add, Delete, Change</td>
<td>5</td>
<td>6. A. &amp; 6. B.</td>
<td>Ownership Interest and/or Managing Control Information (Individuals)</td>
</tr>
<tr>
<td>Chain Home Office</td>
<td>37</td>
<td>7.</td>
<td>Chain Home Office Information</td>
</tr>
<tr>
<td>Contact Person</td>
<td>47</td>
<td>13.</td>
<td>Contact Person(s)</td>
</tr>
<tr>
<td>Additional Authorized Official</td>
<td>55</td>
<td>16.</td>
<td>Delegated Official(s)</td>
</tr>
</tbody>
</table>
10.2.3  Provider Enrollment – Electronic Version of the CMS 855A

The enrollment application for providers that bill to Medicare FIs is the CMS 855A. The application can be obtained from CMS’ web site in both an electronic version and a PDF format. As well, a hardcopy version can be mailed to you by calling Palmetto GBA at (803) 382-6167.

The electronic version will enable you to complete the enrollment application and save the information, making future updates and changes much easier. Additionally, the electronic version provides real-time edit checks to assist in completing the form. The electronic version is compatible with Windows 95 or above, and Windows NT.

How can I obtain the electronic version?

Go to www.CMS.gov/medicare/enrollment/forms/.

What information is available on the Web site?

The site contains general information about the electronic version and how to use it. The following specific information is available:

1. Instructions:
   a) “Full Version User’s Guide” - Detailed instructions for using the electronic version. Click on the link to the “Full Version User’s Guide” for a guide to downloading the software. This guide contains pictures of how the screens will look during the download process and detailed information on using the software. Print this guide and have it available as you begin to use the electronic version.
   b) “Quick Reference User’s Guide” – Abbreviated version of the user’s guide. No pictures but a handy reference for using the electronic version.
   c) “Troubleshooting” – Answers to common questions.

2. Forms – select the first entry - CMS 855A.
   a) Electronic version – This version contains the pages of the CMS 855A application. It provides real-time edit checks to assist in completing the application. However, it does not contain the instructions for completing each section. These instructions can be obtained in the PDF version.
   b) PDF version – This version consists of 57 pages and contains the application and the accompanying instructions (Note: the instructions proceed each section). The PDF version will only allow you to download, print and manually prepare the application.

The application cannot be submitted electronically. An original signature is required, so the form must be printed, signed and mailed.
Please refer to the article in this section, Provider Enrollment Contacts, for persons to call with questions and mailing address information.

10.2.4. Overpayments

A provider may have an overpayment(s) determined as a result of an interim rate review, PIP rate review, submitted Medicare cost report, tentative (initial) settlement of a Medicare cost report, final settlement of a Medicare cost report, or amended final settlement of a Medicare cost report. In each of these situations, a letter is sent to the provider indicating that an overpayment has been determined and stating the amount of the overpayment. The provider has 15 days from the date of the letter to submit full payment or negotiate with their intermediary its plans for repayment. Otherwise, payments will be suspended until the overpayment is fully collected.

When a cost report is filed with an overpayment, the overpayment is due on the cost report due date. If payment does not accompany the cost report, payments will be suspended until the overpayment is fully recouped. Interest will also be assessed beginning with the day after the due date if full payment does not accompany the cost report and the provider has not agreed in advance to liquidate the overpayment within thirty days from the due date of the cost report.

10.2.4.1. Extended Repayment Agreements

The CMS requires intermediaries to obtain additional documentation to support a provider’s need for an extended repayment plan. To ensure that a provider is unable to obtain funds from a financial institution, the CMS requires a provider to demonstrate that it cannot obtain financing other than from the CMS. All requests for repayment plans of 12 months or more must be accompanied by letters from at least two financial institutions denying the provider’s loan request for the amount of the overpayment.

If a provider is unable to obtain a loan from a financial institution, a repayment plan will be considered. The denial letters from the financial institutions should accompany the provider’s repayment plan request. This requirement in no way diminishes the need for the submission of financial data to support the provider’s request.

The letter sent by a provider requesting an extended repayment agreement for an overpayment must include all 15 items of the “Documentation Required to Support a Request for Repayment Schedule” (See Exhibit C). If all 15 items are not received, the provider will remain on 100% withholding until all documentation is received. The letter should specifically refer to the provider number, overpayment amount, overpayment type, FYE, and number of months requested. The letter should also be accompanied by the first payment under the provider’s proposed schedule. Payments under the proposed plan should continue until the provider receives a notice of approval for denial. Failure to continue to make payments under the proposed plan may result in denial of the repayment plan.
Upon receipt, Palmetto GBA will review all documentation supplied by the provider and make a determination to approve, deny or modify the extended repayment schedule request. The interest rate charged on overpayments repaid through an approved extended repayment schedule is the rate that is in effect for the quarter in which the overpayment was determined. The rate remains constant unless the provider defaults or misses two consecutive payments on an extended repayment agreement. When the provider defaults on such an agreement, interest on the balance of the overpayment may be changed to the prevailing rate in effect on the date of the default if the rate is higher than the rate specified in the agreement.

**Exhibit C Extended Repayment Schedule**

**10.2.4.2. Medicare Policy on Interest**

Section 117 of Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982, and CMS Regulations 42 CFR 405.376 establish specific rules for the payment of interest on Medicare overpayments and underpayments. Interest will be assessed at the rate published in the Treasury Department’s monthly “Schedule of Certified Interest Rates with Range of Maturities”. The rate of interest for overpayments determined on or after July 31, 1998, is 13.75%. Interest applies to all determinations made on or after September 3, 1982 unless the overpayment is recouped or the underpayment is paid within 30 days of final determination except for as-filed cost reports. Interest will begin to accrue on the day after the due date for as-filed cost report overpayments that are not accompanied by payment in full and for which arrangements have not been made in advance to liquidate the overpayment within thirty days from the due date of the cost report.

For the purposes of interest assessment, a final determination is considered to occur based on the following:

1. An NPR and a written determination based upon a final settlement or reopening for any reason,

2. The issuance of a written determination based upon an initial or revised initial settlement,

3. The due date of timely filed cost report,

4. A late cost report from the due date until the cost report is filed.

The interest provisions do not apply to overpayments or underpayments determined as a result of interim rate and PIP adjustments or utilization reviews.
In accordance with 42 CFR 405.376, interest will be assessed on the amount due the Medicare program on the day after the determination date. If full payment of the overpayment is made within thirty days of the determination date, the interest is waived. If full payment is not made within thirty days, interest is assessed on the thirty-first day for two months. If the overpayment is repaid in installments or recouped by withholding interim payments, each payment will first be applied to accrued interest and then to principal. Interest will be assessed for each 30 day period or less that payment is delayed. A period of less than 30 days will be treated as a full 30 day period, and the 30 day interest charge will be applied to any overpayment balance. As specified in 42 CFR 419, interest accrued on Medicare overpayments and interest on funds borrowed specifically to repay overpayments are not allowable costs for Medicare reimbursement.

10.2.4.3. Accelerated Payments

Upon written request, an accelerated payment may be issued to a provider of services if the provider has experienced financial difficulties. The financial difficulties must be due to a delay by the intermediary in making payments or in exceptional situations in which the provider has experienced a temporary delay in preparing and submitting bills to the intermediary beyond its normal billing cycle. The financial situation of the agency should also be such that it would not be alleviated by receipts anticipated within 30 days. Any such payment must be approved first by the intermediary and then by CMS. The amount of the payment is computed as a percentage of the net reimbursement for unbilled or unpaid covered services not to exceed 70%. Recovery of the accelerated payment begins the day after the payment is made and should be fully recovered in 90 days. Recovery may be made by recoupment as provider bills are processed or by direct payment.

10.2.4.4. Chain Providers

By Medicare program definition, a chain organization consists of a group of two or more health care facilities (and may also include other businesses) which are owned, leased, or through any other device, controlled by one organization.

For our purposes, all chains are composed of the health care facilities and a central organizing body known as the home office. The Medicare program recognizes the home office as a related organization to the participating providers. However, the home office is not a provider in itself; therefore, the allowable home office costs may not be directly reimbursed by the program. Where the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider’s cost report, and properly reimbursed as part of the provider’s costs. Home office costs directly related to patient care including an appropriate share of indirect costs (overhead, administrative, salaries, etc.), are allowable to the extent they are reasonable. Home office costs which would not be allowable as cost if incurred directly by the provider, cannot be allowed as a home office cost. A home office cost statement must be submitted to the intermediary servicing any member of the chain before the provider can be reimbursed for home office costs.
The financial records of the home office must support the information in the home office cost statement. Additionally, the statement must contain documentation for the home office costs claimed by the provider, and the basis used to allocate these costs to all components of the chain organization. If the home office cost statement is not furnished to the provider’s intermediary, related home office costs must be removed from the calculation of reimbursable costs.

CMS Pub 15-1 Section 2150 and 2153 should be reviewed for more details.

**10.2.5. Credit Balance Reporting**

In accordance with Sections 1815(a) and 1833(e) of the Social Security Act, the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, section 1866 (a)(1)(c) of the Act requires participating providers to furnish information about payments made to them and to refund any money incorrectly paid. In accordance with these provisions, provider must complete a Medicare Credit Balance Report (CMS 838) to help ensure that moneys owed to Medicare are repaid in a timely manner.

The CMS 838 is specifically used to monitor identification and recovery of “credit balances” due to Medicare. A Medicare credit balance is an improper or excess payment made to a provider as a result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer;
- Paid for services planned by not performed or for non-covered services;
- Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts.

For purposes of completing the CMS 838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a “credit.” However, Medicare credit balances include moneys due the program regardless of its classification in a provider’s accounting records. For example, if a provider maintains credit balance accounts for a stipulated period, e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all moneys due the Medicare program.

To help determine whether a refund is due to Medicare, another insurer, the patient or beneficiary, refer to the following manual sections 300, 302, and 341 of the Medicare Home Health Agency Manual which pertain to eligibility and MSP admissions procedures.
The CMS 838 consists of a certification page and a detail page. An officer or the Administrator of your facility must sign and date the certification page. Even if no Medicare credit balances are shown in your records for the reporting quarter, you must still have the officer or Administrator sign the form and submit it to attest this fact. An example of the form is provided on Exhibit D. The form is due within 30 days after the close of each calendar quarter. All Medicare credit balances shown in your records must be reported regardless of when they occurred. Repayment of the credit balance should occur by check or by submission of adjustment requests in hard copy or electronic format. If you submit a check to pay credit balances, and submit adjustment requests for the individual credit balances that pertain to open cost reporting periods then we will assure that moneys are not collected twice.

Hospital based home health agencies are to submit their CMS 838 to Palmetto GBA, even though we are not servicing the hospital.

Exhibit D  Credit Balance Report

10.2.5.1. CMS 838 Field Descriptors

The heading area of the CMS-838 should provide the following information:

- The full name of the provider
- The provider number
- An “A” if the Report reflects Medicare Part A credit balances or a “B” if it reflects Part B credit balances
- The number of current detail pages and the total number of pages forwarded, excluding the certification page, for this provider number
- The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance report data

The 838 consists of 15 columns. The information requested will allow the proper adjustment to be made to the beneficiary’s records. The columns and requested information are:

<table>
<thead>
<tr>
<th>COLUMN 1 - BENEFICIARY NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The last name and first initial of the Medicare beneficiary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLUMN 2 - HEALTH INSURANCE CARD NUMBER (HICN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The HIC number of the Medicare beneficiary</td>
</tr>
<tr>
<td>COLUMN 3 - DOCUMENT CONTROL NUMBER (DCN)</td>
</tr>
<tr>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>- The 13-digit number assigned by Medicare and included on the remittance advice after the claim has processed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLUMN 4 - TYPE OF BILL (TOB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The three digit number indicating the type of bill, i.e., 111 - inpatient, 131 - outpatient, 333 - home health, etc., of the claim</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLUMN 5 - “ADMISSION” DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The “From” date of service (in MM/DD/YY format) of the claim.</td>
</tr>
<tr>
<td>- This is the from date in the Statement Covers Period on the UB-92 not the patient’s admission date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLUMN 6 - “DISCHARGE” DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The “Through” date of service (in MM/DD/YY format) of the claim.</td>
</tr>
<tr>
<td>- This is the through date in the Statement Covered Period on the UB-92 not the patient’s discharge date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLUMN 7 - PAID DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The date (in MM/DD/YY format) the claim was paid by Medicare</td>
</tr>
<tr>
<td>- If a credit balance is caused by a duplicate Medicare payment, ensure that the paid date and DCN number correspond to the most recent payment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLUMN 8 - COST REPORT OPEN/CLOSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Indicate whether or not the cost report has been settled</td>
</tr>
<tr>
<td>- An open cost report is one for which a Notice of Program Reimbursement (NPR) has not been issued. Indicate open cost reports with an “O”</td>
</tr>
<tr>
<td>- A closed cost report has had an NPR issued and has received a final settlement. Indicate closed cost reports with a “C” (Do not consider a cost report open if it was reopened for a specific issue)</td>
</tr>
</tbody>
</table>
### COLUMN 9 - CREDIT BALANCE AMOUNT

- The amount that was determined to be owed to the Medicare program
- This Medicare credit balance amount should be the amount of reimbursement not the submitted charge

### COLUMN 10 - AMOUNT REPAID

- The credit balance repayment amount being repaid with the submission of the report
- Because full payment is required with the submission of the report, Column 10 should equal Column 9

### COLUMN 11 - METHOD OF PAYMENT

All amounts shown in Column 9 should be paid at the time the report is submitted. The method by which you are repaying the Medicare program should be indicated in this column. Payment may be made by check or by the submission of an adjustment bill.

- Use a “C” if repaying the credit balance amount with a check
- Use an “A” if repaying the credit balance amount with an adjustment bill that is submitted with the report
- Use an “X” if repaying the credit balance amount with an adjustment bill that has previously been submitted, but has not appeared on a remittance advice

### COLUMN 12 - MEDICARE AMOUNT OUTSTANDING

- The amount of the credit balance not being repaid (Column 9 minus column 10). This column should show a zero because full payment is required with the submission of the Report.

### COLUMN 13 - REASON FOR CREDIT BALANCE

Indicate the reason for the credit balance by entering the appropriate number which describes why the credit balance exists:
- Enter a “1” if it is the result of a duplicate payment by Medicare

- Enter a “2” if the provider has received a primary payment by another insurer (MSP related claims), or

- Enter a “3” for any other reason, such as billing error

<table>
<thead>
<tr>
<th>COLUMN 14 - VALUE CODE  (Required only if Column 13 is “2”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- This field should be left blank unless there is a “2” in Column 13. Indicate the appropriate value code to show which of the following types of primary payments were made:</td>
</tr>
<tr>
<td>12 Working Aged</td>
</tr>
<tr>
<td>13 End Stage Renal Disease</td>
</tr>
<tr>
<td>14 Auto No Fault/Liability</td>
</tr>
<tr>
<td>15 Workers’ Compensation</td>
</tr>
<tr>
<td>16 Other Government Program</td>
</tr>
<tr>
<td>41 Black Lung</td>
</tr>
<tr>
<td>42 Veteran’s Administration</td>
</tr>
<tr>
<td>43 Disability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLUMN 15 - PRIMARY PAYER AND ADDRESS (Required if Column 13 is “2”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The name and address of the primary insurer identified in Column 14. This column should be left blank if Column 13 does not indicate a MSP situation with a “2”.</td>
</tr>
</tbody>
</table>

*Note: Once a credit balance has been reported on the CMS 838, do not report it on subsequent quarters’ reports. If you have a question regarding a particular claim, please call the credit balance consultant.*
MEDICARE CREDIT BALANCE REPORT CERTIFICATION

The Medicare Credit Balance Report is required under the authority of Section 1815(a), 1833(e), 1886(a) (1) (c), and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT, OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by __________________________

Provider Name and Number

____________________________

for the calendar quarter ended __________________ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable federal laws, regulations, and instructions.

