



Palmetto GBASM
PARTNERS IN EXCELLENCESM

**Online Provider Services
User Manual**
Rev: January 24, 2012

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Revision History

Date	Description
6/21/2010	Initial Release
8/31/2010	Updated 1.3 and 2.1 to clarify PTAN/NPI combination. Added sections 2.6 through 2.11 to clarify registration process.
8/31/2010	Updated 3.2 to include Internet Explorer 8.0 note.
8/31/2010	Updated 4.1 to include note about processed date and check number.
8/31/2010	Updated section 5.0 with more complete eligibility information.
03/21/2011	Updated all sections for J11 MAC relevance. Updated section 5.0 with date look-up information and home health and hospice updates.
06/28/2011	Updated for J11 MAC. Added information to note in eligibility Section 6.6.
1/24/2012	Updated eligibility sections 6.5 and 6.10. Updated remittance Section 5.3.

Glossary and Acronyms

CMS	Centers for Medicare & Medicaid Services
CWF	Medicare Common Working File
EDI	Electronic Data Interchange
EDI Enrollment Agreement	This agreement must be completed by each provider prior to submitting electronic media claims (EMC) or other EDI transactions to Medicare. It is also required to participate in Online Provider Services.
ESRD	End-stage Renal Disease
DOEBA	Date of Earliest Billing Activity
DOLBA	Date of Latest Billing Activity
FAQ	Frequently Asked Question
HETS	HIPAA Eligibility Transaction System
HHEH	Home Health Episode Period
HICN	Health Insurance Claim Number
HIPAA	The Health Insurance Portability and Accountability Act of 1996
IVR	Interactive Voice Response.
MAC	Medicare Administrative Contractor
OPS	The Online Provider Services Application. This application is available through the
NPI	National Provider Identifier. The NPI is a unique identification number for covered health care providers.
Provider Administrator	The provider representative who registered and who has the authority to add users.
Provider User	A person who has been granted permission by the Provider Administrator to access information for that provider.
PCC	Provider Call Center
PTAN	Provider Transaction Access Number. Also called a legacy number or Medicare PIN.
SNF	Skilled Nursing Facility
Tax ID	Tax Identification Number. Also called a TIN.
TSC	Technical Service Center

1.0 General Information

1.1 What is Online Provider Services (OPS)?

OPS is an Internet-based, provider self-service secure applications. Palmetto GBA's goal is to give the provider secure and fast access to their Medicare information seamlessly via our Web site through the OPS application.

The OPS application provides information access over the Web for the following online services:

- Eligibility
- Claims Status
- Remittances Online
- Financial Information (payment floor and last 3 checks paid)

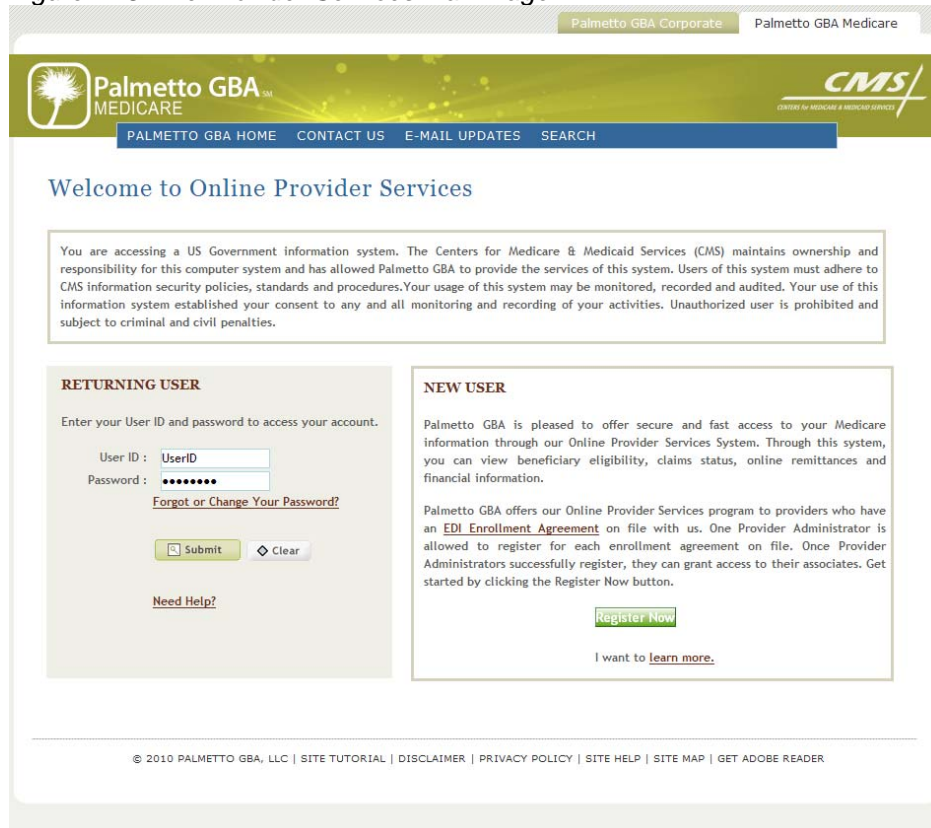
You can participate in OPS if you have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA.

NOTE: Users must have an EDI enrollment agreement on file with Palmetto GBA to participate. To find instructions to get one, go to the [EDI section](#) of PalmettoGBA.com.

The OPS home page is:

https://www5.palmettogba.com/ecx_improvev2/

Figure 1: Online Provider Services Main Page



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PALMETTO GBA HOME CONTACT US E-MAIL UPDATES SEARCH

Welcome to Online Provider Services

You are accessing a US Government information system. The Centers for Medicare & Medicaid Services (CMS) maintains ownership and responsibility for this computer system and has allowed Palmetto GBA to provide the services of this system. Users of this system must adhere to CMS information security policies, standards and procedures. Your usage of this system may be monitored, recorded and audited. Your use of this information system established your consent to any and all monitoring and recording of your activities. Unauthorized user is prohibited and subject to criminal and civil penalties.

RETURNING USER

Enter your User ID and password to access your account.

User ID :

Password :

[Forgot or Change Your Password?](#)

[Need Help?](#)

NEW USER

Palmetto GBA is pleased to offer secure and fast access to your Medicare information through our Online Provider Services System. Through this system, you can view beneficiary eligibility, claims status, online remittances and financial information.

Palmetto GBA offers our Online Provider Services program to providers who have an [EDI Enrollment Agreement](#) on file with us. One Provider Administrator is allowed to register for each enrollment agreement on file. Once Provider Administrators successfully register, they can grant access to their associates. Get started by clicking the Register Now button.

I want to [learn more.](#)

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1.2 How much does Online Provider Services (OPS) cost?

There is no cost to the provider for registering and using Online Provider Services (OPS).

1.3 Who can participate in Online Provider Services (OPS)?

You can participate in OPS if you have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA. The EDI Enrollment Agreement is a form that is included in the EDI Enrollment Packet which can be located under the [EDI areas](#) of PalmettoGBA.com. If you do not have an EDI Enrollment agreement on file with us, please go to PalmettoGBA.com and click on your line of business from the left-hand menu. Then, click on EDI from the left-hand menu. Click on the Enrollment link listed on the page for online articles about EDI enrollment.

Note: ONLY ONE Provider Administrator per EDI Enrollment Agreement related to a PTAN/NPI combination performs the registration process. The Provider Administrator grants permissions to additional users related to that PTAN/PTAN combination.

1.4 How to report misuse or suspicious use of the Online Provider Services (OPS)?

If you suspect misuse or suspicious use of the system, contact the Technical Support Center (TSC) at (866) 749-4301 immediately.