Check One: (Signed) __________________________

( ) No Credit Balances to report this quarter

____________________________

Title

( ) The Credit Balance report is attached

____________________________

Date

Palmetto GBA
Home Health Training Manual, 2005
### 10.2.5.2. CMS 838 Example

**Provider Name:**

**Provider Number:**

**Quarter Ending:**

**Medicare Part:** ("A" or "B")

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<tr>
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<th>(12)</th>
<th>(13)</th>
<th>(14)</th>
<th>(15)</th>
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</thead>
<tbody>
<tr>
<td>Beneficiary Name</td>
<td>HIC #</td>
<td>ICN No.</td>
<td>Type of Bill</td>
<td>Admission Date (MM/DD/YY)</td>
<td>Discharge Date (MM/DD/YY)</td>
<td>Paid Date (MM/DD/YY)</td>
<td>Cost Report Open/Close</td>
<td>Amount of Credit</td>
<td>Amount Repaid</td>
<td>Method of Payment</td>
<td>Medicare Amount</td>
<td>Reason for Credit Balance</td>
<td>Value</td>
<td>Primary P &amp; Addres</td>
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Form Approved
OMB no. 0938-0600 (6/96)

*Palmetto GBA*

*Home Health Training Manual, 2005*
10.2.6. Remittance Advice

Remittance Advices reflecting processed claims are issued to providers on a daily basis either electronically or in hard copy form. The remittance advice format is standard, according to CMS’s instruction.

The following are field descriptors for the Standard Paper Remittance Advice (RA). The item numbers refer to the example included following this section but do not appear on the actual RA.

The field locators apply to either Part A or Part B services. Please refer to the header information to determine whether the services are Part A or Part B.

<table>
<thead>
<tr>
<th>ITEM 1 - PATIENT NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Last name, first and middle initial from FL 10 of the UB-92</td>
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</table>

<table>
<thead>
<tr>
<th>ITEM 2 - PATIENT CNTRL NUMBER</th>
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</thead>
<tbody>
<tr>
<td>- Patient control number as assigned by your agency</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 3 - RC</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Reason code as assigned on the claim for comments, changes or denials.</td>
</tr>
<tr>
<td>- Refer to the CAS Standard Reason Code</td>
</tr>
<tr>
<td>- Up to four reason codes may be listed in this column</td>
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</table>

<table>
<thead>
<tr>
<th>ITEM 4 - REM</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Remark codes provide specific claim information</td>
</tr>
<tr>
<td>- Up to four codes may be displayed in this column.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 5 - DRG #</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Diagnosis related grouping (DRG) number assigned to the claim per CMS</td>
</tr>
</tbody>
</table>
ITEM 6 - DRG OUT AMT

- Outlier portion of the diagnosis related grouping payment

ITEM 7 - COINSURANCE

- Coinsurance calculated after processing to be paid by Medicare patient for this claim

ITEM 8 - PAT REFUND

- Patient refund. The amount due to patient based on CMS’s records

ITEM 9 - CONTRACT ADJ

- Contract adjustment. The amount used to balance claim charges to payment amount. Calculated as follows:

  Claim reported charges
  - minus the sum of all MSP value codes (12-16, 41-43, 47)
  - minus claim non-covered charges
  - minus Gramm Rudman Reduction (value code 75)
  - minus claim denied charges
  - minus professional component (value code 05)
  - minus ESRD reduction (value code 71)
  - minus blood deductible
  - minus cash deductible
  - minus coinsurance
  - minus net provider reimbursement amount
  - minus patient refund amount

ITEM 10 - HIC NUMBER

- Health insurance claim (HIC) number assigned to the patient by the SSA and included on the UB-92
| ITEM 11 - ICN | - Internal control number (ICN) assigned by the FI unique to this claim. Also known as the document control number (DCN) |
| ITEM 12 - OUTCD | - Type of outlier as indicated for this claim |
| | 69 - operating PPS day outlier |
| | 70 - operating PPS cost outlier |
| ITEM 13 - CAPCD | - Type of capital outlier for this claim |
| | A4 - day outlier |
| | A5 - cost outlier |
| ITEM 14 - DRG CAP AMT | - Capital portion of the DRG payment |
| ITEM 15 - COVD CHGS | - Covered charges on the claim |
| ITEM 16 - ESRD NET ADJ | - Amount of ESRD network for this claim (value code 71) |
| ITEM 17 - PER DIEM RATE | - Rate used when payment is based on a percentage of charges, rates paid per diem or average cost per visit |
| ITEM 18 - FROM DT | - From date as listed on the UB 92 FL 6 |
ITEM 19 - THRU DT

- Thru date as listed on the UB92 FL 6

ITEM 20 - NACHG

- Patient name change codes are as followed:
  
  QC - Patient’s name has changed
  74 - Patient’s name has not changed

ITEM 21 - HICHG

- Patient Medicare HIC number change codes are as follows:
  
  C - Patient’s HIC number has changed
  N - Patient’s HIC number has not changed

ITEM 22 - TOB

- Type of Bill (TOB) as listed on the UB-92 FL 4

ITEM 23 - PROF COMP

- Professional fees billed but not paid by fiscal intermediary

ITEM 24 - MSP PAYMENT

- Total MSP primary payer amounts for this claim

ITEM 25 - NCOV CHGS

- Submitted charged of non-covered services for this claim

ITEM 26 - INTEREST

- The amount of interest due to provider and/or beneficiary for this claim

ITEM 27 - HCPCS AMT

- Total of payable line item amounts for HCPCS billed on this claim
ITEM 28 - CLM STAT

- Code specifying the status of this claim:

  01 - Paid as primary
  02 - Paid as secondary
  03 - Paid as tertiary
  04 - Denied
  05 - Pended
  19 - Medicare primary payer and intermediary sent claim to another insurer
  20 - Medicare secondary payer and intermediary sent claim to another insurer
  21 - Medicare tertiary payer and intermediary sent claim to another insurer
  22 - Adjustment to prior claim
  23 - Not a Medicare claim, intermediary sent to another insurer

ITEM 29 - COST

- The number of days claimable as Medicare patient days on the cost report

ITEM 30 - COVDYS

- The number of days/visits covered by the primary payer or days/visits that would have been covered had Medicare been the primary payer for this claim

ITEM 31 - NCOVDY

- The number of days/visits not covered by the primary payer for this claim

ITEM 32 - DRG OPR AMT

- Operating portion of the DRG payment

ITEM 33 - DEDUCTIBLES

- The deductible calculated after processing

ITEM 34 - DENIED CHGS

- Denied services on this claim
ITEM 35 - NET REIMB
- The provider’s net reimbursement amount for this claim

ITEM 36 - DAYS COST
- The number of days claimable as Medicare patient days on the cost report

ITEM 37 - COVDY
- The number of days/visits covered by the primary payer or days/visits that would have been covered had Medicare been the primary payer for this remit

ITEM 38 - NCOVDY
- The number of days/visits not covered by the primary payer for this remit

ITEM 39 - COVD CHARGES
- Covered charges for this remit

ITEM 40 - NCOVD CHARGES
- Charges for non-covered services for this remit

ITEM 41 - DENIED CHARGES
- Charges for services denied by the FI

ITEM 42 - PROF COMP
- Professional fees billed but not paid by the FI

ITEM 43 - MSP PAYMENT
- Total of MSP primary payer amounts for this remit
## SECTION 10

### ITEM 44 - DEDUCTIBLES
- The deductible calculated after processing

### ITEM 45 - COINSURANCE
- Coinsurance calculated after processing to be paid by the Medicare beneficiary for this remit

### ITEM 46 - PAT REFUND
- The amount due to the patient based on CMS’s records

### ITEM 47 - INTEREST
- The amount of interest due to the provider and/or patient for this remit

### ITEM 48 - CONTACT ADJ
- The amount used to balance claim charges to payment amount (To calculate see above details)

### ITEM 49 - HCPCS AMOUNT
- Total of payable line item amounts for HCPCS billed on this remit

### ITEM 50 - NET REIMB
- The provider’s net reimbursement amount for this remit

The following items refer to the pass thru amounts

### ITEM 51 - CAPITAL
- Capital pass thru payments

### ITEM 52 - RETURN ON EQUITY
- Not applicable (N/A)
<table>
<thead>
<tr>
<th>ITEM 53 - DIRECT MED ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Direct/indirect medical education pass thru payments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 54 - KIDNEY ACQUISITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Kidney acquisition pass thru payments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 55 - BAD DEBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Bad debt pass thru payments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 56 - NONPHYSICIAN ANESTHETISTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- CRNA pass thru payments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 57 - TOTAL PASS THRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Total pass thru</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 58 - PIP PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Periodic Interim Payment (PIP) payment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 59 - SETTLEMENT PAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Sum of all lump sums, tentative settlements, final settlements, etc. Providers are notified via a letter from PARD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 60 - ACCELERATED PAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Sum of accelerated payments, which are issued to providers who are having claims problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM 61 - REFUNDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Refunds sent to the provider (usually for credit balance refunds)</td>
</tr>
</tbody>
</table>
ITEM 62 - PENALTY RELEASE
- Money released to a provider for late credit balance report or cost report. This money had previously been withheld for late report.

ITEM 63 - CLAIMS ACCOUNTS RECEIVABLE
- Withholding for adjustment bills that were processed and money was due Medicare

ITEM 64 - ACCELERATED PAYMENTS
- Withholding for a previously issued accelerated payment

ITEM 65 - PENALTY
- Withholding for late credit balance report or cost report

ITEM 66 - SETTLEMENT
- Withholding for lump sums, tentatives, and final settlements. Providers are notified of these overpayments via a letter from PARD

ITEM 67 - TOTAL WITHHOLDING
- Total withholding for claims accounts receivable, accelerated payment, penalty and settlement

ITEM 68 - DRG OUT AMT
- Outlier portion of DRG payment

ITEM 69 - PROV INTEREST
- Interest due provider

ITEM 70 - HCPCS AMT
- Total HCPCS amount on this RA
### SECTION 10

<table>
<thead>
<tr>
<th>ITEM 71 - NET REIMB</th>
<th>- Net reimbursement on this RA</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITEM 72 - TOTAL PASS THRU</td>
<td>- Total pass thru amount</td>
</tr>
<tr>
<td>ITEM 73 - PIP PAYMENTS</td>
<td>- Total periodic interim payment</td>
</tr>
<tr>
<td>ITEM 74 - SETTLEMENT PAYMENTS</td>
<td>- Total amount for settlement payments</td>
</tr>
<tr>
<td>ITEM 75 - ACCELERATED PAYMENTS</td>
<td>- Total amount in accelerated payments</td>
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<tr>
<td>ITEM 76 - REFUNDS</td>
<td>- Total amount in refunds</td>
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<tr>
<td>ITEM 77 - PENALTY RELEASE</td>
<td>- Amount released</td>
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<tr>
<td>ITEM 78 - WITHHOLDING</td>
<td>- Total amount withheld on this RA</td>
</tr>
<tr>
<td>ITEM 79 - PROVIDER PAYMENT</td>
<td>- Total amount paid on this RA</td>
</tr>
<tr>
<td>ITEM 80 - CHECK/EFT NUMBER</td>
<td>- Check or EFT number issued for this RA</td>
</tr>
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</table>
### 10.2.6.1. RA Example

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient Control Number</th>
<th>RC</th>
<th>DRG#</th>
<th>DRG Out AMT</th>
<th>Coinsurance</th>
<th>Pat Refund</th>
<th>Contract Adj</th>
<th>HIC Number</th>
<th>ICN Number</th>
<th>OutCD</th>
<th>CapCD</th>
<th>Cap CD AMT</th>
<th>CoVd Chgs</th>
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**Palmetto GBA**

*Home Health Training Manual, 2005*
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**SUMMARY**

CLAIM DATA:

<table>
<thead>
<tr>
<th>DAYS</th>
<th>RETURN ON EQUITY</th>
<th>DIRECT MEDICAL EDUCATION</th>
<th>PROVIDER PAYMENT RECAP</th>
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PASS THRU AMOUNTS:

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<th>DAYS</th>
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<th>52</th>
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<table>
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<th>DAYS</th>
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<tbody>
<tr>
<td>613.20</td>
<td>.00</td>
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</tbody>
</table>

- **40** COVD : 613.20 |
- **41** DENIED : .00 |
- **42** PROF COMP : .00 |
- **43** MSP PYMT : .00 |
- **44** DEDUCTIBLES : .00 |
- **45** COINSURANCE : .00 |
- **46** PAT REFUND : .00 |
- **47** INTEREST : .00 |
- **48** CONTRACT ADJ : .00 |
- **49** PROC CD AMT : .00 |
- **50** NET REIMB : .00 |
- **51** CAPITAL : .00 |
- **52** RETURN ON EQUITY : .00 |
- **53** DIRECT MEDICAL EDUCATION : .00 |
- **54** KIDNEY ACQUISITION : .00 |
- **55** BAD DEBT : .00 |
- **56** NON PHYSICIAN ANESTHETISTS : .00 |
- **57** TOTAL PASS THRU : .00 |
- **58** PIP PAYMENT : .00 |
- **59** SETTLEMENT PAYMENTS : .00 |
- **60** ACCELERATED PAYMENTS : .00 |
- **61** REFUNDS : .00 |
- **62** PENALTY RELEASE : .00 |
- **63** CLAIMS ACCOUNTS RECEIVABLE : .00 |
- **64** ACCELERATED PAYMENTS : .00 |
- **65** PENALTY : .00 |
- **66** SETTLEMENT : .00 |
- **67** DRG OUT AMT : .00 |
- **68** INTEREST : .00 |
- **69** PROC CD AMT : .00 |
- **70** NET REIMB : .00 |
- **71** PIP PAYMENTS : .00 |
- **72** TOTAL PASS THRU : .00 |
- **73** PIP PAYMENTS : .00 |
- **74** SETTLEMENT PYMTS : .00 |
- **75** ACCELERATED PYMTS : .00 |
- **76** WITHHOLD FROM PAYMENTS : .00 |
- **77** PENALTY RELEASE : .00 |
- **78** WITHHOLD : .00 |
- **79** NET PROV PAYMENT : .00 |

Palmetto GBA  
Home Health Training Manual, 2005
10.2.7. Provider Statistical and Reimbursement Reports

Provider Statistical and Reimbursement (PS&R) Reports accumulate processed claims data, such as processed visits, net reimbursement, charges and other information. Palmetto GBA offers providers the ability to access their agencies’ PS&R summary reports on the bulletin board system (BBS). These reports are updated twice a month and reflect cumulative information for each provider. **To access PS&R reports on the BBS, you need to complete an enrollment form. Requests for detailed payment reconciliation reports should be submitted in writing to your Reimbursement Consultant.**

With HHPPS there are new PS&R reports that capture information about the episodes of care. Below is list of all the PS&R reports with indications of the ones that are new.

The subsequent pages illustrate how visits, charges, payments and episodes of care for services rendered on and after the implementation of HHPPS on October 1, 2000 are to be presented on the cost report.

1) **320 Provider Summary Report** – This report is for Medicare Part B services furnished under a plan of care and its reimbursements for periods prior to the October 1, 2000 HHPPS implementation date.

2) **New 322 HHPPS Rap Report** – This report displays an accounting of the Medicare Part B Requests for RAPs that were submitted during the fiscal year beginning on and after October 1, 2000.

3) **New 329 HHPPS Provider Summary Report** – This report displays the visit, charges and reimbursement for HHPPS claims paid and processed on and after October 1, 2000, for each episode type, i.e., LUPA, SCIC, Full, Full with Outlier…for the fiscal year, under Medicare Part B.

4) **330 Provider Summary Report** – This report is for Medicare Part A services and reimbursement for periods prior to the October 1, 2000 HHPPS implementation date.

5) **New 332 HHPPS Rap Report** – This report displays an accounting of the Medicare Part A RAPs were submitted on and after October 1, 2000.

6) **New 339 HHPPS Provider Summary Report** – This report displays the visits, charges and reimbursement for HHPPS claims paid and processed on and after October 1, 2000, for each episode type, i.e., LUPA, SCIC, Full, Full with Outlier…
7) **340 Provider Summary Report** – This report is for Medicare Part B services provided that are not covered under a plan of care. These services can include calcimar administration. This can also include influenza and pneumococcal vaccinations prior to the implementation of Outpatient Prospective Payment System (OPPS).