Palmetto GBA reserves the right to terminate any user's access if suspicious or improper activity is determined. Access can be terminated without notice.

1.5 How do I contact technical support?

Please use this manual to answer your questions and troubleshoot problems. If you need additional support with registering, logging in, administration or viewing information on our site, contact the TSC at (866) 749-4301.

1.6 Why can't I view or print information in Online Provider Services (OPS)?

If are using Internet Explorer 8.0 or higher, please make sure you have selected the compatibility settings to help make OPS work better. In your browser, click on Tools from the top menu. Then click on Compatibility View Settings. At the bottom of the screen, click the box that says display all Web sites in Compatibility View.

You will also want to make sure your JavaScript is enabled. In Internet Explorer, go to the Tools menu, click on Internet Options, go to the Security tab and click 'Reset all zones to default.'

Some Web browser Add-ons or your security software may be blocking Web page scripts. Check your Web browser settings and help sections to troubleshoot display problems.

2.0 Registration

2.1 How do providers register for Online Provider Services (OPS)?

You can participate in OPS if you have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA. ONLY ONE Provider Administrator per EDI Enrollment Agreement may register for OPS. The Provider Administrator may grant access to the different features of the application to their associates, who are Provider Users. If you are a Provider User, you must contact the Provider Administrator for your provider to request access to the system.

It's easy to register. Just go to the OPS link from PalmettoGBA.com. You'll see the OPS introduction screen.

Only one Provider Administrator per EDI Enrollment Agreement can register. You must enter the information listed below to register.

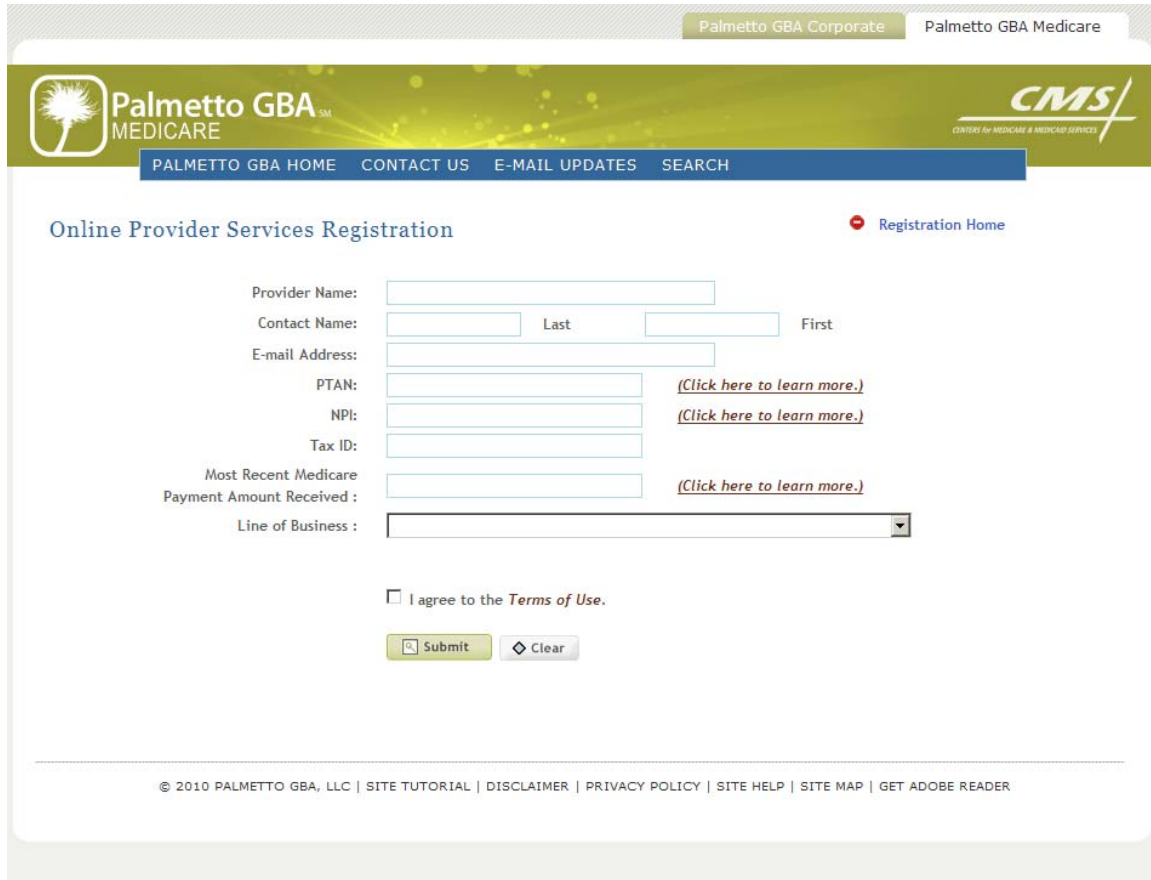
- Provider Name
- Contact Name (We suggest you enter the name on the EDI Enrollment Agreement.)
- E-Mail Address
- PTAN
- NPI
- TAX ID
- Most Recent Medicare Payment Amount Received (If you have several payments received in one day, use the amount related to the highest check number.)
- Line of business: Choose from drop-down selections

You must also agree to the Terms of Use to register. If all information matches, you may choose a password and security questions and answer.

If the information you enter matches the information on file with Palmetto GBA, you will be assigned a User ID and can choose your password and security question/answer. If you have entered registration information in an incorrect format, the OPS application will display an error message in red at the top of the screen. Carefully read that error message and enter the information again.

Note: You must register for each PTAN/NPI combination. If you have multiple NPIs associated with a PTAN, you must register each PTAN/NPI combination. Each combination will have a unique User ID.

Figure 2: OPS Registration Screen



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Online Provider Services Registration [Registration Home](#)

Provider Name:

Contact Name: Last First

E-mail Address:

PTAN: [\(Click here to learn more.\)](#)

NPI: [\(Click here to learn more.\)](#)

Tax ID:

Most Recent Medicare Payment Amount Received : [\(Click here to learn more.\)](#)

Line of Business :

I agree to the [Terms of Use.](#)

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2.2 How do I choose my password?

You will automatically be assigned a user ID in a format defined by CMS. You will be allowed to choose your own password. Your password is case sensitive and:

- Must be at least 8 characters long
- Must contain an upper case letter
- Must contain a lower case letter
- Must have at least one special character (such as @, #, or \$)
- Must contain numbers (0-9) and letters (A-Z, a-z)
- Must start with a letter
- No leading portion of first or last names may occur
- Must be changed every 30 days
- Cannot contain spaces
- Cannot use same password as the last thirteen passwords.

More secure passwords are those which are based on pass phrases and/or non-dictionary words (including "nonsense" words), combined with obscure character substitutions.