8) New → **34P Provider Summary Report** – This report is for Medicare Part B services that are not under a plan of care. The services reflected in this report are for influenza and pneumococcal vaccinations paid under a fee schedule as covered under OPPS.

9) New → **998 Hospital Outpatient** - Displays a summary of charges, reimbursement, deductibles and coinsurance, (if applicable) from the 34P report.

10) **320 MSA Beneficiary Census Report** – Displays the census and visits applied to each Metropolitan Statistical Area (MSA)/non-MSA, for Medicare Part B Services provided under a plan of care for periods prior to October 1, 2000.

11) New → **329 MSA Beneficiary Census Report** – Displays the census and visits applied to each MSA/non-MSA for Medicare Part B Services furnished under a plan of care for periods on and after the October 1, 2000 HHPPS implementation.

12) **330 MSA Beneficiary Census Report** – Displays the census and visits applied to each MSA/non-MSA for Medicare Part A services for periods prior to October 1, 2000.

13) New → **339 MSA Beneficiary Census Report** – Displays the census and visit applied to each MSA/non-MSA for Medicare Part A services for periods on and after the October 1, 2000 HHPPS implementation.

14) **999 MSA Beneficiary Census Report** – Displays the census and visits applied to each MSA/non-MSA for all Medicare services for the entire fiscal period. This will include services before and after October 1, 2000.
<table>
<thead>
<tr>
<th>COLUMN 1 “Title XVIII”</th>
<th>COLUMN 3 “Other Visits”</th>
<th>COLUMN 5 “Total Visits”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter the Title XVIII visits for each discipline for services rendered through September 30, 2000. NOTE: For cost reporting periods that overlap October 1, 2000, i.e., 1/1/00-12/31/00, DO NOT ENTER data pertaining to services performed on and after 10/1/2000.</td>
<td>Enter in column 3 all the agency visits, EXCEPT THOSE pertaining to Title XVIII visits, for each discipline.</td>
<td>Enter the sum of columns 1 and 3. For cost reporting periods that overlap October 1, 2000, i.e., 1/1/00-12/31/00, in addition to summing columns 1 and 3, enter the Title XVIII visits that were performed for the fiscal year that were performed on and after October 1, 2000. Note: During the PPS transition period, the sum of columns 1 and 3 will not equal the product of column 5.</td>
</tr>
<tr>
<td>Column 1 “Title XVIII”</td>
<td>Column 3 “Other Visits”</td>
<td>Column 5 “Total Visits”</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>For cost reporting periods that overlap October 1, 2000, PS&amp;R data for this column can be obtained from reports 320 and 330.</td>
<td></td>
<td>For cost reporting periods that overlap October 1, 2000, PS&amp;R data for the periods beginning October 1, 2000 through the fiscal year end can be obtained from reports 329 and 339 HHPPS Provider Summary Reports.</td>
</tr>
</tbody>
</table>
### PART IV - PPS ACTIVITY DATA - Applicable for Services Rendered on or After October 1, 2000

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>Full Episodes without Outliers</th>
<th>Full Episodes with Outliers</th>
<th>LUPA Episodes</th>
<th>PEP Only Episodes</th>
<th>SCIC within a PEP</th>
<th>SCIC Only Episodes</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 Skilled Nursing Visits</td>
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<td></td>
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<tr>
<td>31 Skilled Nursing Visit Charges</td>
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<td></td>
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<td>32 Physical Therapy Visits</td>
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<td>34 Occupational Therapy Visits</td>
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<td></td>
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<td></td>
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<td>35 Occupational Therapy Visit Charges</td>
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<td></td>
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<td>36 Speech Pathology Visits</td>
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<td>37 Speech Pathology Visit Charges</td>
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<tr>
<td>38 Medical Social Service Visits</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39 Medical Social Service Visit Charges</td>
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<td>40 Home Health Aide Visits</td>
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<td>41 Home Health Aide Visit Charges</td>
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<tr>
<td>42 Total Visits (Sum of lines 30,32,34,36,38,40)</td>
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<td></td>
<td></td>
<td></td>
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<td>43 Other Charges</td>
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<td></td>
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</tr>
<tr>
<td>44 Total Charges (Sum of lines 31,33,35,37,39,41,43)</td>
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<td></td>
<td></td>
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<td>45 Total Number of Episodes</td>
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<td></td>
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<tr>
<td>46 Total Number of Outlier Episodes</td>
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<td></td>
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<tr>
<td>47 Total Non-Routine Medical Supply Charges</td>
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</tbody>
</table>

The information on this worksheet is to capture Title XVIII visits and charges furnished under the HH PPS, which are visits and services provided on and after October 1, 2000. Note that column one is used to capture visits and charges for Full Episodes without Outliers, while column 2 is to be used to capture and report visits and charges for Full Episodes with Outliers.

HH PPS Provider Summary Report’s, 329 and 339 can be used to complete this worksheet. Please note that the visits and charges from each report, for each type of episode will need to be summed together in order to complete this section correctly.

Do not prorate visits and charges for episodes that overlap the cost report’s fiscal year end. Visits and charges for episodes that overlap the cost report’s fiscal year end are to be counted in the following fiscal year. For example, if a provider with a December 31, 2000 fiscal year end has a full episode that starts on December 15, 2000 and ends, February 13, 2001, all the visits, charges and reimbursement would be included in the December 31, 2001 fiscal year end.
In Worksheet C, Part II, it is important to note that the rows 1-6 are subscripted to Pre and Post HH PPS implementation dates. Providers using the PS&R in completing their cost reports need to recall that reports 320 (Part B visit and charges furnished under a plan of care) and 330 (Part A visits and charges) are for periods prior to October 1, 2000. Reports 329 and 339 are used to capture HHPPS Medicare visits, charges and reimbursement for services performed on and after October, 1, 2000.

Rows 8-14 of Worksheet C, Part II, are used in comparing the cost of pre-HHPPS visits (visits prior to October 1, 2000), to the per-visit cost limitation per MSA/non-MSA. Visit and MSA/non-MSA information prior to October 1, 2000, is available on the PS&R reports 320, 330 and pre-PPS 999 census.
## PART III - SUPPLIES AND DRUGS COST COMPUTATION

<table>
<thead>
<tr>
<th>Other Services</th>
<th>Patient</th>
<th>From Wkst B, Col. 6, Line:</th>
<th>Total Charges from HHA Record</th>
<th>Total Cost</th>
<th>Ratio (Col 2 ÷ 3)</th>
<th>Medicare Covered Charges</th>
<th>Cost of Services</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>15</td>
<td>Cost of Medical Supplies - Pre 10/1/2000</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>15.01</td>
<td>Cost of Medical Supplies - Post 9/30/2000</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Cost of Drugs - Pre 10/1/2000</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.01</td>
<td>Cost of Drugs - Post 9/30/2000</td>
<td>13</td>
<td></td>
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</tbody>
</table>

In column 2, lines 15 and 16, enter the cost of medical supplies and drugs as computed on Worksheet B. The cost entered on lines 15.01 and 16.01 must equal the costs entered on 15 and 16 respectively. In column 3 enter the total charges for medical supplies and drugs for the entire cost reporting period. The charges entered on lines 15.01 and 16.01 of column 3 must equal the charges entered on lines 15 and 16 respectively.

Enter in columns 5, 6, and 7, lines 15 and 15.01, the charges for medical supplies that were **not paid** on a fee schedule. Information for these columns and rows can be found in the PS&R reports 330, 320 and 340 respectively.

Enter in column 6, lines 16 and 16.01 the charges for influenza and pneumococcal vaccines and their respective administration. Information for these rows can be found on the 340 and 34P report.

Enter in column 7, lines 16 and 16.01 the charges for covered osteoporosis drugs and services rendered.

<table>
<thead>
<tr>
<th>Medicare Program Unduplicated Census Count for Each MSA Pre 10/1/2000 (From Your Intermediary)</th>
<th>Per Beneficiary Annual Limitation Per Part B</th>
<th>Cost of Medicare Services</th>
<th>Total (Sum of Cols 3 &amp; 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total Cost of Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 &amp; 11, respectively, lines 1-6 (exclusive of subscripts))</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (Sum of lines 17 and 18)</td>
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</tr>
<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cost Per Visit Limitation for Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 &amp; 11, respectively, line 14)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total (Sum of lines 20 and 21)</td>
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<td></td>
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</table>

### MSA Code (Col 1 x 2)

<table>
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<tr>
<th>MSA Code (Col 1 x 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Per Beneficiary Cost Limitation for MSA: 01</td>
</tr>
<tr>
<td>Per Beneficiary Cost Limitation for MSA: 02</td>
</tr>
<tr>
<td>Per Beneficiary Cost Limitation for MSA: 03</td>
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<td>Per Beneficiary Cost Limitation for MSA: 04</td>
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<td>Per Beneficiary Cost Limitation for MSA: 05</td>
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<td>Per Beneficiary Cost Limitation for MSA: 06</td>
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<tr>
<td>Per Beneficiary Cost Limitation for MSA: 07</td>
</tr>
<tr>
<td>Per Beneficiary Cost Limitation for MSA: 08</td>
</tr>
<tr>
<td>Per Beneficiary Cost Limitation for MSA: 09</td>
</tr>
<tr>
<td>Aggregate Per Beneficiary Cost Limitation (Sum of lines 23 and subscripts thereof)</td>
</tr>
</tbody>
</table>

In column 0, enter the MSA/non-MSA code(s) from Worksheet S-3, Part III.

In column 1, enter the Medicare program (Title XVIII) unduplicated census count for services provided prior to October 1, 2000. Medicare census information, as processed by the intermediary, can be obtained from the MSA pre-PPS census report 999.
### PART A  PART B

<table>
<thead>
<tr>
<th>Description</th>
<th>PART A Services</th>
<th>PART B Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total reasonable cost (See Instructions)</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Total PPS Payment - Full Episodes without Outliers</td>
<td>12.01</td>
<td></td>
</tr>
<tr>
<td>Total PPS Payment - Full Episodes with Outliers</td>
<td>12.02</td>
<td></td>
</tr>
<tr>
<td>Total PPS Payment – LUPA Episodes</td>
<td>12.03</td>
<td></td>
</tr>
<tr>
<td>Total PPS Payment - PEP Only Episodes</td>
<td>12.04</td>
<td></td>
</tr>
<tr>
<td>Total PPS Payment - SCIC within a PEP Episodes</td>
<td>12.05</td>
<td></td>
</tr>
<tr>
<td>Total PPS Payment - SCIC Only Episodes</td>
<td>12.06</td>
<td></td>
</tr>
<tr>
<td>Total PPS Outlier Payment - Full Episodes with Outliers</td>
<td>12.07</td>
<td></td>
</tr>
<tr>
<td>Total PPS Outlier Payment - PEP Only Episodes</td>
<td>12.08</td>
<td></td>
</tr>
<tr>
<td>Total PPS Outlier Payment - SCIC within a PEP Episodes</td>
<td>12.09</td>
<td></td>
</tr>
<tr>
<td>Total PPS Outlier Payment - SCIC Only Episodes</td>
<td>12.10</td>
<td></td>
</tr>
<tr>
<td>Total Other Payments</td>
<td>12.11</td>
<td></td>
</tr>
<tr>
<td>DME Payment</td>
<td>12.12</td>
<td></td>
</tr>
<tr>
<td>Oxygen Payment</td>
<td>12.13</td>
<td></td>
</tr>
<tr>
<td>Prosthetics and Orthotics Payment</td>
<td>12.14</td>
<td></td>
</tr>
<tr>
<td>Part B deductibles billed to Medicare patients (exclude coinsurance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal (Sum of lines 12.12-12.14 minus line 13)</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Excess reasonable cost (from line 10)</td>
<td>14</td>
<td></td>
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<tr>
<td>Subtotal (Line 14 minus line 15)</td>
<td>15</td>
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</tr>
<tr>
<td>Coinsurance billed to Medicare patients (From your records)</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Net cost (Line 16 minus line 17)</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Reimbursable bad debts (From your records)</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Vaccine</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Total Costs - Current cost reporting period (See Instructions)</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Recovery of excess depreciation resulting from agencies' termination or decrease in Medicare utilization</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Total cost before sequestration and other adjustments (line 21 plus/minus line 22 minus sum of lines 23 and 24)</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Other Adjustments (see instructions) (specify)</td>
<td>25.5</td>
<td></td>
</tr>
<tr>
<td>Sequestration Adjustment (See Instructions)</td>
<td>26</td>
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</tr>
<tr>
<td>Amount reimbursable after sequestration and other adjustments (Line 25 plus line 25.5 minus line 26)</td>
<td>27</td>
<td></td>
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<tr>
<td>Total interim payments (From Worksheet D-1, line 4)</td>
<td>28</td>
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</tr>
<tr>
<td>Tentative settlement (For intermediary use only)</td>
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<tr>
<td>Balance due HHIA/Medicare program (Line 27 minus line 28) (Indicate overpayments in brackets)</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2</td>
<td>30</td>
<td></td>
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<tr>
<td>Balance due HHIA/Medicare program (Line 29 minus line 30) (Indicate overpayments in brackets)</td>
<td>31</td>
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</table>

On lines 12.01 through 12.10 of Worksheet D, Part II, “Computation of Reimbursement Settlement,” enter the reimbursement amounts for each HH PPS episode as needed. It should be noted, HH PPS episodes (visits, charges and reimbursement) that overlap the Medicare cost report’s fiscal year end are counted in the year that the episode is completed. Therefore, HH PPS episodes (visits, charges and reimbursement) are not prorated to the fiscal year. For example, if a provider with a December 31, 2000 fiscal year end has a full episode that starts on December 15, 2000 and ends, February 13, 2001, all the visits, charges and reimbursement would be included in the December 31, 2001 fiscal year end.

HHPPS reimbursement as processed by the intermediary are included on the PS&R reports 329 (Medicare Part B services furnished under a plan of care) and 339 (Medicare Part A).
In Worksheet H-6, Part I, it is important to note that the rows 1-6 are subscripted to Pre and Post HH PPS implementation dates. Providers using the PS&R in completing their cost reports need to recall that reports 320 (Part B visit and charges furnished under a plan of care) and 330 (Part A visits and charges) are for periods prior to October 1, 2000. Reports 329 and 339 are used to capture HH PPS Medicare visits, charges and reimbursement for services performed on and after October 1, 2000.
Worksheet H-6 Hospital Cost Report

'ART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

<table>
<thead>
<tr>
<th>Description</th>
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</table>

ORM CMS-2552-96 (9/2000)  (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3648)
On lines 10.01 through 10.10 of worksheet H-7, Part II, “Computation of Reimbursement Settlement,” enter the reimbursement amounts for each HH PPS episode as needed. It should be noted, HHPPS episodes (visits, charges, and reimbursement) that overlap the Medicare cost report’s fiscal year end are counted in the year that the episode is completed. Therefore, HHPPS episodes (visits, charges and reimbursement) are not prorated to the fiscal year. (For example, if a provider with a December 31, 2000 fiscal year end has a full episode that starts on December 15, 2000 and ends, February 13, 2001, all the visits, charges and reimbursement would be included in the December 31, 2001 fiscal year end.)

HHPPS reimbursement, as processed by the intermediary, are included on the PS&R reports 329 (Medicare Part B services furnished under a plan of care) and 339 (Medicare Part A).

10.3. Cost Report Activities

There are several articles on the Palmetto GBA Web site (PalmettoGBA.com) with information on cost report filing. After opening the web site, make the following selections: Providers / Regional Home Health & Hospice Intermediary (RHHI) / Audit & Reimbursement / Cost Report Filing. Some of the articles are referred to below. (Note: On the Web site, links to other items are indicated in blue and underlined.)