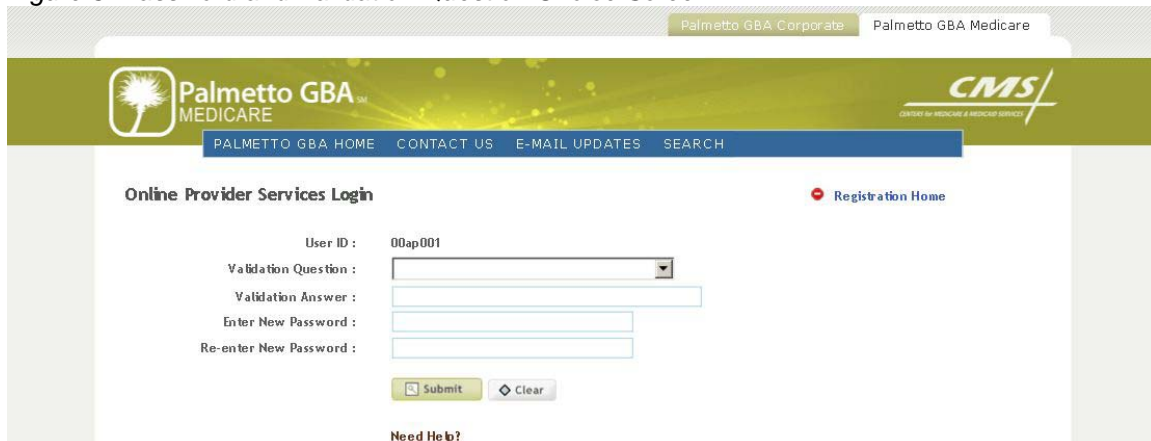
Use the following guidelines to protect your password and your information:

- Don't use something easily identifiable such as your birthday, child's birthday, phone number, or street address
- Don't use letters or numbers that are near each other on the keyboard (ex. hjkl) or appear in a logical sequence (ex. 123456 or abcdefg)
- Don't ever share your password with anyone else
- Don't leave your password written down in any place where someone could find it. If you absolutely *must* write down your passwords, keep them in a secure, locked place
- If your browser supports password storage, you may want to disable this feature for security purposes
- Do not leave the OPS system accessible on your computer when you are away from the computer.
- Log off and close your browser each and every time you exit the system.

2.3 How do I choose my security question?

You have several questions from which to choose. Answers to your security question are case sensitive and include spaces. Enter your answer carefully. You must answer this question exactly as it is entered to change your password or reset your password if you have lost it. You can verify or change your security question and answer through your My Account tab once you are logged in. See *Figure 3*.

Figure 3: Password and Validation Question Choice Screen



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Online Provider Services Login [Registration Home](#)

User ID : 00ap001

Validation Question :

Validation Answer :

Enter New Password :

Re-enter New Password :

[Need Help?](#)

2.4 Someone from my office has already registered. How do I get access?

You must contact your Provider Administrator to request access to the system. If you do not know who your Provider Administrator is, you will want to contact your Provider's staff to find out if they have registered to the system and who is the Provider Administrator.

If you are a Provider Administrator, you can see who is designated as Provider Administrators on the Admin Tab.

2.5 I am having trouble with my registration; what should I do?

Only one Provider Administrator per provider can register for Online Provider Services (OPS). If an administrator from your office has already registered, please contact that person for access to OPS.

If you are the Provider Administrator and your registration information is entered in an incorrect format, the OPS application will display an error message in red at the top of your screen. Carefully read that error message and enter the information again.

If you are sure you entered all information correctly and cannot register, make sure you have an EDI enrollment agreement on file with CMS. If you do not, please access the EDI section of PalmettoGBA.com for helpful articles about how to complete the EDI agreement. If you are sure you have an EDI agreement on file, but still cannot register, please call the Technical Support Center (TSC) at (866) 749-4301.

2.6 I have multiple NPIs and PTANs. Do I need to register each one?

You must register for each PTAN/NPI combination. If you have multiple NPIs associated with a PTAN, you must register each PTAN/NPI combination. Each combination will have a unique User ID.

2.7 How do I find out my PTAN?

You must have a Provider Transaction Account Number (PTAN) to register for Online Provider Services (OPS). Palmetto GBA cannot release patient or provider specific information if you do not identify yourself with your PTAN. You may access the National Plan & Provider Enumeration System (NPPES) [NPI Registry](#) to search for the PTANs listed for your office.

2.8 How do I find out my NPI?

You must have a National Provider Identifier (NPI) to register for Online Provider Services (OPS). Palmetto GBA cannot release patient or provider specific information if you do not identify yourself with your NPI. You may access the National Plan & Provider Enumeration System (NPPES) [NPI Registry](#) to search for the NPIs listed for your office.

2.9 How do I find out my Tax Identification Number (TIN)?

You must have a Tax Identification Number (TIN) to register for Online Provider Services (OPS). Palmetto GBA cannot release patient or provider specific information if you do not identify yourself with your TIN. It is referred to as the Tax ID on the registration page of OPS. If you do not know your Tax ID, check with your administrative office or refer to your tax records.

2.10 How do I find out my last payment received?

Call the IVR to verify your last payment received. You must call the IVR related to your line of business. IVR telephone numbers are listed in the [Contact Us](#) pages of PalmettoGBA.com/Medicare.

2.11 I am getting an error message that I do not have an EDI enrollment agreement on file. What do I do?

You can participate in OPS if you have a signed electronic data interchange (EDI) Enrollment Agreement on file with Palmetto GBA. If you receive an error that you do not have an EDI enrollment agreement on file with Palmetto GBA, please double check your records and make sure you are choosing the line of business that relates to your EDI Enrollment Agreement.

The EDI Enrollment Agreement is a form that is included in the EDI Enrollment Packet which can be located under the [EDI areas](#) of PalmettoGBA.com.

3.0 Login

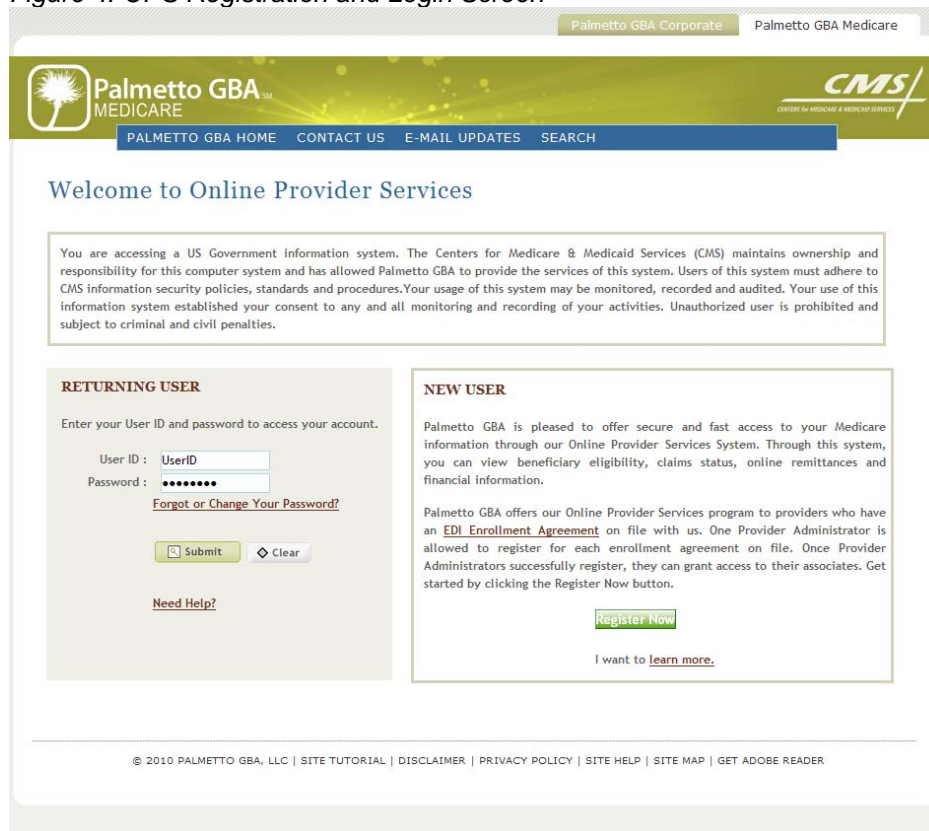
3.0 How do I login to Online Provider Services (OPS)?

You must have either registered for OPS or been given access to OPS by a Provider Administrator for your provider. If you have completed these steps, you will have a User ID. Access our OPS introduction screen and enter your User ID and password. See *Figure 4*.

If you were assigned a password by your Provider Administrator and this is the first time you have logged in, you will be prompted to agree to the terms of use, change your password and choose your security question and answer. Once you have successfully completed these steps, you will be given access to OPS.

Note: A **logout** link is located in the upper left of each screen, once you have logged in. You must logout to end your session. If you do not logout, your User ID will be locked for 1 hour.

Figure 4: OPS Registration and Login Screen



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You are accessing a US Government information system. The Centers for Medicare & Medicaid Services (CMS) maintains ownership and responsibility for this computer system and has allowed Palmetto GBA to provide the services of this system. Users of this system must adhere to CMS information security policies, standards and procedures. Your usage of this system may be monitored, recorded and audited. Your use of this information system established your consent to any and all monitoring and recording of your activities. Unauthorized user is prohibited and subject to criminal and civil penalties.

RETURNING USER

Enter your User ID and password to access your account.

User ID :

Password :

[Forgot or Change Your Password?](#)

[Need Help?](#)

NEW USER

Palmetto GBA is pleased to offer secure and fast access to your Medicare information through our Online Provider Services System. Through this system, you can view beneficiary eligibility, claims status, online remittances and financial information.

Palmetto GBA offers our Online Provider Services program to providers who have an [EDI Enrollment Agreement](#) on file with us. One Provider Administrator is allowed to register for each enrollment agreement on file. Once Provider Administrators successfully register, they can grant access to their associates. Get started by clicking the Register Now button.

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3.2 Once I login, some of my tabs are grayed out or cannot be accessed. What should I do?

If you have been granted access by the Provider Administrator for your office, your Provider Administrator has chosen the tabs you can access. Please contact your Provider Administrator.

If you are the Provider Administrator for your office, you automatically have access to all the functions. If you are the Provider Administrator and are having problems accessing the tabs, please call the Technical Support Center (TSC) at (866) 749-4301.

Tip: If you are using Internet Explorer 8.0, please make sure you have selected the compatibility settings to help make OPS work better. In your browser, click on Tools from the top menu. Then click on Compatibility View Settings. At the bottom of the screen, click the box that says display all websites in Compatibility View.

3.3 How do I receive a User ID?

If you are a Provider Administrator, your User ID is assigned when you register.

If you are a Provider User, meaning you have been granted access by your Provider Administrator, your Provider Administrator will give you a User ID.

3.4 What if I do not know my User ID?

If you are a Provider User, meaning you have been granted access by your Provider Administrator, contact your Provider Administrator if you do not know your User ID.

If you are a Provider Administrator and you cannot find your User ID, please call the Technical Support Center (TSC) at (866) 749-4301.

3.5 What happens if I cannot log into Online Provider Services (OPS)?

You must enter your password exactly as it was entered when you chose it. If you do not remember your password, you can click on the Forgot or Change Your Password link from the Returning User box of the OPS introduction screen. See *Figure 5*. You must answer your security question correctly to reset your password. See *Figures 6, 7 & 8*.

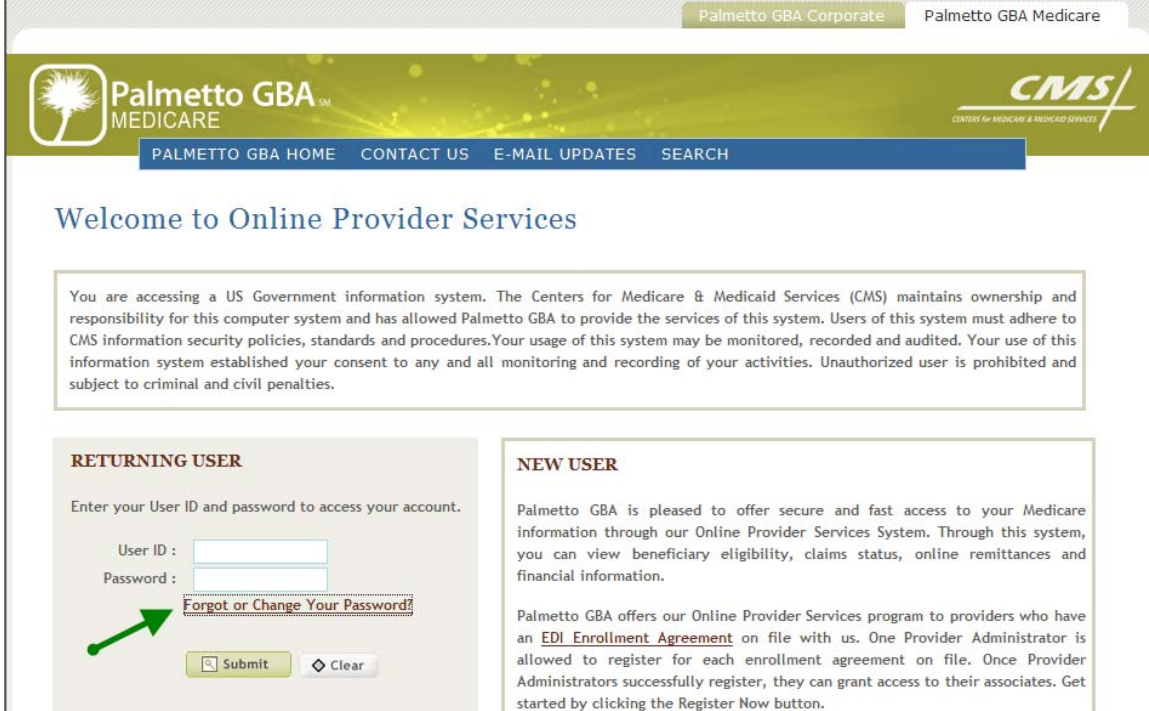
Keep in mind that if you attempt to login incorrectly three times, you will be locked out for an hour. If you are locked out three times in a row, your access will be revoked. If you are a Provider User, meaning you have been granted access by the Provider Administrator for your provider, contact your Provider Administrator to verify your identity and regain access.

If you are a Provider Administrator you must call the Technical Support Center (TSC) at (866) 749-4301 to verify your identity and re-gain access.

You can verify or change your security question and answer through your My Account tab once you are logged in.

Note: You cannot change your password more than one time for every 24-hour period. Keep in mind to exit OPS, click on the logout link in the upper right of every page. If you do not do this, you will be locked out for an hour. We do not unlock accounts that are in the hour lock-out period.

Figure 5: Request to Change or Reset Password



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RETURNING USER

Enter your User ID and password to access your account.