- The hospital and home health agency cost report forms have been modified. These must be filed in an electronic format.
  - To obtain information from a CMS approved vendor, please see the article List of Approved Cost Report Vendors.
  - To obtain the instructions to the cost report forms, please see the article Obtaining Instructions to Cost Report Forms. This article instructs one how to download the complete instructions.
- The cost report questionnaire is now easier to complete as some sections are no longer required. Please see the article Modifications to Cost Report Questionnaire to determine the sections that do not need to be completed.

10.3.1 Electronic Cost Reports

Effective for cost reporting periods ending on or after March 31, 1997, all freestanding home health agencies must submit cost reports in a standardized electronic format. A list of approved software vendors is available on the web site as noted above. Additionally, where a HHA has manually completed the cost report, CMS provides “free” software to enable a HHA to file an electronic data set to the fiscal intermediary. Information concerning this is noted on the vendor list. (The phone number to request the free software is (860) 659-4300, option 3.)
10.3.2. Cost Report Submission

We will send cost report reminder letters and PS&R summary reports at least 30 days prior to the due date of your agency’s cost report. The reminder letter explains the due date, what information needs to be submitted, where to send it, etc. This information is also provided in this section.

Cost reports are due by the last day of the fifth month following the close of a provider's fiscal year. See Exhibit H for a schedule of cost report due dates. Extensions, with the approval of CMS, are granted only when a provider’s operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control. An example of such extraordinary circumstances might be a flood or fire that forced a provider to cease operations.

The US Postal Service postmarked date or a dated shipping label from a commercial carrier determines the receipt date of a cost report or payment of an overpayment. If any other mailing service or a postage meter is used, the date that the cost report or payment is received controls the date of receipt (CMS Publication 13-2, Section 2219.4).

If the cost report indicates that an amount is due the Medicare Program, interest will accrue on that amount from the date the cost report is due unless:

1. Full payment accompanies the cost report, or
2. The provider agrees in advance to liquidate the overpayment over the next (30) day period.  
   **If the provider chooses this option, the provider must inform us of this fact in writing before your cost report due date.**

If a cost report if filed after the due date, and it is later determined that an overpayment exists, interest will be assessed on the overpayment from the date the cost report was due to the date the cost report was filed.

If a provider is unable to repay the cost report overpayment within thirty (30) days, a request for an extended repayment may be submitted. This request, with required documentation, can be submitted with or prior to the submission of the cost report in order to avoid withholding of payments. The required documentation includes, but is not limited to, balance sheets, income statements, cash flow statements and statements of source and application funds. The first payment of the proposed repayment schedule **must** be included with the documentation. For a listing of the required documentation, please review the information on the Palmetto GBA Web site by selecting Providers / Regional Home Health & Hospice Intermediary (RHHI) / Audit & Reimbursement / Overpayments.

If the cost report is not filed by the due date, payments to the agency will be withheld.
Also, if a cost report is filed with an overpayment and either full payment or a documented request for a repayment schedule does not accompany the report, payments to the agency will be withheld. Upon receiving an acceptable cost report and collection of all overpayments, the withheld payments will be released.

In the case of an overpayment, the agency's check should be made payable to MEDICARE FEDERAL HIB (please be sure to include the provider number and reason for the repayment on the check) and mail to:

Supervisor, Medicare Finance (AG-361)  
Palmetto GBA  
2300 Springdale Drive, Bldg. One  
PO Box 7004  
Camden, South Carolina 29020 – 7004

Cost reports and supporting work papers and schedules should be sent to either of the following addresses.

Columbia, SC office:

Palmetto GBA – Provider Reimbursement  
Attn: Cost Report Acceptance – AG-330  
2300 Springdale Drive, Bldg. One  
PO Box 7004  
Camden, South Carolina 29020 - 7004

Palm Harbor, Florida office:

Palmetto GBA - Provider Reimbursement  
Attn: Cost Report Acceptance – CA-106  
34650 U.S. Highway 19 N., Suite 202  
Palm Harbor, FL 34684-2156
EXHIBIT HCOST REPORT DUE DATES

10.3.3. Cost Report Acceptability

For a provider’s cost report to be accepted, the cost report must be filed completely. The following items must be submitted for the cost report to be considered complete.

• Diskette submitted must contain:
  - ECR file
  - Print image file of the cost report (except when using CMS free software)
• Certification page (Worksheet S) as produced from the ECR file with the actual signature of an officer (administrator or chief financial officer)
• Certification page must include the encryption code of both the ECR file and the print image file
• Completed cost report questionnaire (CMS Form 339) with original signature on certification page and applicable supporting documentation

In addition, the following supporting information must be submitted.

• Documentation required by the cost report questionnaire (CMS Form 339), please refer to the web site article addressing modifications to the questionnaire
• Copy of the working trial balance
• Copy of the audited financial statements where applicable
• Supporting documentation for reclassifications, adjustments, related organizations, contracted therapists and protested items.

Please note that if a filed cost report is determined to be incomplete, the provider will be notified that the cost report has been rejected. Until a complete cost report is received, payments will be withheld.

If the items listed as “supporting information” are not received with the cost report, intermediaries have been instructed to request missing items. If the requested items are not received within 15 days, intermediaries are to reject the cost report.

10.3.4. Tentative Settlement Process

CMS requires intermediaries to issue tentative settlements in 60 days from the receipt of an acceptable cost report. This calculation is completed by the reimbursement consultant. Our procedure for computing tentative settlements includes a math review of your cost report, verification of cost limits and settlement data adjustments to the most current PS&R.
Exhibit I  Tentative Settlement Calculation
11. TERMINOLOGY & EXHIBITS

The following information is contained in this section:

- Terminology
- Acronyms
- Exhibits
11.1. Terminology

The following definitions and abbreviations are listed in alphabetical order.

- A -

**Accommodations** - Designates the type of room (private, semiprivate, or ward) provided. Includes board, special diets and general nursing services.

**Actual Charge** - The amount a physician or supplier actually bills a patient for a particular medical service or supply. (This may differ from the customary, prevailing, and/or reasonable charges under Medicare.)

**Administrative Law Judge (ALJ)** - One who presides at an administrative hearing, with power to administer oaths, take testimony, rule on questions of evidence, and make agency determinations of fact.

**Alternate Delivery Systems (ADS)** - A means of offering choices or options in modes of health care, often reducing costs but not quality of care. Examples of alternative delivery systems are health maintenance organizations, outpatient diagnostic services and preferred provider organizations.

**Alternate Intermediary** - One of the several organizations handling claims from home health agencies under the federal health coverage program. The term is used to describe the role of a regional intermediary when it administers Medicare A claims for a home health agency in place of the intermediary originally assigned by the Centers for Medicare & Medicaid Services (CMS).

**Ambulatory Care** - Outpatient health care provided to patients who do not need to occupy an inpatient, acute care hospital bed. The words ambulatory and outpatient are often used interchangeably.

**Ancillary Services** - Services other than accommodations that are medically necessary for the proper care and treatment of an illness or injury, such as labs and x-rays. Ancillary services do not include drugs.

**Anti-Fraud Unit** - The department established to monitor providers, suppliers, beneficiaries, and physicians in order to detect abusive or fraudulent activities.

**Attending Physician** - A physician designated by the client as the physician who is to have the most significant role in the determination and delivery of the individual’s medical care.
- B -

**Beneficiary** - The person entitled to receive Medicare benefits.

- C -

**Carrier** - A term used to describe the contractor administering the Medicare Part B program.

**Case-Mix Index** – A scale that measures the relative difference in resource intensity amount different groups in the clinical model.

**Centers for Medicare & Medicaid Services (CMS)** - Federal government agency responsible for administering the Medicare benefit.

**CMS - 1450** - The form used to bill the Medicare Part A program for facility services. Also known as the UB-92.

**CMS - 1500** - The form used to bill the Medicare Part B program for professional services.

**Certification** - A statement by the attending physician which certifies that the beneficiary required the skilled services provided.

**CFR** - Code of Federal Regulations (CFR) is a codification of the general and permanent regulations published in the *Federal Register* by the federal government.

**Claim** - A request to a carrier or intermediary by a provider acting on behalf of a beneficiary for payment of benefits under Medicare.

**Coinsurance** - An arrangement under which the patient shares a stated portion of the cost of care, e.g., 80/20, where the beneficiary pays 20 percent of the charges.

**Common Working File (CWF)** - The CWF is an “on line” Medicare benefit entitlement and utilization data base file.

**Common Working File (CWF) Host** - One of nine data-based locations that receives requests from intermediaries and carriers, known as satellite offices, regarding beneficiary eligibility and utilization of the Medicare benefit.

**Community Mental Health Centers (CMHCs)** - A specially qualified outpatient facility which provides psychiatric / psychological services and partial hospitalization services.
Comprehensive Omnibus Budget Reconciliation Act (COBRA) - Legislation passed in 1986 that requires companies to offer continuing group insurance coverage to certain employees and dependents. This act also extended the working age limit set under TEFRA beyond age 69 and established third party payment for VA Hospitals.

Consultant Services - When an employee of a home health agency meets with a physician to discuss the updating of the home health plan of treatment, the services are “consultant services”.

Coordination of Benefits (COB) - A method of limiting health insurance benefits to no more than 100 percent of the actual charge by coordinating payment amounts for all insurers involved. (See Secondary Payer.)

Co-payment - This amount, sometimes referred to as “coinsurance”, indicates the percentage of liability Medicare requires of the beneficiary, for example, 80/20, where the beneficiary pays 20 percent of the charges.

Coverage - The benefits available to a beneficiary.

Covered Services - Those services which are allowed by Medicare, as regulated by the Centers for Medicare & Medicaid Services.

Custodial Care - Treatment of services, regardless of who recommends them or where they are provided, that could be given safely and reasonably by a person not medically skilled, and are designed mainly to help the patient with activities of daily living. Examples include help with walking, bathing, dressing, and using the toilet.

Customary - The amount a physician or supplier most frequently charges for each service and supply furnished.

Deductible - The initial amount payable by the subscriber or beneficiary for medical/hospital services.

Diagnosis - A statement of the patient’s condition. The primary diagnosis is the main reason for treatment or hospitalization.

Discipline - One of the six home health disciplines covered under the Medicare home health benefit (skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech-language pathology services, and medical social services).
Document Control Number (DCN) - A term used to refer to the number assigned to a claim when received for processing. This number is required to retrieve a microfilm copy of a claim.

Durable Medical Equipment (DME) - Items are considered durable medical equipment if they meet the following criteria: (1) they must be durable enough to withstand repeated use, (2) they must be primarily and customarily manufactured to service a medical purpose, and (3) they must not be useful in the absence of illness or injury. Examples include wheelchairs, walkers and crutches. The BBRA 99 removed DME from HH PPS consolidated billing-suppliers may bill DMERCs directly.

- E -

Electronic Media Claims (EMC) - Any system which utilizes non-paper methods of filing claims, usually by telephone, service bureau or tape-to-tape methods.

Eligibility Date - The date on which, upon application, a beneficiary could receive Medicare benefits. Eligibility may occur before the date of entitlement.

End-Stage Renal Disease (ESRD) - Advanced kidney disease involving dialysis treatment and/or kidney transplant.

Entitlement Date - The effective date of Medicare coverage.

Episode – A 60-day unite of payment for HH PPS.

Extended Care Facility / Skilled Nursing Facility (ECF/SNF) - An institution which is Medicare approved or is accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) as an extended care facility.

- F -

Final Claim (FC) – The claim billed after the RAP. All services provided during the 60-day episode are included on this claim, and the second portion of the reimbursement is generated after the claim is adjudicated.

Fiscal Year (FY) - A facility’s accounting period of twelve months.
HCPCS Code - CMS Common Procedure Coding System - A system of letter and number codes assigned to procedures, medications, supplies and equipment used for pricing and billing. A list of HCPCS is accessible on the CMS web site (www.CMS.gov/stat/pufiles.htm).

Health and Human Services (HHS) - The department under which the Medicare program is administered.

Health Insurance Claim Number (HICN) - A number issued to Medicare beneficiaries to identify entitlement to Medicare benefits. It is usually a Social Security number followed by an alphabetic suffix. The number must appear on all claims filed for Medicare beneficiaries.

Health Insurance Prospective Payment System Code (HIPPS) – Procedural coding used in FL 44 of UB-92 in association with certain CMS prospective payment systems (Skilled Nursing Facility, Home Health). HIPPS will be assigned to HHRGs for HH PPS.

Health Maintenance Organization (HMO) - A prepaid health care plan with a defined membership providing comprehensive health services. HMOs stress preventative health care, patient education and normally experience lower inpatient utilization than tradition insurance plans.

Home Care - Health care services performed or supplied in the recipient’s home.

Home Health Advance Beneficiary Notice (HHABN) – The HHABN is a notice that is provided to home health beneficiaries in advance of furnishing what HHAs believe to be non covered care by Medicare or of reducing or termination ongoing care.

Home Health Agency (HHA) - An approved organization which provides patients with skilled nursing and / or therapeutic care in their homes.

Hospice - A public or private organization that provides care to terminally ill clients and their families.

Hospital Insurance - The part of Medicare that helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care, and hospice care.

Inpatient - Person confined to a facility as a bed patient.
Intermediary - The organization handling claims from hospitals, skilled nursing facilities, home health agencies, hospices, and outpatient rehabilitation providers under federal or state health coverage program. The term describes the role of Palmetto GBA as the agency administering Medicare A.

Intermediate Care Facility (ICF) - An institution providing a level of care less than that afforded in an ECF/SNF but above the level of care available in a home setting.

International Classification of Diseases - Ninth Edition - Clinical Modification (ICD-9-CM) - A diagnosis and procedure coding system used primarily to classify data for the purposes of record keeping and analysis.

- L -

Length of Stay - The number of days services were provided in a benefit period.

Line Item – Service or item-specific detail of claim. Contains repeated entries of FLs 42-49 of UB-92.

Low Utilization Payment Adjustment (LUPA) – An episode of four or less visits paid by national standardized per visit rates instead of HHRGs.

- M -

Market Basket Index – An index that reflects changes over time in the prices of an appropriate mix of goods and services included in home health services.

Medicaid (Title XIX) - A state/federal program designed to provide hospital and medical benefits to indigent persons of all ages. It is also referred to as Title XIX Medical Assistance.

Medical Insurance - The part of Medicare that helps pay for medically necessary doctors’ services, outpatient hospital services, and a number of other medical services and supplies not covered by the hospital insurance part of Medicare, as well as some home health services.

Medical Necessity - Services required and medically appropriate for the treatment of an illness or injury. Such services must be consistent with recognized standards of health care and should not involve excessive costs in comparison with alternative services which would be effective for the treatment of the patient.

Medicare - Public Law 89-97, which provides hospitals and physician benefits for eligible persons (age 65 or older, permanently disabled after 24 consecutive months of disability, or those with chronic renal disease who require hemodialysis or kidney transplant after three-month waiting
period). Medicare Part A provides hospital benefits; Medicare Part B provides benefits for professional services.

**Medicare Disability** - Benefits paid to persons totally and permanently disabled.

**Medicare Secondary Payer (MSP)** - Situations in which federal law requires that Medicare pay benefits after another payer has adjudicated claims. Medicare is a secondary payer when the beneficiary is covered by certain types of employer group insurance, Workers’ Compensation, VA, Black Lung, no-fault, liability, or other federal health coverage.

**Medicare Summary Notice (MSN)** - A notice sent to the beneficiary explaining services which have been billed to Medicare by a health care provider. The MSN replaces the notice of utilization (NOU), the benefit denial letter (BDL), and the explanation of Medicare benefits (EOMB).

**Medigap** - A health insurance policy designed to supplement Medicare.

- **N** -

**National Standard Per Visit Rates** – National rates for each of the six home health disciplines based on historical claims data. Used in payment of LUPAs and calculation of outliers.

- **O** -

**Omnibus Budget Reconciliation Act (OBRA)** - Sets of federal laws enacted in 1990 and 1993 to reconcile several budget deficits. OBRA laws have also changed MSP requirements.

**Outlier** – Additions to a full episode payment in cases where costs of services delivered are estimated exceed a fixed loss threshold. HH PPS outliers are computed as part of Medicare claims payment by Pricer software.

**Outpatient** - A patient receiving medical care, but not occupying an acute care bed, or receiving room and board and general nursing care. This includes services offered in a physician’s office, the outpatient facility of a hospital or ambulatory centers.

- **P** -

**Paperless Claims System** - See Electronic Media Claims.
Partial Episode Payment (PEP) – A reduced episode payment that may be made based on the number of service days in an episode (always less than 60-days, employed in cases of beneficiary-elected transfers or agency discharges with readmission during the 60-day benefit).

Participating Physician or Supplier - A physician or supplier who has contracted with Medicare to accept Medicare’s allowed amount as payment in full for covered services. Payment is made directly to the participating physician or supplier.

Payment Floor - The number of days before clean claims can be released for payment. Effective January 1, 1993, CMS implemented a payment floor differential for paper claims versus electronic claims. See additional information in the Claims Processing Section.

Peer Review - A mechanism whereby services and charges made by professional persons are subject to review by their peers.

Physical Medicine Services - Physical therapy, occupational therapy, or other physical restorative and maintenance services that are provided in the specialty of physical medicine.

Physical Therapist (PT) - A trained, licensed person engaged in the treatment of disability, injury, and disease by external physical means, such as massage, exercise, heat and light.

Plan of Care (POC) - Medicare home health service for the homebound beneficiaries must be delivered under a plan of care established by a physician.

Prepayment Health Care Plans - Healthcare providers such as Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPS). Medicare pays these plans on a monthly basis for each Medicare beneficiary. Medicare beneficiaries get all Medicare-covered hospital and medical insurance benefits through the plan.

Pricer – Software modules in Medicare claims processing systems, specific to certain benefits, used in pricing claims, most often under prospective payment systems.

Primary Payer - The insurance carrier charged with the first responsibility for payment of the beneficiary’s claim.

Principal Diagnosis - The main reason that a patient was admitted to home care for services.

Prospective Payment System (PPS) – Medicare payment for medical care based on predetermined payment rates or periods, linked to the anticipated intensity of services delivered and/or the beneficiary’s condition.

Provider Number - An assigned number that identifies the provider of services. It may also be referred to as a Medicare number.
- R -

**Recertification** - The attending physician certifies that the beneficiary requires continued skilled services after the expiration of the initial certification and then periodically thereafter.

**Reconsideration** - A new independent, thorough evaluation of evidence pertaining to services previously determined to be non-covered. It is initiated upon a formal request for appeal by the beneficiary or the provider.

**Regional Home Health Intermediary (RHHI)** - An organization handling claims from hospices or home health agencies for Medicare. Palmetto GBA is one of four fiscal intermediaries nationally designated to process Medicare home health and hospice claims in the United States.

**Remittance Advice (RA)** - A computer printout used to explain Medicare’s reimbursement of charges submitted.

**Request for Anticipated Payment (RAP)** – An initial request for payment submitted at the beginning of each 60-day episode. Payment is not subject to the payment floor.

**Revenue Code** – Payment codes for services or items placed in FL 42 of UB-92 found in Medicare and/or NUBC (National Uniform Billing Committee) manuals (42X, 43X, etc.). Note: a new revenue code 0023 will be used on a distinct line item when billing episode payments (HIPPS in HCPCS field, separate line items for visits and supplies follow on FC). An “X” in the last digit of numeric three digit revenue codes means that value can vary from 0-9. CMS manuals can be found on the CMS web site (www.CMS.gov/pubforms/p2192toc.htm).

**Rural Health Clinic** - A specially qualified outpatient facility located in an area designated as rural, where there is a shortage of health care services or medical professionals.

- S -

**Secondary Payer** – The insurer or payer whose benefits are paid after another insurer or payer has processed a claim. Under certain circumstances, Medicare is secondary payer (see Medicare as Secondary Payer.)

**Significant Change in Condition (SCIC)** – When changes in patient condition dictate, a single episode may be paid under multiple HHRGs, the amount for each HHRG pro-rated to the number of service days delivered under that HHRG, and all the pro-rated amounts added for the final episode payment.
Skilled Nursing Facility (SNF) - An institution approved by Medicare and Medicaid or accredited by the Joint Commission on Accreditation of Healthcare Organizations that is primarily engaged in provider inpatient skilled nursing care or rehabilitation services for injured, disabled or sick persons. Also called an Extended Care Facility.

Supplemental Health Insurance - Also called “Medigap” insurance; provider health insurance designed to fill some of the gaps in Medicare.

Supplemental Security Income (SSI) Program - A federally administered program for people of any age who qualify for an additional Social Security, Railroad Retirement or disability allowance because of low or limited income. Persons qualifying for SSI are eligible to receive Title XIX (Medicaid) Medical Assistance.

Swingbed Program - The use of unoccupied acute care hospital beds as skilled care beds to serve patients when other skilled care beds are not available.

Timely Filing - The final date on which claims must be received to be considered for payment by Medicare.

Type of Bill (TOB) – Coding representing the nature of each UB-92 claim (i.e., type of benefit, such as homebound home health, payment source, such as specific Medicare trust fund; and frequency of bill, such as initial or cancellation). These codes are found in Medicare and/or NUBC (National Uniform Billing Committee) manuals. CMS manuals can be found on the CMS web site (www.CMS.gov/pubforms/p2192toc.htm).

UB-92 - A universal billing form developed by the American Hospital Association and representatives of the insurance industry to simplify and standardize billing and collection of health care data. Also known as the CMS-1450. The claim or bill form, in either paper or electronic version, used by most institutional health care providers to bill Medicare.

Working Aged - Type of MSP under which Medicare is the secondary payer for beneficiaries 65 or over who are covered under an employer group health plan (EGHP) as the result of the active employment of the beneficiary or spouse.
10/1/00 – The Congressionally legislated effective date for HH PPS.

1500 – The claim form, in either paper or electronic version, used by most non-institutional health care providers and suppliers to bill Medicare Part B. Published by CMS as the Form 1500.

485 – CMS form number for the HH plan of care.
11.2. Acronyms

The following is a list of commonly used acronyms:

ADL Activities of Daily Living  
ADR Additional Development Request  
ASC Ambulatory Surgical Center  
BBA Balanced Budget Act of 1997  
BBRA Balanced Budget Refinement Act of 1999  
BCBSA Blue Cross and Blue Shield Association  
BENE Beneficiary  
CFO Chief Financial Officer (financial reports)  
CHAMPS Civilian Health & Medical Program of the Uniformed Services  
CHOW Change of Ownership  
CMI Case Mix Index  
CMS Centers for Medicare & Medicaid Services  
CMS -RO Centers for Medicare & Medicaid Services - Regional Office  
CMS - CO Centers for Medicare & Medicaid Services - Central Office  
CMS-PUB CMS Publication  
CMS PUB 7 State Agency Manual  
CMS PUB 9 Outpatient Physical Therapy Manual  
CMS PUB 10 Hospital Manual  
CMS PUB 11 HHA Manual  
CMS PUB 12 SNF Manual  
CMS PUB 13 Intermediary Manual  
CMS PUB 14 Carrier Manual  
CMS PUB 15 Provider Reimbursement Manual  
CMS PUB 19 Peer Review Organization Manual  
CMS PUB 21 Hospice Manual  
CMS PUB 23 Regional Office Manual  
CMS PUB 27 Rural Health Clinic Manual  
CMS PUB 29 Renal Facility Manual  
CMS PUB 60 Intermediary Letters  
CO Central Office (CMS - Baltimore, MD)  
CON Certificate of Need  
COP Conditions of Participation  
CORF Comprehensive Outpatient Rehabilitation Facility  
CPT Current Procedural Terminology  
CR Cost Report  
CRNA Certified Registered Nurse Anesthetist  
DME Durable Medical Equipment  
DMERC Durable Medical Equipment Regional Carrier
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>EDP</td>
<td>Electronic Data Processing</td>
</tr>
<tr>
<td>EEG</td>
<td>Electroencephalography</td>
</tr>
<tr>
<td>EFT</td>
<td>Electronic Funds Transfer</td>
</tr>
<tr>
<td>EIN</td>
<td>Employer Identification Number</td>
</tr>
<tr>
<td>EKG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>EMC</td>
<td>Electronic Media Claim</td>
</tr>
<tr>
<td>ERA</td>
<td>Electronic Remittance Advice</td>
</tr>
<tr>
<td>ESRD</td>
<td>End Stage Renal Dialysis</td>
</tr>
<tr>
<td>FC</td>
<td>Final Claim</td>
</tr>
<tr>
<td>FFY</td>
<td>Federal Fiscal Year</td>
</tr>
<tr>
<td>FI</td>
<td>Fiscal Intermediary</td>
</tr>
<tr>
<td>FISS</td>
<td>Fiscal Intermediary Shared System</td>
</tr>
<tr>
<td>FL</td>
<td>Field Locator on the UB-92</td>
</tr>
<tr>
<td>FOIA</td>
<td>Freedom of Information Act</td>
</tr>
<tr>
<td>FMR</td>
<td>Focused Medical Review</td>
</tr>
<tr>
<td>FR</td>
<td>Federal Register</td>
</tr>
<tr>
<td>FS</td>
<td>Final Settlement</td>
</tr>
<tr>
<td>FSS</td>
<td>Florida Shared System</td>
</tr>
<tr>
<td>FYE</td>
<td>Fiscal Year End</td>
</tr>
<tr>
<td>GAAP</td>
<td>Generally Accepted Accounting Principles</td>
</tr>
<tr>
<td>GAGAS</td>
<td>Generally Accepted Governmental Auditing Standards</td>
</tr>
<tr>
<td>GAO</td>
<td>General Accounting Office</td>
</tr>
<tr>
<td>HCPCS</td>
<td>CMS’s Common Procedure Coding System</td>
</tr>
<tr>
<td>HH</td>
<td>Home Health</td>
</tr>
<tr>
<td>HHA</td>
<td>Home Health Agency</td>
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<tr>
<td>HH PPS</td>
<td>Home Health Prospective Payment System</td>
</tr>
<tr>
<td>HHRG</td>
<td>Home Health Resource Grouper Code</td>
</tr>
<tr>
<td>HHS</td>
<td>Health &amp; Human Services</td>
</tr>
<tr>
<td>HI</td>
<td>Hospital Insurance (Medicare Part A)</td>
</tr>
<tr>
<td>HIC</td>
<td>Health Insurance Card</td>
</tr>
<tr>
<td>HICN</td>
<td>Health Insurance Card Number</td>
</tr>
<tr>
<td>HIM</td>
<td>Health Insurance Manual</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<tr>
<td>HIPPS</td>
<td>Health Insurance Prospective Payment System Code</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
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<tr>
<td>ICF</td>
<td>Intermediate Care Facility</td>
</tr>
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<td>IADL</td>
<td>Instrumental Activities of Daily Living</td>
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<td>IPS</td>
<td>Interim Payment System</td>
</tr>
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<td>IP</td>
<td>Inpatient</td>
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<tr>
<td>IS</td>
<td>Initial Settlement</td>
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<tr>
<td>LCC</td>
<td>Lower of Cost or Charges</td>
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<td>LOS</td>
<td>Length of Stay</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>--------------</td>
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<tr>
<td>LS</td>
<td>Lump Sum</td>
</tr>
<tr>
<td>LUPA</td>
<td>Low Utilization Payment Adjustment</td>
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<tr>
<td>MCR</td>
<td>Medicare Cost Report</td>
</tr>
<tr>
<td>MICROMAX</td>
<td>Substitute Cost Report Forms</td>
</tr>
<tr>
<td>MR</td>
<td>Medical Review</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>MS</td>
<td>Medical Social Services</td>
</tr>
<tr>
<td>MSA</td>
<td>Metropolitan Statistical Areas</td>
</tr>
<tr>
<td>MSN</td>
<td>Medicare Summary Notice</td>
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<tr>
<td>MSP</td>
<td>Medicare Secondary Payer</td>
</tr>
<tr>
<td>NCSB</td>
<td>Neurological, Cognitive, Sensory, and Behavioral Variables</td>
</tr>
<tr>
<td>NOU</td>
<td>Notice of Utilization</td>
</tr>
<tr>
<td>NUBC</td>
<td>National Uniform Billing Committee</td>
</tr>
<tr>
<td>OASIS</td>
<td>Outcome and Assessment Information Set</td>
</tr>
<tr>
<td>OBRA</td>
<td>Omnibus Budget Reconciliation Act</td>
</tr>
<tr>
<td>OBQI</td>
<td>Outcome Based Quality Improvement</td>
</tr>
<tr>
<td>OCESAA</td>
<td>Omnibus Consolidated and Emergency Supplement Appropriations Act for Fiscal Year 1999</td>
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<tr>
<td>OES</td>
<td>Occupational Employment Survey</td>
</tr>
<tr>
<td>OP</td>
<td>Outpatient</td>
</tr>
<tr>
<td>OP(P)T</td>
<td>Outpatient Physical Therapy</td>
</tr>
<tr>
<td>OSC</td>
<td>Office of Standards &amp; Certification (CMS)</td>
</tr>
<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
</tr>
<tr>
<td>OSP</td>
<td>Office of Special Programs (CMS)</td>
</tr>
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<td>OT</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>PARD</td>
<td>Provider Audit &amp; Reimbursement Department</td>
</tr>
<tr>
<td>PIE</td>
<td>Partners in Excellence</td>
</tr>
<tr>
<td>PIP</td>
<td>Periodic Interim Payment</td>
</tr>
<tr>
<td>POR</td>
<td>Provider Overpayment Report</td>
</tr>
<tr>
<td>POT</td>
<td>Plan of Treatment</td>
</tr>
<tr>
<td>PPS</td>
<td>Prospective Payment System</td>
</tr>
<tr>
<td>PRO</td>
<td>Professional Review Organization/Peer Review Organization</td>
</tr>
<tr>
<td>PS&amp;R</td>
<td>Provider Statistical &amp; Reimbursement Report</td>
</tr>
<tr>
<td>PT</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>QC</td>
<td>Quality Control</td>
</tr>
<tr>
<td>RAP</td>
<td>Request for Anticipated Payment</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>RHCCI</td>
<td>Regional Home Health Intermediary</td>
</tr>
<tr>
<td>RO</td>
<td>Regional Office (CMS)</td>
</tr>
<tr>
<td>RRC</td>
<td>Rural Referral Center</td>
</tr>
<tr>
<td>RT</td>
<td>Respiratory Therapy</td>
</tr>
<tr>
<td>SADMERC</td>
<td>Statistical Analysis Durable Medical Equipment Regional Carrier</td>
</tr>
<tr>
<td>SCIC</td>
<td>Significant Change in Condition</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>SMI</td>
<td>Supplemental Medical Insurance (Medicare Part B)</td>
</tr>
<tr>
<td>SN</td>
<td>Skilled Nursing Service</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>SP</td>
<td>Speech-Language Pathology</td>
</tr>
<tr>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>TEFRA</td>
<td>Tax Equity &amp; Fiscal Responsibility Act</td>
</tr>
<tr>
<td>TIN</td>
<td>Taxpayer Identification Number</td>
</tr>
<tr>
<td>TOB</td>
<td>Type of Bill</td>
</tr>
<tr>
<td>TS</td>
<td>Tentative Settlement</td>
</tr>
<tr>
<td>UB</td>
<td>Uniform Billing</td>
</tr>
<tr>
<td>UDR</td>
<td>Uniform Desk Review</td>
</tr>
<tr>
<td>UPIN</td>
<td>Unique Physician Identification Number</td>
</tr>
<tr>
<td>UR</td>
<td>Utilization Review</td>
</tr>
<tr>
<td>WTB</td>
<td>Working Trial Balance</td>
</tr>
</tbody>
</table>
11.3. PARD Exhibits

The following exhibits are discussed in the Provider Audit and Reimbursement section of this manual (Section 10).
EXHIBIT A  Extended Repayment Schedule

DOCUMENTATION SUPPORTING
A REQUEST FOR EXTENDED REPAYMENT

A written request must be submitted that refers to the specific overpayment for which an extended repayment is being requested. This request must detail the number of months requested, indicate the monthly payment amount, and include the first payment. If more than one overpayment exists, a separate request must be made for each overpayment; the intermediary may align the payment dates and include knowledge of both overpayments in its review of the provider’s request.