User ID :

Password :

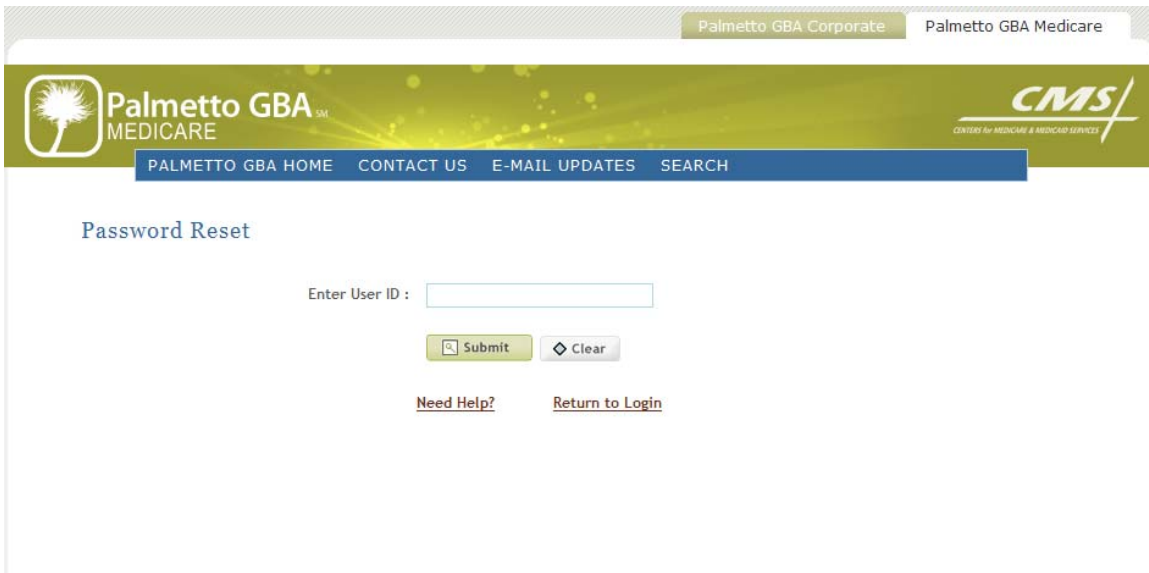
[Forgot or Change Your Password?](#)

NEW USER

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Palmetto GBA offers our Online Provider Services program to providers who have an [EDI Enrollment Agreement](#) on file with us. One Provider Administrator is allowed to register for each enrollment agreement on file. Once Provider Administrators successfully register, they can grant access to their associates. Get started by clicking the Register Now button.

Figure 6: Password Reset, Enter User ID



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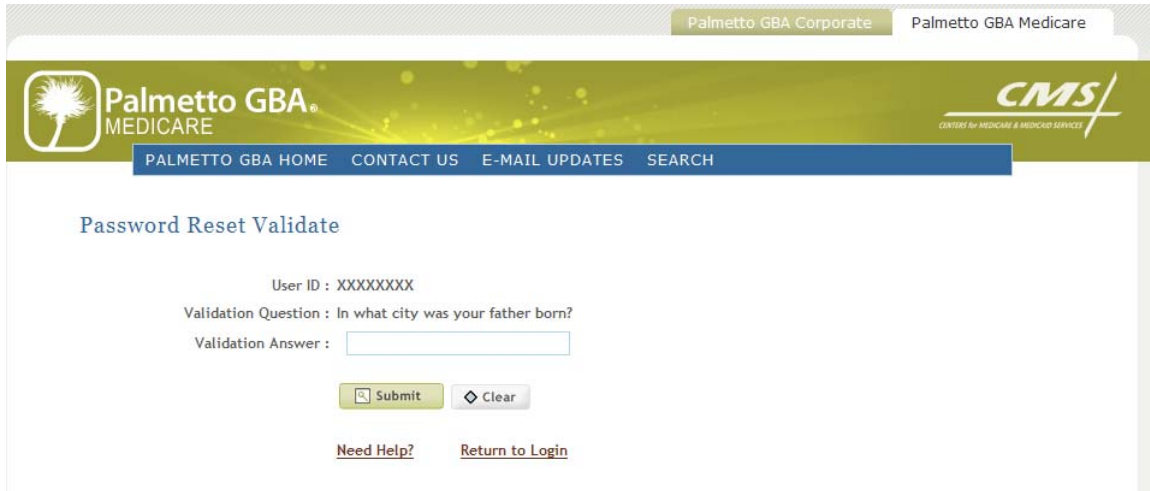
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Password Reset


Enter User ID :


[Need Help?](#) [Return to Login](#)

Figure 7: Password Reset Validate, Answering Validation Question



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Password Reset Validate

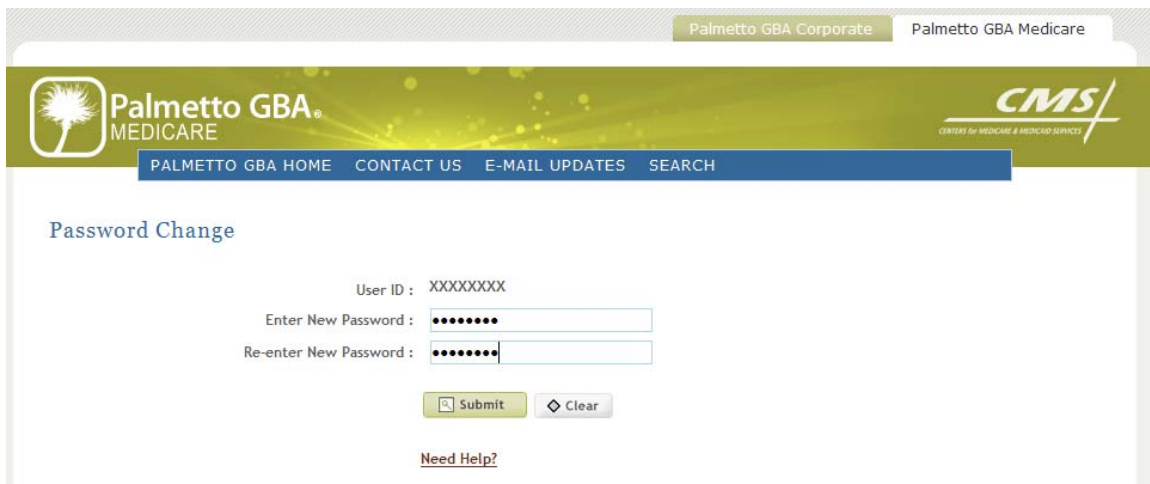
User ID : XXXXXXXX

Validation Question : In what city was your father born?


Validation Answer :


[Need Help?](#) [Return to Login](#)

Figure 8: Password Change Screen



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Password Change

User ID : XXXXXXXX

Enter New Password :

Re-enter New Password :

[Need Help?](#)

3.6 I cannot answer my security question; what should I do?

If you are a Provider User, meaning you have been granted access by the Provider Administrator for your provider, contact your Provider Administrator to verify your identity and regain access.

If you are a Provider Administrator and you cannot answer your security question, please call the Technical Support Center (TSC) at (866) 749-4301.

Keep in mind that you can update your security question through your My Account tab.

3.7 How do I change my password?

Click on the Forgot or Change Your Password link from the Returning User box of the OPS introduction screen. You must answer your security question correctly to reset your password. If you want to change or verify your security question and answer, you can update it through your My Account tab once you are logged in.

Keep in mind that if you attempt to change your password incorrectly three times you will be locked out for an hour. If you are locked out three times in a row, your access will be revoked. If you are a Provider User, meaning you have been granted access by the Provider Administrator for your provider, contact your Provider Administrator to verify your identity and regain access.

If you are a Provider Administrator you must call the Technical Support Center (TSC) at (866) 749-4301 to verify your identity and re-gain access.

<p>Note: You cannot change your password more than one time for every 24-hour period.</p>
--

3.8 I left the system without logging out. Now, I cannot get back in. What should I do?

A logout link is located in the upper left of each screen, once you have logged in. You must logout to end your session. If you do not logout, your User ID will be locked for 1 hour. If you continue to be locked out, and you are a Provider User, meaning you have been granted access by the Provider Administrator for your provider, contact your Provider Administrator to verify your identity and regain access.