All of the below information must be submitted before the overpayment can be removed from withholding. If an incomplete request is submitted, the recoupment of the overpayment will continue until the request is completed or the overpayment is fully recouped.

The following documentation must be submitted for each request, regardless of the length of the request, to support the provider’s need for an extended repayment schedule. This listing can also be found in the Medicare Intermediary Manual, Part 2 (HCFA-Pub. 13-2, Section 2224.1) Please feel free to submit any other documentation that would demonstrate your ability to repay the debt in full.

1. Balance sheets – the most current balance sheet and the one for the last complete Medicare reporting period (preferably prepared by the provider’s accountant). If consolidated statements (including more than one entity) are submitted, separate statements showing the individual provider’s contribution to those statements must also be submitted.

   NOTE: If the time period between the two balance sheets is less than six months (or the provider cannot submit balance sheets prepared by its accountant), it must submit balance sheets for the last TWO complete Medicare reporting periods in addition to the most current balance sheet.

2. Income statements related to the balance sheets (preferably prepared by the provider’s accountant).

3. Cash Flow Statements for the periods covered by the balance sheets. If the date of the request for an extended repayment schedule is more than three (3) months after the date of the most recent balance sheet, a cash flow statement should be prepared for all months between that date and the date of the request.

   In addition, whether or not the date of the request is more than three (3) months after that of the most recent balance sheet, a projected cash flow statement should be included for the six (6) months following the date of the request.

4. Projected cash flow statement covering the remainder of the current fiscal year. If fewer than six (6) months remain, a projected cash flow statement for the following year should be included.

5. Amount of outstanding accelerated payments.
6. List of restricted cash funds by amounts as of the date of request and the purpose for which each fund is to be used.

7. List of investments by type (stock, bond, etc.), amount, and current market value as of the date of the report.

8. List of notes and mortgages payable by amounts as of the date of the report, and their due dates.

9. Schedule showing amounts due to and from related companies or individuals included in the balance sheets. The schedule should show the names of related organizations or persons and show where the amounts appear on the balance sheet such as Accounts Receivable, Notes Receivable, etc. (See Section 1000ff of the Provider Reimbursement Manual, Part I for definition of related organizations).

10. Schedule showing types and amounts of expenses (included in the income statements) paid to related organizations. The names of the related organizations should be shown.

11. The percentage of occupancy by type of patient (Medicare, Medicaid, private pay) covered by the income statements. For home health and outpatient type facilities, this percentage should be based on visits to total by type. For hospitals and other inpatient type facilities, this percentage should be based on bed days utilized to total available in addition to bed days for that type to total bed days for the period.

12. Requests for extended repayment of more than twelve (12) months must be accompanied by at least two letters from separate financial institutions denying the provider’s loan request for the amount of the overpayment.

13. First payment according to proposed repayment schedule.

14. Copy of the overpayment notification letter or a copy of the first page of the as-filed cost report indicating the amount of the overpayment.

If the provider is unable to furnish some of the documentation, it should fully explain why it is unable to.

Your first payment, referenced “ERS Request”, should be made payable to MEDICARE FEDERAL HIB and mailed directly to:

Supervisor, Medicare Finance (AG-361)
Palmetto GBA, LLC
2300 Springdale Drive, Bldg. One
Camden, SC  29020
Mail a copy of your check and above requested information to:

Palmetto GBA, LLC  
Finance and Accounting  
ERS Technician, Part A Overpayments  
2300 Springdale Drive, Bldg. One  
Camden, SC  29020

cc: Overpayment File  
ERS File
EXHIBIT B  EXTENDED REPAYMENT SCHEDULE

The following information is from the Medicare Intermediary Manual, Part 2, Chapter III-Payment to the Providers concerning Extended Repayments.

2224. REPAYMENT EXTENDED LONGER THAN 12 MONTHS.

If a provider demonstrates that repayment within a 12 month period would create extraordinary financial hardship, it may request a longer period of repayment. Where the provider requests a schedule which would run longer than 12 months from the date of the first demand letter, refer the request, with your recommendations, to the RO for disposition. The documentation listed in § 2224.1 is required (as it is for extended repayment periods of 12 months or less) for the RO to make its determination. The period for recoupment will not be extended unless the provider demonstrates (with supporting documentation) that repayment within a 12-month period would create extraordinary financial hardship.

The RO ordinarily will not establish a repayment schedule for more than 36 months from the date of the first demand letter. The repayment schedule may be effective with the date the repayment schedule is proposed (or submitted by the provider). The RO will approve only when it determines that such an action would benefit the program.

2224.1 Documentation Supporting a Request for Extended Repayment.--Request the provider to furnish, in addition to its proposed repayment schedule, the following:

- Balance sheets--the most current balance sheet and the one for the last complete Medicare reporting period (preferably prepared by the provider's accountant).

NOTE: If the time period between the two balance sheets is less than 6 months (or the provider cannot submit balance sheets prepared by its accountant), it must submit balance sheets for the last two complete Medicare reporting periods.

- Income statements--related to the balance sheets (preferably prepared by the provider's accountant).

It is suggested that both the balance sheets and income statements include the following statements:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS BALANCE SHEET OR INCOME STATEMENT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

CERTIFICATION BY OFFICER OF ADMINISTRATOR OF PROVIDER(S)
I HEREBY CERTIFY that I have examined the balance sheet and income statement prepared by and that to the best of my knowledge and belief, it is a true, correct, and complete statement from the books and records of the provider.

Signed
Officer or Administrator of
Provider(s)
Title
Date

o Statement of Sources and Application of Funds--for the periods covered by the income statements (see Exhibit 6 for recommended format).

o Cash flow statements--for the periods covered by the balance sheets (see Exhibit 7 for recommended format). If the date of the request for an extended repayment schedule is more than 3 months after the date of the most recent balance sheet, a cash flow statement should be provided for all months between that date and the date of the request.

In addition, whether or not the date of the request is more than 3 months after that of the most recent balance sheet, a projected cash flow statement should be included for the 6 months following the date of the request.

o Projected cash flow statement--covering the remainder of the current fiscal year. If fewer than 6 months remain, a projected cash flow statement for the following year should be included. (See Exhibit 7 for recommended format.)

o Amount of outstanding--accelerated payments.

o List of restricted cash funds--by amount as of the date of request and the purpose for which each fund is to be used.

o List of investments--by type (stock, bond, etc.), amount, and current market value as of the date of the report.

o List of notes and mortgages payable--by amounts as of the date of the report, and their due dates.

o Schedule showing amounts--due to and from related companies or individuals included in the balance sheets. The schedule should show the names of related organizations or persons and show where the amounts appear on the balance sheet--such as Accounts Receivable, Notes Receivable, etc. (See §§ l000ff. of the Provider Reimbursement Manual, Part I for definition of related organizations.)
This information may provide a lead to possible setoffs between underpayments and overpayments of related participating providers.

- Schedule showing types--and amounts of expenses (included in the income statements) paid to related organizations. The names of the related organizations should be shown.

- The percentage of occupancy--by type of patient (e.g., Medicare, Medicaid, private pay) and total available bed days for the periods covered by the income statements; and

- Requests for extended repayment--of 12 months or more must be accompanied by at least two letters from separate financial institutions denying the provider's loan request for the amount of the overpayment.

If a provider is unable to furnish some of the documentation, it should fully explain why it is unable to. Where the provider's explanation is reasonable and the documentation is otherwise acceptable, forward the request for extended repayment to the RO with your recommendation. Continue recoupment of the overpayments pending receipt of the documentation and a decision on the extended repayment request.

An extended repayment schedule protocol assists you in evaluating extended repayment requests. (See Exhibit 5-A) Complete the protocol for all extended repayment requests. Forward a completed copy to the RO on those requests that exceed 12 months.
Exhibit 5-A

PROVIDER MEDICARE OVERPAYMENTS

Protocol for Reviewing Extended Repayment Schedule (ERS)

<table>
<thead>
<tr>
<th>Provider</th>
<th>Provider Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Report FYE</td>
<td>Overpayment Amount $</td>
</tr>
<tr>
<td>Date of Demand Letter</td>
<td>No. of Months Requested for ERS</td>
</tr>
<tr>
<td>Date ERS Approved/Not Approved (12 mos. or less) No. of Mos. Approved</td>
<td></td>
</tr>
<tr>
<td>Date Referred to RO for Consideration</td>
<td></td>
</tr>
<tr>
<td>Name of Intermediary</td>
<td></td>
</tr>
<tr>
<td>Reviewed By</td>
<td>Date</td>
</tr>
<tr>
<td>Intermediary Analyst Date</td>
<td></td>
</tr>
<tr>
<td>Supervisor Review</td>
<td>Date</td>
</tr>
<tr>
<td>Intermediary Official</td>
<td></td>
</tr>
</tbody>
</table>

1. Summarize the major reasons why the overpayment occurred.

2. Review the documentation sent by the provider for completeness. (Refer to §2224.1 for recommended documentation.) Analyze the financial data submitted to determine the availability of cash, marketable securities, accounts receivable, restricted and unrestricted endowment funds, or special funds. Consider whether these funds could be used for partial or full payment of the overpayment. Also, requests for ERS of 12 months or more must be accompanied by at least two letters from separate financial institutions denying the provider's loan request for the amount of the overpayment.

3. Perform the following calculations by using the most current financial data submitted by the provider to determine if it qualifies for an ERS.

   a. Current Ratio

   The current ratio relates the dollar value of current assets to the dollar value of current liabilities in order to evaluate an organization's ability to pay its current debt. Derived as:

   \[
   \text{CURRENT ASSETS} = \frac{\text{CURRENT LIABILITIES}}{}
   \]

   This ratio defines the number of dollars held in current assets per dollar of current liabilities (e.g., it relates current assets to current liabilities). Multiple coverage of liabilities is desirable. Generally, high values for the current ratio imply a good ability to pay short-term obligations and thus a low probability of technical insolvency.
Normally, consider a current ratio of 2 to 1 adequate to meet current liabilities. However, a provider with a current ratio (2 to 1 or greater) may have short-term payment problems if its current assets are not expected to be in liquid form (cash or short-term investments) in time to meet the expected payment dates of the current liabilities.

b. Quick Ratio

A liquidity ratio which measures the number of dollars of liquid assets (cash plus marketable securities plus accounts receivable) that are available per dollar of current liabilities. Derived as:

\[
\text{CASH + MARKETABLE SECURITIES + ACCOUNTS RECEIVABLE} = \text{CURRENT LIABILITIES}
\]

This is a more stringent measure of liquidity than the current ratio. Use it to determine the adequacy of cash, accounts receivable, and marketable securities to pay current liabilities.

Normally, consider a quick ratio of 1.5 to 1 adequate to meet current liabilities. However, a provider with a high quick ratio may have short-term payment problems if there are excessive amounts of slow-paying or doubtful accounts receivable which may not be turned into cash soon enough to meet maturing current liabilities. Conversely, a low quick ratio may not imply a future liquidity crisis if current liabilities include terms that will not require payment from existing current assets.

4. Determine if there are any settlements (interim rate adjustments or cost report) in process which could be used to offset the outstanding overpayment.

5. Based upon the previous steps, summarize whether or not a repayment schedule should be approved or denied. If approval is recommended, indicate the number of months, how you calculated the monthly payment and the reason(s) for the approval. If denial is recommended, indicate the reason(s).


Exhibit 6

STATEMENT OF SOURCE AND APPLICATION OF FUNDS

FOR THE PERIOD ________________

Funds Provided by:

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operations - Net income for the period</td>
<td>$XXXXX</td>
</tr>
<tr>
<td>Add: Charges not affecting working capital (depreciation, amortization, etc.)</td>
<td>XXXX</td>
</tr>
<tr>
<td></td>
<td>$XXXXX</td>
</tr>
<tr>
<td>Less: Operating revenues not affecting working capital</td>
<td>XXXX</td>
</tr>
<tr>
<td>Total fund provided by Operation</td>
<td>$XXXXX</td>
</tr>
<tr>
<td>Long term loans</td>
<td>XXXX</td>
</tr>
<tr>
<td>Unrestricted cash donations</td>
<td>XXXX</td>
</tr>
<tr>
<td>Other (identify)</td>
<td>XXXX</td>
</tr>
<tr>
<td>Total Funds Provided</td>
<td>$XXXXX</td>
</tr>
</tbody>
</table>

Funds Applied to:

<table>
<thead>
<tr>
<th>Use</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement of long-term obligations (mortgages, notes, bonds, etc.)</td>
<td>$XXXXX</td>
</tr>
<tr>
<td>Purchase of equipment</td>
<td>XXXX</td>
</tr>
<tr>
<td>Purchase of land</td>
<td>XXXX</td>
</tr>
<tr>
<td>Dividends to stockholders</td>
<td>XXXX</td>
</tr>
<tr>
<td>Other (identify)</td>
<td>XXXX</td>
</tr>
<tr>
<td>Total Funds Applied</td>
<td>-XXXXX</td>
</tr>
<tr>
<td>Net Increase (Decrease) in Working Capital*</td>
<td>$XXXXX</td>
</tr>
</tbody>
</table>
Exhibit 6(Cont.)

Working Capital* (end of period) (date) $XXXX

Less: Working Capital* (beginning of period) (date) XXXX

Net Increase (Decrease) in Working Capital $XXXX

*Current Assets less Current Liabilities
Exhibit 7

CASH FLOW STATEMENT
FOR THE PERIOD

Cash provided by:

- Operations (Schedule A) (See Exhibit 8) $XXXX
- Cash donations (unrestricted) XXXX
- Long term borrowing XXXX
- Investment earnings (cash dividends, interest) XXXX
- Sale of long term investments XXXX
- Sale of equipment XXXX
- Issuance of bonds XXXX
- Decrease in current assets - other than Accounts Receivable, Prepaid Expense, and Inventory XXXX
- Increase in current liabilities - other than Accounts Payable and Prepaid Income XXXX
- Others XXXX

Total cash provided $XXXX
Cash applied to:

- Purchase of equipment $XXXX
- Payment of long term debt XXXX
- Payment of bond redemption fund XXXX
- Purchase of long term investments XXXX
- Payment of dividends XXXX

Purchase of land and/or building (purchase price less mortgage, capital stock and non cash assets given toward purchase) XXXX

Increases in current assets - other than Accounts Receivable, Prepaid Expenses, and Inventory XXXX

Decreases in current liabilities - other than Accounts Payable and Prepaid Income XXXX

Others XXXX

Total Cash Applied XXXX

Increase (Decrease) in Cash $XXXX

Cash at end of period (date) $XXXX

Less: Cash at beginning of period (date) XXXX

Increase (Decrease) in Cash XXXX
Exhibit 8

PROJECTED CASH FLOW

CASH FROM OPERATIONS (SCHEDULE A)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Net Income (or Net Loss)</td>
<td>$XXXX</td>
</tr>
<tr>
<td>Increases:</td>
<td></td>
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<tr>
<td>Depreciation expense</td>
<td>$XXXX</td>
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<tr>
<td>Loss from sale of equipment</td>
<td>XXXX</td>
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<tr>
<td>Decrease in net Accounts Receivable</td>
<td>XXXX</td>
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<tr>
<td>Decrease in Prepaid Expense</td>
<td>XXXX</td>
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<tr>
<td>Decrease in Inventory</td>
<td>XXXX</td>
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<tr>
<td>Increase in Accounts Payable</td>
<td>XXXX</td>
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<tr>
<td>Increase in Prepaid Income</td>
<td>XXXX</td>
</tr>
<tr>
<td>Others</td>
<td>XXXX XXXX</td>
</tr>
<tr>
<td>Gross Cash from Operations</td>
<td>$XXXX</td>
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<tr>
<td>Decreases:</td>
<td></td>
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<tr>
<td>Gain from sale of equipment</td>
<td>$XXXX</td>
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<tr>
<td>Increase in net Accounts Receivable</td>
<td>XXXX</td>
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<tr>
<td>Increase in Prepaid Expense</td>
<td>XXXX</td>
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<tr>
<td>Increase in Inventory</td>
<td>XXXX</td>
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<tr>
<td>Decrease in Accounts Payable</td>
<td>XXXX</td>
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<tr>
<td>Decrease in Prepaid Income</td>
<td>XXXX</td>
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<tr>
<td>Others</td>
<td>XXXX</td>
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<td>----------------------</td>
<td>------</td>
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<tr>
<td>Net Cash from Operations</td>
<td></td>
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</tbody>
</table>
2224.2 Documentation for an Extended Repayment Schedule.--After you have reviewed the documentation submitted in support of the extended repayment schedule request, send your recommendation to the RO for approval. Submit the following:

- All information submitted by the provider. (See § 2224.1);
- The date of the initial contact between you and the provider concerning the overpayment;
- Copies of all correspondence (including demand letters) about the overpayment and the request for the extended repayment schedule;
- The amount of the overpayment; cost report year in which it occurred; dates and amounts of any repayments; dates and amounts of payments (interim or retroactive) held in account.
- The cost reports in which the overpayments appeared or were found. Furnish any information you have on the financial status of related organizations, as determined through audits and other sources such as mercantile reports;
- The provider's proposed repayment schedule and rationale;
- Your recommendation and supporting rationale including a completed extended repayment schedule protocol (see Exhibit 5-A); and
- Your opinion, based on experience, as to the reliability of the financial data.

2224.3 Monitoring An Approved Extended Repayment Schedule.--After an extended repayment schedule has been approved, continue to monitor the case to ascertain whether recoupment is being effectuated as contemplated. If it becomes apparent that the repayment schedule will not result in a liquidation of the indebtedness within the time period contemplated, take further action, preferably the renegotiation of the amount of installment payments so that the overpayment will be recouped within the time period originally agreed upon. Report to the RO any significant changes in the provider's financial condition or any indication that it misstated or failed to disclose pertinent facts which may raise a question of the provider's ability to refund the overpayment. Notify the RO immediately by telephone and send a detailed written statement of the problem.
EXHIBIT C Credit Balance Report

MEDICARE CREDIT BALANCE REPORT CERTIFICATION

The Medicare Credit Balance Report is required under the authority of Section 1815(a), 1833(e), 1886(a) (1) (c), and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT, OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by

Provider Name and Number

for the calendar quarter ended and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable federal laws, regulations, and instructions.

Check One: ( ) No Credit Balances to report this quarter

( ) The Credit Balance report is attached

(Signed) ______________________________
Officer or Administrator

Title ______________________________

Date ______________________________
# EXHIBIT D Credit Balance Report

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<tbody>
<tr>
<td>Beneficiary Name</td>
<td>HIC #</td>
<td>ICN No.</td>
<td>Type</td>
<td>Admission Date (MM/DD/YY)</td>
<td>Discharge Date (MM/DD/YY)</td>
<td>Paid</td>
<td>Date (MM/DD/YY)</td>
<td>Cost Report</td>
<td>Amount of Credit</td>
<td>Amount</td>
<td>Method of Medicare</td>
<td>Amount</td>
<td>Reason for Credit</td>
<td>Outstanding</td>
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</tbody>
</table>

Form Approved
OBB no. 0938-0600 (6/96)
EXHIBIT E  Hospice Payment Calculation

Medicare Program—Update to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer for FY 2003

The Centers for Medicare & Medicaid Services (CMS) has published Program Memorandum A-02-059, Change Request (CR) 2248, dated July 10, 2002 which discusses updates to the hospice payment rates, hospice cap, hospice wage index and the hospice pricer for Fiscal Year 2003.

GENERAL INFORMATION

Hospice Payment Rates

The law governing the payment for hospice care requires annual updates to the hospice payment rates. Section 1814(i)(1)(C)(ii) of the Social Security Act (the Act) stipulates that the payments for hospice care for fiscal years after 2002 will increase by the market basket percentage increase for the fiscal year. Therefore, the FY2003 payment rates will be the FY2002 payment rates, (minus the 0.75 percent increase mandated by §131(a)(b) of the Balanced Budget Refinement Act of 1999 (BBRA), increased by 4.2 percentage points, which is the total market basket percentage increase for FY 2003. This payment methodology has been codified in regulations found at 42 CFR §418.306(a)(b).

Hospice Cap Amount

The Hospice Cap is updated annually in accordance with §1814(i)(2)(B) of the Act and provides an increase (or decrease) in the hospice cap amount. Specifically, the cap amount is increased or decreased, for accounting years after 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the Consumer Price Index for all Urban Consumers.

Hospice Wage Index

The Hospice Wage Index is used to adjust payment rates to reflect local differences in wages according to the revised wage index. The Hospice Wage Index is updated annually in accordance with recommendations made by a negotiated rulemaking advisory committee and published in the Federal Register on August 8, 1997. Section 42 CFR 418.306(c) requires that the updated hospice wage index be published annually as a Notice in the Federal Register.

Hospice Pricer

The annual hospice payment updates will be implemented through the Hospice Pricer software found in the intermediary standard systems. The new Pricer module will not contain any new
calculation logic, but will simply apply the existing calculations to the updated payment rates shown in II.A. below. An updated Metropolitan Statistical Area (MSA) table will be installed in the module, to reflect the 2003 hospice wage index. The input and output records of the Pricer module will not be changed. No billing changes are required of hospices to receive the updated rates.

UPDATES AND IMPLEMENTATION INFORMATION

FY 2003 Hospice Payment Rates

The FY2003 hospice payment rates are effective for care and services furnished on or after October 1, 2002, through September 30, 2003.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
<th>Wage Component Subject to Index</th>
<th>Non-Weighted Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$114.20</td>
<td>$78.47</td>
<td>$35.73</td>
</tr>
<tr>
<td>652</td>
<td>Continuous Home Care</td>
<td>$666.52</td>
<td>$457.97</td>
<td>$208.55</td>
</tr>
<tr>
<td></td>
<td>Full rate = 24 hours of care/$27.77 hourly rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$118.13</td>
<td>$63.94</td>
<td>$54.19</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$508.01</td>
<td>$325.18</td>
<td>$182.83</td>
</tr>
</tbody>
</table>

Hospice Cap

The latest hospice cap amount for the cap year ending October 31, 2002, is $17,390.89.

Hospice Wage Index

The Hospice Wage Index Notice will be effective on October 1, 2002, and published in the Federal Register before that date. The revised wage index and payment rates will be incorporated in the hospice Pricer and forwarded to the intermediaries following publication of the notice.
Intermediary Instructions

Regional Home Health Intermediaries (RHHIs) should encourage hospice providers to split claims if they span the effective date. RHHIs must alert hospices that the RHHI will use FY 2002 rates if the hospice chooses not to split the claim and that the RHHI will perform no subsequent adjustments to these claims.

RHHIs and the audit intermediaries of hospital-based hospice agencies must educate hospice providers about these updates prior to October 1, 2002. The new rates and the wage indices (obtained from the Federal Register via the Government Printing Office Website at www.access.gpo.gov) must be published via the intermediary’s website. RHHIs must also send the above information to all hospice professional groups and software support organizations in its files.
DATE

EXHIBIT A

Administrator
Provider
Address

SUBJECT: MEDICARE BENEFICIARIES ELECTING HOSPICE CARE FOR
Provider Name
PROVIDER NUMBER: Prov#

Dear Administrator:

The Centers for Medicare & Medicaid Services (CMS) requires intermediaries to annually review Medicare payments made to hospice providers. The purpose of this review is to ensure total hospice payments do not exceed the aggregate cap amount determined by CMS. The aggregate cap amount is computed by multiplying the number of hospice beneficiaries by the cap amount effective for the twelve months, which ended October 31, xxxx. The cap amount for this period is $xx,xxx. In order to perform our review, we must obtain from your hospice the number of beneficiaries who elected hospice care during the period September 28,xxxx to September 27,xxxx. As is noted in the Hospice Provider Manual, HCFA-Pub. 21, Section 407:

The Hospice will be responsible for reporting the number of Medicare beneficiaries electing hospice care during the period to the intermediary. This must be done within 30 days after the end of the cap period.

Please find enclosed a form, which can be used to submit the required information. Please return the completed form to our office by DATE. We will notify you of the effect, if any, of the cap on total reimbursement, as well as that of the inpatient day limitation.

If you have any questions, please call me at extension xxxx.

Sincerely,

Medicare Audit and Reimbursement

Enclosures
EXHIBIT B

Hospice Name: ____________________________
Hospice Number: __________________________

REPORT OF BENEFICIARIES ELECTING HOSPICE CARE

PERIOD OF ELECTION: September 28, xxxx through September 27, xxxx

I. BENEFICIARIES INCLUDED:

Those beneficiaries who initially elected hospice coverage during the “period of election.” For purposes of this determination, a beneficiary can only be included in the calculation of the hospice cap one time, the year in which the initial election is made. This is without regard to how many years a patient may receive hospice care.

Number of beneficiaries electing benefits from this hospice only: _____

II. BENEFICIARIES ELECTING BENEFITS FROM TWO OR MORE HOSPICES:

For beneficiaries receiving services from two or more hospices, a proportional allocation of the cap amount will be necessary. Please complete the attached questionnaire for beneficiaries believed to have elected hospice care from other hospices. Do not include these beneficiaries in the count in “I” above. We will coordinate this allocation with the other hospices and intermediaries, if needed.
EXHIBIT B

Hospice Name: ____________________________

Hospice Number: __________________________

TRANSFERRING HOSPICE BENEFICIARY QUESTIONNAIRE

<table>
<thead>
<tr>
<th>The Patient’s Name</th>
<th>Was Provided In This Hospice</th>
<th>Name, Address and/or Phone #</th>
<th>Provided In Other Hospice</th>
</tr>
</thead>
<tbody>
<tr>
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EXHIBIT G  Hospice Cap Calculation

Insert Excel Spreadsheet
HOSPICE CAP CALCULATION - EXHIBIT G

PROVIDER NAME: Any Hospice
PROVIDER NUMBER: xx-xxxx
CAP YEAR: 11/1/00 - 10/31/01

REVIEW OF MEDICARE INPATIENT DAYS

1. TOTAL HOSPICE CARE DAYS PER THE PS&R 6030
2. * 20% x 20%
3. ALLOWABLE MEDICARE INPATIENT DAYS 1206
4. ACTUAL INPATIENT DAYS PER THE PS&R 30

**DAYS IN EXCESS OF THE ALLOWABLE DAYS 0

** If the total number of inpatient days exceeded the allowable number of days the limitation for your agency is determined as follows:

A. MEDICARE REIMBURSEMENT FOR INPATIENT SERVICES $0.00
   X THE PERCENTAGE OF MAX ALLOWABLE DAYS 0.00% $0.00
   (line 3/line 4)
   B. DAYS IN EXCESS OF ALLOWABLE DAYS 0
   MULTIPLIED BY THE ROUTINE HOME CARE RATE $0.00 $0.00
   C. SUM OF A AND B $0.00

MEDICARE REIMBURSEMENT FOR INPATIENT CARE PER PS&R $0.00

TOTAL AMOUNT DUE THE INTERMEDIARY $0.00

CAP ON OVERALL MEDICARE REIMBURSEMENT

1. MEDICARE BENEFICIARIES ELECTING HOSPICE CARE 50
2. STATUTORY CAP AMOUNT FOR THE CAP YEAR ENDED $16,650.85
3. ALLOWABLE MEDICARE PAYMENTS $832,542.50
4. ACTUAL PAYMENTS PER THE PS&R $500,000.00
5. PAYMENTS IN EXCESS OF THE CAP AMOUNT $0.00
EXHIBIT H  Cost Report Due Date Schedule

Program Memorandum
Intermediaries

Transmittal A-01-149

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 27, 2001

CHANGE REQUEST 2012

SUBJECT: Amended Production Dates for the Provider Statistical and Reimbursement (PS&R) Report and Extension of Due Date For Filing Provider Cost Reports

The purpose of this Program Memorandum (PM) is to replace Transmittal A-01-117, which advised all fiscal intermediaries (FIs) and providers of the release timelines for the PS&R report program, and the due dates for provider cost reports.

PS&R Program

On December 31, 2001, CMS will be forwarding to the FIs version 27.0 of the PS&R program. Version 27.0 will include changes to the PS&R program that were a result of the introduction of the Home Health Prospective Payment System (HHPPS) and the Outpatient Prospective Payment System (OPPS). The FIs that are using the Fiscal Intermediary Standard System (FISS) will install version 27.0 and are expected to begin processing claims data through the PS&R system no later than March 1, 2002. The installation process will include downloading, and testing the PS&R program as well as updating all JCL and peripheral programs.

FIs that are using the Arkansas Part A Standard System (APASS) will be allowed an additional 30-day grace period, because the APASS maintainer is in the process of updating the claims processing program. What this means is that the cost report due dates for APASS user FIs and providers will be 30 days later than those using the FISS maintainer system.

Provider Cost Reports

All hospitals (Form CMS-2552-96, except critical access hospitals), skilled nursing facilities (SNFs) (Form CMS-2540-96) with a provider based home health agency, home health agencies (Form CMS-1728-94), and community mental health centers (Form CMS 2088-92) are required to adhere to the cost report due dates recorded in the chart below. The chart also includes information pertaining to the FIs' responsibility to produce PS&R reports and the dates the reports are to be forwarded to the providers. The cost report due dates are based on allowing the providers 38 days to complete the cost report plus an allowance of seven days for the postal service to deliver the PS&R. Critical access hospitals, except for those with provider based HHA’s, will continue to file cost reports in accordance with timelines defined in 42 CFR 413.24(f)(2) and CMS Pub.15-2, chapter 100, section 104.

<table>
<thead>
<tr>
<th>Cost Reporting Year Ending Dates</th>
<th>Claims Processed Through Dates</th>
<th>PS&amp;R Mailed to Provider by Dates*</th>
<th>Cost Report Due Dates*</th>
</tr>
</thead>
<tbody>
<tr>
<td>August-September 30, 2000</td>
<td>December 31, 2000</td>
<td>April 12, 2002</td>
<td>May 27, 2002</td>
</tr>
<tr>
<td>October-December 31, 2001</td>
<td>March 31, 2002</td>
<td>August 9, 2002</td>
<td>September 23, 2002</td>
</tr>
<tr>
<td>April-May 31, 2002</td>
<td>August 30, 2002</td>
<td>September 21, 2002</td>
<td>November 5, 2002</td>
</tr>
</tbody>
</table>

* APASS user FIs and providers are allowed an additional 30 days from these dates to mail the PS&R’s and to submit cost reports.

CMS-Pub. 60A

Palmetto GBA
Home Health Training Manual, 2005
FIs must make tentative settlements no later than 90 days after receipt of an acceptable cost report from the provider. The FIs must take into consideration the providers prior history in determining the percentage of the underpayment that will be reimbursed the provider as the tentative settlement amount. The 90-day period is a one-time exception to Section 42 CFR 413.64 and Transmittal A-01-82, which stipulates that the tentative settlement be made within 60 days of receipt of the cost report.

FIs that are also functioning as regional home health intermediaries (RHHI) will need to transmit electronically to the audit intermediaries (AI’s) all PS&R related information at least five business days before the dates identified in the column labeled "PS&R Mailed to Provider by Dates".

This PM does not preclude a provider from filing cost reports timely, and basing the filing of the cost report on the provider's own records and claims data. Intermediaries should exercise caution when issuing tentative settlements in the absence of the PS&R.

**SNF Cost Reports**

Due to delays in the programming for the free software for SNF cost reports, an extension will be granted to providers with fiscal years ending February 2001 through July 2001, to submit the SNF cost report.

**The effective date for this PM is December 31, 2001.**

**The implementation date for this PM is December 31, 2001.**

**The instructions contained in this PM should be implemented within your current operating budget.**

**This PM may be discarded after December 31, 2002.**

If you have any administrative questions, contact David Goldberg (410-786-4512), Tom Talbott (410-786-4592) or Edward Tregoe (410-786-6827).