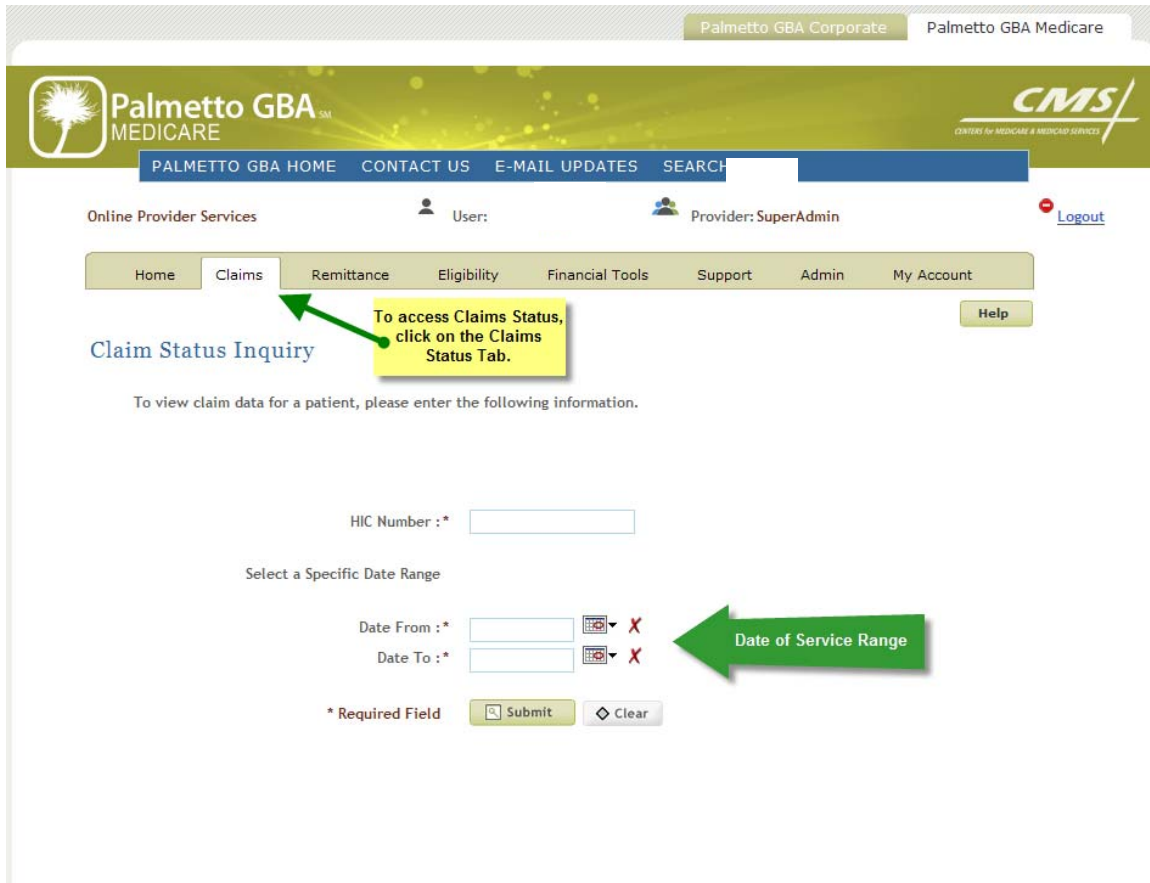
If you are a Provider Administrator you must call the Technical Support Center (TSC) at (866) 749-4301 to verify your identity and re-gain access.

4.0 Claims Status

4.1 How to Access Claims Status

If you have access to claims status and are successfully logged in, lick on the Claims Tab. The claims status screen will appear. See *Figure 9*.

Figure 9: Claims Tab



Palmetto GBA Corporate Palmetto GBA Medicare

Palmetto GBA
MEDICARE

PALMETTO GBA HOME CONTACT US E-MAIL UPDATES SEARCH

Online Provider Services User: Provider: SuperAdmin Logout

Home **Claims** Remittance Eligibility Financial Tools Support Admin My Account Help

Claim Status Inquiry

To view claim data for a patient, please enter the following information.

HIC Number : *

Select a Specific Date Range

Date From : * X

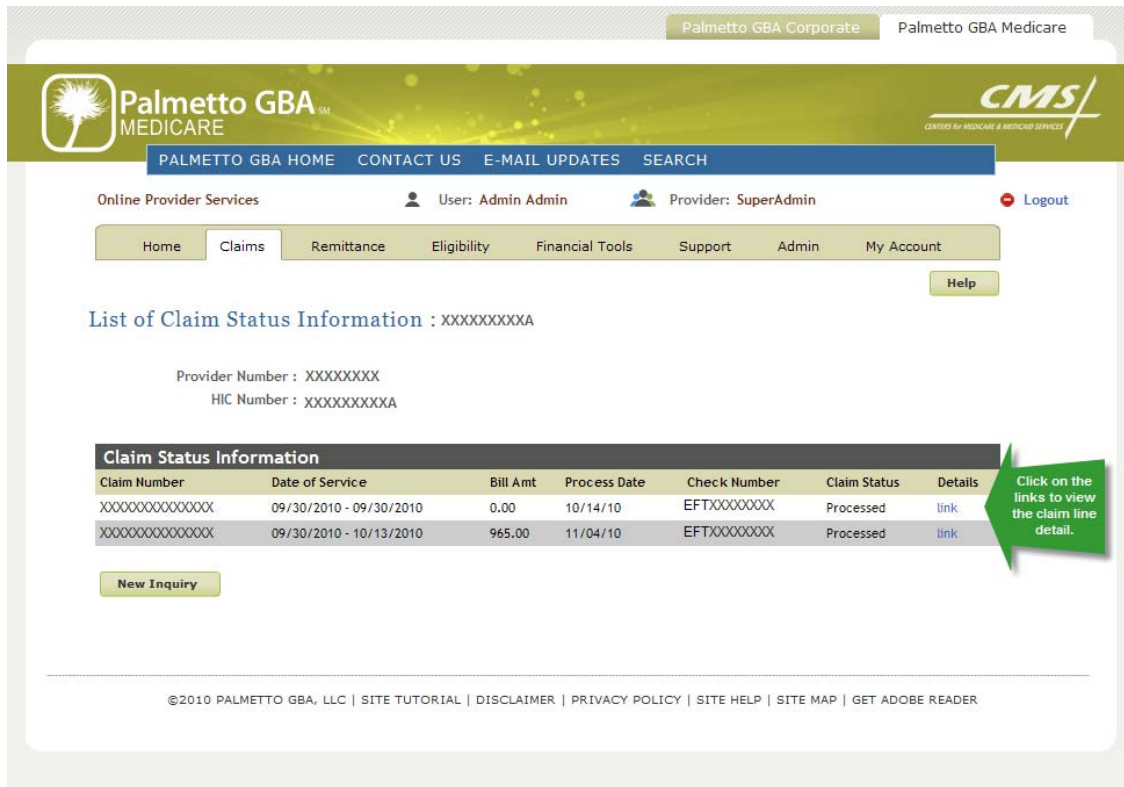
Date To : * X

* Required Field


You must enter a HIC number and the date range of date of service for the claims you seek. The claims status date range will default to 45 days from the beginning date. You can choose a smaller date range. But, you cannot choose a larger date range than 45 days. Retrieving claims information older than 6 months may take additional time. In addition, offline claims will not be displayed. Many claims are offline after 3 years, sometimes earlier.

If claims are found for the date range entered, you will receive a list of claims found. Each claim line will have a link to the claims details. See *Figure 10 and 11*.