If you have any technical questions, contact Michael O'Leary (410-786-6432).
**Exhibit I**

**TENTATIVE SETTLEMENT WKST C**

**PART I AGGREGATE AGENCY COST PER VISIT COMPUTATION**

**COST PER VISIT COMPUTATION**

<table>
<thead>
<tr>
<th>PATIENT SERVICES</th>
<th>FROM WKST C, COL. 2, LINE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 SKILLED NURSING</td>
<td>6</td>
</tr>
<tr>
<td>2 PHYSICAL THERAPY</td>
<td>7</td>
</tr>
<tr>
<td>3 OCCUPATIONAL THERAPY</td>
<td>8</td>
</tr>
<tr>
<td>4 SPEECH PATHOLOGY</td>
<td>9</td>
</tr>
<tr>
<td>5 MEDICAL SOCIAL SERVICE</td>
<td>10</td>
</tr>
<tr>
<td>6 HOME HEALTH AID</td>
<td>11</td>
</tr>
<tr>
<td>7 TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

**PART II - COMPUTATION OF THE AGGREGATE MEDICARE COST AND THE AGGREGATE OF THE MEDICARE LIMITATION BY MSA AREA**

<table>
<thead>
<tr>
<th>MSA AREA 1: 1840</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TOTAL MEDICARE COST COMPUTATION</th>
<th>FROM WKST C, PART I, COL 4, LINE:</th>
<th>AVERAGE COST PER VISIT</th>
<th>PART A VISITS</th>
<th>PART B ENT VISITS</th>
<th>PART B VISITS</th>
<th>PART A COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 SKILLED NURSING - PRE 10/01/2000</td>
<td>1</td>
<td>$56.71</td>
<td>18</td>
<td>82</td>
<td></td>
<td>$1,021</td>
</tr>
<tr>
<td>2 PHYSICAL THERAPY - PRE 10/01/2000</td>
<td>2</td>
<td>$83.23</td>
<td>23</td>
<td>141</td>
<td></td>
<td>$1,914</td>
</tr>
<tr>
<td>3 OCCUPATIONAL THERAPY - PRE 10/01/2000</td>
<td>3</td>
<td>$71.89</td>
<td>2</td>
<td>10</td>
<td></td>
<td>$144</td>
</tr>
<tr>
<td>4 SPEECH PATHOLOGY - PRE 10/01/2000</td>
<td>4</td>
<td>$49.24</td>
<td></td>
<td>17</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>5 MEDICAL SOCIAL SERVICE - PRE 10/01/2000</td>
<td>5</td>
<td>$91.15</td>
<td>1</td>
<td>2</td>
<td></td>
<td>$91</td>
</tr>
<tr>
<td>Service</td>
<td>Visits</td>
<td>Cost</td>
<td>Part A Visits</td>
<td>Part B Ent Visits</td>
<td>Part B Visits</td>
<td>Part A Cost Limit</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>---------------</td>
<td>-------------------</td>
<td>---------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>HOME HEALTH AID - PRE 10/01/2000</strong></td>
<td>6</td>
<td>$56.18</td>
<td>4</td>
<td>146</td>
<td></td>
<td>$225</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>48</td>
<td>398</td>
<td></td>
<td></td>
<td></td>
<td>$3,395</td>
</tr>
<tr>
<td><strong>SKILLED NURSING - POST 9/30/2000</strong></td>
<td>1</td>
<td>$56.71</td>
<td>144</td>
<td>137</td>
<td></td>
<td>$8,166</td>
</tr>
<tr>
<td><strong>PHYSICAL THERAPY - POST 9/30/2000</strong></td>
<td>2</td>
<td>$83.23</td>
<td>288</td>
<td>217</td>
<td></td>
<td>$23,970</td>
</tr>
<tr>
<td><strong>OCCUPATIONAL THERAPY - POST 9/30/2000</strong></td>
<td>3</td>
<td>$71.89</td>
<td>81</td>
<td>40</td>
<td></td>
<td>$5,823</td>
</tr>
<tr>
<td><strong>SPEECH PATHOLOGY - POST 9/30/2000</strong></td>
<td>4</td>
<td>$49.24</td>
<td>7</td>
<td>27</td>
<td></td>
<td>$245</td>
</tr>
<tr>
<td><strong>MEDICAL SOCIAL SERVICE - POST 9/30/2000</strong></td>
<td>5</td>
<td>$91.15</td>
<td>8</td>
<td>5</td>
<td></td>
<td>$729</td>
</tr>
<tr>
<td><strong>HOME HEALTH AID - POST 9/30/2000</strong></td>
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<td>$56.18</td>
<td>163</td>
<td>159</td>
<td></td>
<td>$9,157</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>691</td>
<td>585</td>
<td></td>
<td></td>
<td></td>
<td>$48,191</td>
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</table>

**TOTAL MEDICARE COST LIMIT COMPUTATION**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Limits</th>
<th>Part A Visits</th>
<th>Part B Ent Visits</th>
<th>Part B Visits</th>
<th>Part A Cost Limit</th>
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</thead>
<tbody>
<tr>
<td>8 SKILLED NURSING</td>
<td>$103.62</td>
<td>18</td>
<td>82</td>
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<td>$1,865</td>
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<tr>
<td>9 PHYSICAL THERAPY</td>
<td>$118.76</td>
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<td>141</td>
<td></td>
<td>$2,731</td>
</tr>
<tr>
<td>10 OCCUPATIONAL THERAPY</td>
<td>$119.18</td>
<td>2</td>
<td>10</td>
<td></td>
<td>$238</td>
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<tr>
<td>11 SPEECH PATHOLOGY</td>
<td>$120.30</td>
<td>-</td>
<td>17</td>
<td></td>
<td>$0</td>
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<tr>
<td>12 MEDICAL SOCIAL SERVICE</td>
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<td>$145</td>
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<td>13 HOME HEALTH AID</td>
<td>$47.80</td>
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<td>146</td>
<td></td>
<td>$191</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$5,171</td>
<td>48</td>
<td>398</td>
<td></td>
<td>$5,171</td>
</tr>
</tbody>
</table>
### TENTATIVE SETTLEMENT WKST C PART I, II (1)

<table>
<thead>
<tr>
<th>TOTAL COST</th>
<th>TOTAL VISITS</th>
<th>AVERAGE COST PER VISIT</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tr>
<tr>
<td>$53,082</td>
<td>936</td>
<td>$56.71</td>
</tr>
<tr>
<td>$68,417</td>
<td>822</td>
<td>$83.23</td>
</tr>
<tr>
<td>$11,575</td>
<td>161</td>
<td>$71.89</td>
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<tr>
<td>$2,708</td>
<td>55</td>
<td>$49.24</td>
</tr>
<tr>
<td>$1,823</td>
<td>20</td>
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<td>$56.18</td>
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<tr>
<td>$167,439</td>
<td>2,525</td>
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### PART B ENTL COST

<table>
<thead>
<tr>
<th>PART B ENTL COST</th>
<th>PART B COST</th>
<th>TOTAL (SUM OF COL 8 &amp; 9)</th>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$4,650</td>
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<td>$5,671</td>
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<td>$11,735</td>
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<td>$719</td>
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<td>$863</td>
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<td>$837</td>
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<td>$837</td>
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<tr>
<td>$182</td>
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<td>$273</td>
</tr>
<tr>
<td>#</td>
<td>PART B ENTL COST LIMIT</td>
<td>PART B COST LIMIT</td>
</tr>
<tr>
<td>---</td>
<td>------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>6</td>
<td>$8,202</td>
<td>$8,427</td>
</tr>
<tr>
<td>7</td>
<td>$26,326</td>
<td>$29,721</td>
</tr>
<tr>
<td>1.01</td>
<td>$7,769</td>
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</tr>
<tr>
<td>2.01</td>
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<td>$1,874</td>
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<tr>
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<td>$456</td>
<td>$1,185</td>
</tr>
<tr>
<td>6.01</td>
<td>$8,933</td>
<td>$18,090</td>
</tr>
<tr>
<td>7</td>
<td>$39,424</td>
<td>$87,614</td>
</tr>
</tbody>
</table>
### PART III SUPPLIES AND DRUGS COST COMPUTATION

| 15 | MEDICAL SUPPLY COST - PRE 10/1/2000 | $0 | $0 | 0.000000 | $0 | $0 | $0 |
| 15.01 | MEDICAL SUPPLY COST - POST 9/30/2000 | $0 | $0 | 0.000000 | $0 | $0 | $0 |
| 16 | COST OF DRUGS - PRE 10/1/2000 | $0 | $0 | 0.000000 | $0 | $0 | $0 |
| 16.01 | COST OF DRUGS - POST 9/30/2000 | $0 | $0 | 0.000000 | $0 | $0 | $0 |


| 17 | TOTAL COST OF MEDICARE SERVICES (SUM OF FROM EACH WKST C PT II COL 8, 9, & 11, LINE 7) | $3,395 | $26,326 |
| 18 | COST OF SUPPLIES (FROM PART III, COL 7, AND 8, LINE 15) | | $0 | $0 |
| 19 | TOTAL COST | $3,395 | $26,326 |

| 20 | TOTAL COST PER VISIT LIMIT FOR MEDICARE SERVICES (SUM FROM EACH WKST C PT II, COL 8, 9, & 11, LINE 14) | $5,171 | $35,748 |
| 21 | COST OF MEDICAL SUPPLIES | | $0 | $0 |
| 22 | TOTAL COST LIMIT | $5,171 | $35,748 |

<table>
<thead>
<tr>
<th>MSA CODE</th>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.01</td>
<td>PER BENEFICIARY COST LIMITATION FOR MSA:</td>
<td>1840</td>
<td>24.00</td>
<td>$3,682.75</td>
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</tr>
<tr>
<td>Line</td>
<td>Description</td>
<td>Avg Cost per Visit</td>
<td>Medicare Visits Before 1/1/98</td>
<td>Medicare Cost Before 1/1/98</td>
<td>Medicare Visits After 1/1/98</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------</td>
<td>--------------------</td>
<td>-------------------------------</td>
<td>------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>25</td>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Speech Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Total (Sum of Lines 25 - 27)</td>
<td></td>
<td></td>
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</tbody>
</table>

**23.05** PER BENEFICIARY COST LIMITATION FOR MSA: $0.00

**23.06** PER BENEFICIARY COST LIMITATION FOR MSA: $0.00

**23.07** PER BENEFICIARY COST LIMITATION FOR MSA: $0.00

**23.08** PER BENEFICIARY COST LIMITATION FOR MSA: $0.00

**23.09** PER BENEFICIARY COST LIMITATION FOR MSA: $0.00

**23.10** PER BENEFICIARY COST LIMITATION FOR MSA: $0.00

**24** AGGREGATE PER BENEFICIARY COST LIMITATION $10,095 $78,291

**PART V OUTPATIENT THERAPY REDUCTION COMPUTATION**
<table>
<thead>
<tr>
<th>PART B NOT SUBJECT TO COINSURANCE AND DEDUCTIBLE</th>
<th>PART B SUBJECT TO COINSURANCE/DEDUCTIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>$0</td>
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<tr>
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**COIARY COST LIMITATION**

<table>
<thead>
<tr>
<th>TOTAL PART B COST</th>
<th>TOTAL (SUM OF COLS 3 &amp; 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$29,721</td>
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<td>$29,721</td>
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</tr>
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<td>$0</td>
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<tr>
<td></td>
<td>$40,920</td>
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</table>

<table>
<thead>
<tr>
<th>(COL 1 X 2 )</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL PART B COST</th>
<th>TOTAL (SUM OF COLS 3 &amp; 4)</th>
</tr>
</thead>
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<td>$0</td>
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<tr>
<td></td>
<td>$40,920</td>
</tr>
<tr>
<td>APPLICATION OF REASONABLE COST REDUCTION</td>
<td>REASONABLE COST NET OF ADJUSTMENTS</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>$0</td>
<td>$0 25</td>
</tr>
<tr>
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</tr>
<tr>
<td>$0</td>
<td>$0 27</td>
</tr>
<tr>
<td>$0</td>
<td>$0 28</td>
</tr>
</tbody>
</table>

$88,386
## TENTATIVE SETTLEMENT WORKSHEET D AND D - 1

**PROVIDER NAME:**

**PROVIDER NUMBER:** 00-0000

**PERIOD START:** 7/1/2000  
**RECEIPT DATE:** 5/28/2002

**PERIOD END:** 6/30/2001  
**PS&R DATE:** 6/16/2002

**PREPARED BY:**

**REVIEWED BY:**

### REIMBURSEMENT UNDER IPS

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>PART A</th>
<th>PART B ENTL</th>
</tr>
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<tbody>
<tr>
<td>1 COST OF SERVICES</td>
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<td>$26,326</td>
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<tr>
<td>2 TOTAL CHARGES FOR TITLE XVIII - PART A AND PART B SERVICES PRE-10/01/2000</td>
<td>$3,830</td>
<td>$27,580</td>
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<tr>
<td>3 TOTAL CHARGES FOR TITLE XVIII - PART A AND PART B SERVICES POST 9/30/2000</td>
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<td></td>
</tr>
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<td>4 EXCESS REASONABLE COST</td>
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<td>$0</td>
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<td>5 NET COST</td>
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<td>$26,326</td>
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<tr>
<td>6 PRIMARY PAYMENTS</td>
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<td>$0</td>
</tr>
<tr>
<td>7 TOTAL REASONABLE COST</td>
<td>$3,395</td>
<td></td>
</tr>
<tr>
<td>7.01 TOTAL PPS REIMBURSEMENT - FULL EPISODE WITHOUT OUTLIERS</td>
<td>$89,586</td>
<td></td>
</tr>
<tr>
<td>7.02 TOTAL PPS REIMBURSEMENT - FULL EPISODE WITH OUTLIERS</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>7.03 TOTAL PPS REIMBURSEMENT - LUPA EPISODE</td>
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<td>7.04 TOTAL PPS REIMBURSEMENT - PEP EPISODE</td>
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<td>7.05 TOTAL PPS REIMBURSEMENT - SCIC WITHIN A PEP EPISODE</td>
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<td>7.06 TOTAL PPS REIMBURSEMENT - SCIC EPISODE</td>
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<td>7.07 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODE WITH OUTLIERS</td>
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<td>7.09 TOTAL PPS OUTLIER REIMBURSEMENT - SCIC WITHIN A PEP EPISODE</td>
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<td>7.11 TOTAL OTHER PAYMENTS</td>
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<td>7.12 DME PAYMENTS</td>
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<td>7.13</td>
<td>OXYGEN PAYMENTS</td>
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<td>7.14</td>
<td>PROSTHETIC AND ORTHOTICS PAYMENTS</td>
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<td>SUBTOTAL (LINE 7.01 - LINE 7.14 MINUS LINE 8)</td>
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<td>NET IPS COST AND PPS REIMBURSEMENT</td>
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<td>TOTAL INTERIM PAYMENTS AND PPS REIMBURSEMENT MADE TO PROVIDER</td>
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<td>LUMP SUM PAYMENTS</td>
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<tr>
<td>15.06</td>
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<td>15.07</td>
<td>TOTAL LUMP SUM PAYMENTS (TOTAL OF LINES 15.01-15.06)</td>
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<td>AS-FILED OVERPAYMENT AMOUNT</td>
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<td>TOTAL PAYMENTS PAID TO PROVIDER (TOTAL OF LINES 14, 15.07 AND 16)</td>
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<td>AMOUNT DUE PROVIDER (PROGRAM) LINES 13-17</td>
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<td>AMOUNT DUE PROVIDER (PROGRAM)</td>
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<td>LATE COST REPORT OVERPAYMENT CHARGE</td>
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<td>(OVERPAYMENT AMT X CURRENT INTEREST/12MONTHS X # OF MONTHS LATE)</td>
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<td>21</td>
<td>TOTAL AMOUNT DUE PROVIDER/(PROGRAM)</td>
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<tr>
<td>PART B</td>
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