Figure 10: List of Claims Status Information



Palmetto GBA Corporate Palmetto GBA Medicare

Palmetto GBA MEDICARE 

PALMETTO GBA HOME CONTACT US E-MAIL UPDATES SEARCH

Online Provider Services User: Admin Admin Provider: SuperAdmin Logout

Home Claims Remittance Eligibility Financial Tools Support Admin My Account Help

List of Claim Status Information : XXXXXXXXXA

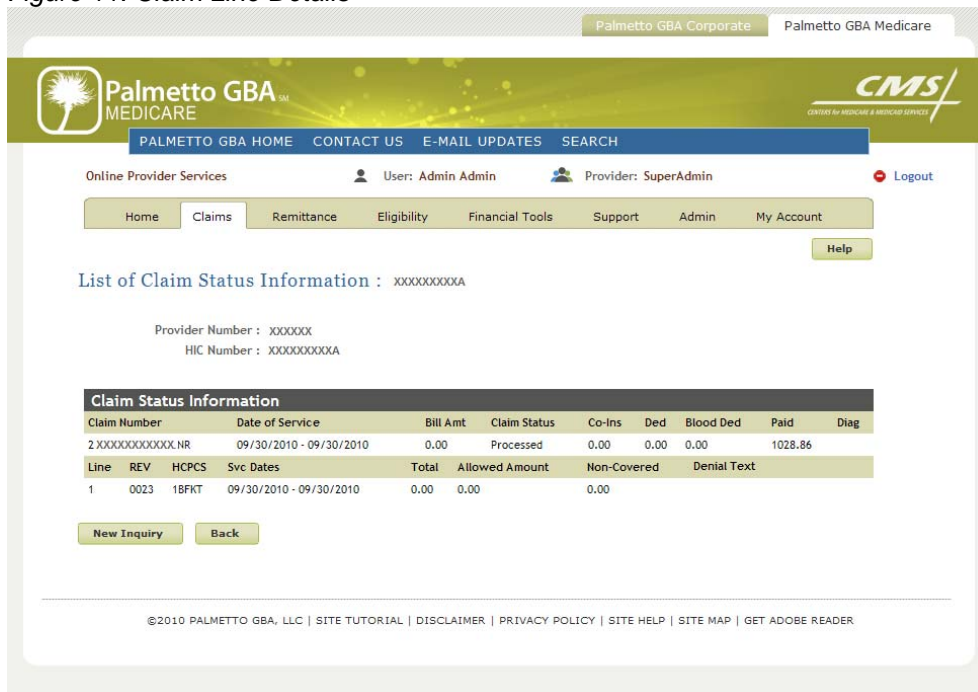
Provider Number : XXXXXXXX
HIC Number : XXXXXXXXXA

Claim Status Information						
Claim Number	Date of Service	Bill Amt	Process Date	Check Number	Claim Status	Details
XXXXXXXXXXXXXX	09/30/2010 - 09/30/2010	0.00	10/14/10	EFTXXXXXXXX	Processed	link
XXXXXXXXXXXXXX	09/30/2010 - 10/13/2010	965.00	11/04/10	EFTXXXXXXXX	Processed	link


New Inquiry

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Figure 11: Claim Line Details



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PALMETTO GBA HOME CONTACT US E-MAIL UPDATES SEARCH

Online Provider Services User: Admin Admin Provider: SuperAdmin Logout

Home Claims Remittance Eligibility Financial Tools Support Admin My Account Help

List of Claim Status Information : XXXXXXXXXA

Provider Number : XXXXXXXX
HIC Number : XXXXXXXXXA

Claim Status Information									
Claim Number	Date of Service	Bill Amt	Claim Status	Co-Ins	Ded	Blood Ded	Paid	Diag	
2XXXXXXXXXXXXNR	09/30/2010 - 09/30/2010	0.00	Processed	0.00	0.00	0.00	1028.86		
Line	REV	HCPDS	Svc Dates	Total	Allowed Amount	Non-Covered	Denial Text		
1	0023	18FKT	09/30/2010 - 09/30/2010	0.00	0.00	0.00			

New Inquiry Back

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4.2 I am getting a message that there is no information to display for the date period chosen; what should I do?

If no claims are displayed for the date period you have chosen, you may want to choose a different date range or double-check your records to make sure you have entered the correct HIC number. Claims that are paid, in process, returned or denied are displayed. Information is retrieved from CMS standard systems and is as current as the standard systems. Claims that are offline or returned without processing will not appear.

The claims status date range will default to 45 days from the beginning date. You can choose a smaller date range. But, you cannot choose a larger date range than 45 days. Retrieving claims information older than 6 months may take additional time. In addition, offline claims will not be displayed. Many claims are offline after 3 years, sometimes earlier.

4.3 I think my claim information is incorrect; what should I do?

If you believe the information is incorrect, you must contact your Provider Contact Center. Follow the instructions under the Contact Us area of PalmettoGBA.com/Medicare.

4.4 How far back can I look for claims status information?

Retrieving claims information older than 6 months may take additional time. In addition, offline claims will not be displayed. Many claims are offline after 3 years, sometimes earlier.

The claims status date range will default to 45 days from the beginning date. You can choose a shorter date range. But, you cannot choose a date range longer than 45 days.

4.5 I am being told I have entered an invalid HIC number; what next?

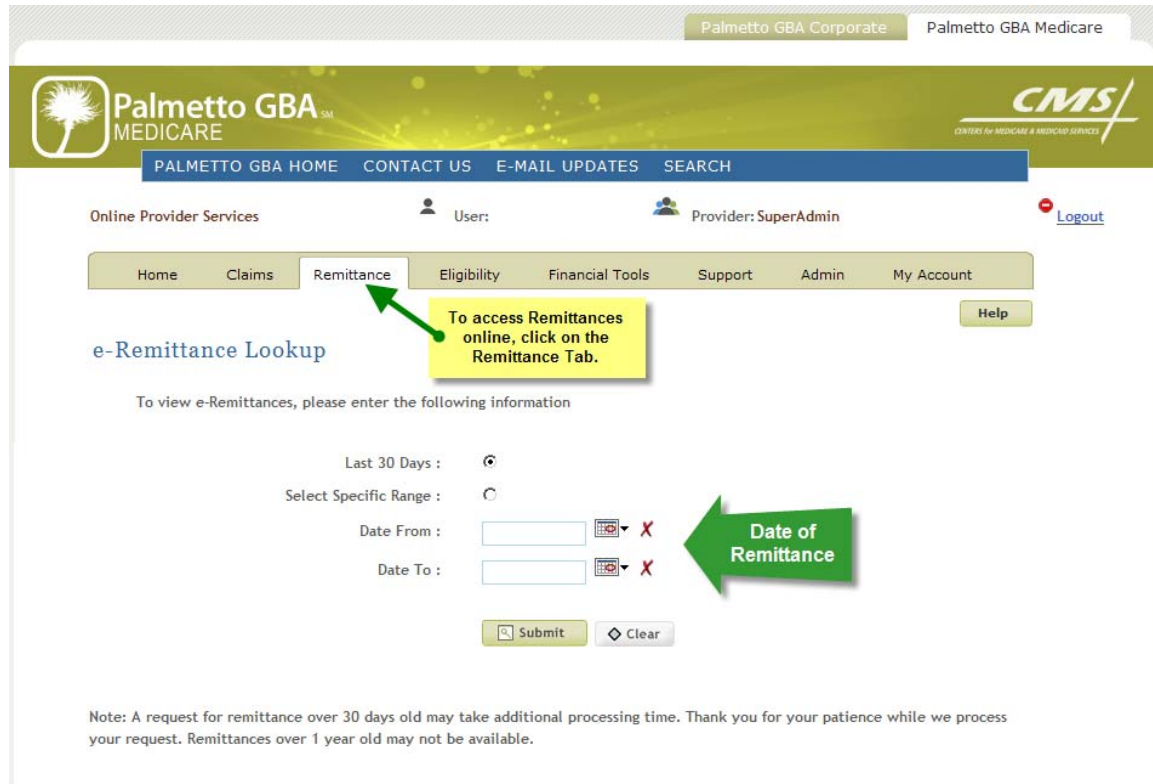
You must double check the HIC number. It should be entered without spaces, dashes or any other special characters.

5.0 Remittances

5.1 How to Access Remittances Online

If you have access to remittances online and are successfully logged in, click on the Remittance Tab. The Remittance screen will appear. See *Figure 12*.

Figure 12: Remittance Tab



The screenshot shows the Palmetto GBA Medicare online provider services interface. At the top, there are tabs for "Palmetto GBA Corporate" and "Palmetto GBA Medicare". The main header includes the Palmetto GBA Medicare logo, navigation links (PALMETTO GBA HOME, CONTACT US, E-MAIL UPDATES, SEARCH), and the CMS logo. Below the header, the user is logged in as "User:" and "Provider: SuperAdmin". A navigation menu contains "Home", "Claims", "Remittance", "Eligibility", "Financial Tools", "Support", "Admin", and "My Account". The "Remittance" tab is highlighted, and a yellow callout box with a green arrow points to it, stating "To access Remittances online, click on the Remittance Tab." Below the navigation menu, the "e-Remittance Lookup" section is visible. It prompts the user to "To view e-Remittances, please enter the following information". There are two radio buttons: "Last 30 Days" (selected) and "Select Specific Range". Under "Select Specific Range", there are "Date From" and "Date To" input fields, each with a calendar icon and a red "X" icon. A green arrow points to these fields with the text "Date of Remittance". Below the input fields are "Submit" and "Clear" buttons. At the bottom, a note states: "Note: A request for remittance over 30 days old may take additional processing time. Thank you for your patience while we process your request. Remittances over 1 year old may not be available."

To access remittances you can choose to view remittances for the last 30 days or for a specific date range. The remittance selection screen defaults to the last 30 days.

The remittance date range will default to 45 days from the beginning date. You can choose a shorter date range. But, you cannot choose a longer date range than 45 days.

5.2 How far back can I view remittances?

SC Part A, SC Part B, NC Part A, WV Part B, J1 Part A, J1 Part B and Railroad Medicare

Remittances are readily available for approximately one year. If you need to retrieve remittances over one year old, Online Provider Services (OPS) may experience a delay. Palmetto GBA does not guarantee that older remittances are available.

Virginia Part B

Virginia Part B remittances are available from approximately March 22, 2010, to the present. Virginia Part B remittances prior to that date will not be available through OPS.

Virginia and West Virginia Part A

Virginia and West Virginia Part A remittances are available beginning approximately May 17, 2011. Virginia and West Virginia Part A remittances prior to that date will not be available through OPS.

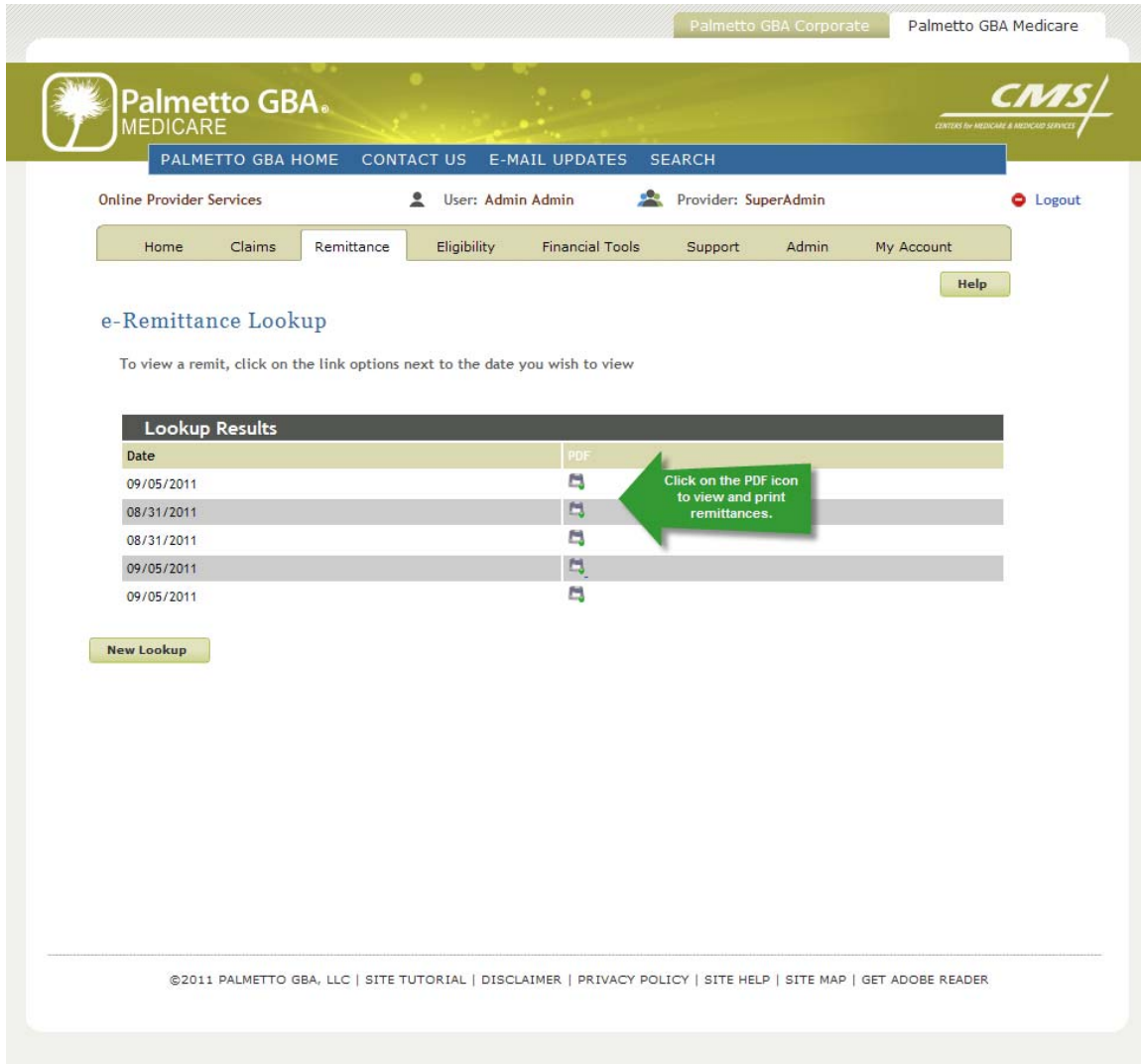
NC Part B

North Carolina Part B remittances are available beginning approximately June 3, 2011. North Carolina Part B remittances prior to that date will not be available through OPS.

5.3 How do I print a remittance?

View your remittance by clicking on the Portable Document Format (PDF) link in the remittance list. You may sort the remittance list by clicking on the date column header. Once your remittance is displayed, click on the print icon in the menu of your Acrobat Reader to print the remittance. If you do not have Acrobat Reader software, you can [download](#) it at no cost. See *Figure 13*.

Figure 13: Remittance Look-up Results



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PALMETTO GBA HOME CONTACT US E-MAIL UPDATES SEARCH

Online Provider Services User: Admin Admin Provider: SuperAdmin Logout

Home Claims **Remittance** Eligibility Financial Tools Support Admin My Account Help

e-Remittance Lookup

To view a remit, click on the link options next to the date you wish to view

Lookup Results	
Date	PDF
09/05/2011	
08/31/2011	
08/31/2011	
09/05/2011	
09/05/2011	

New Lookup

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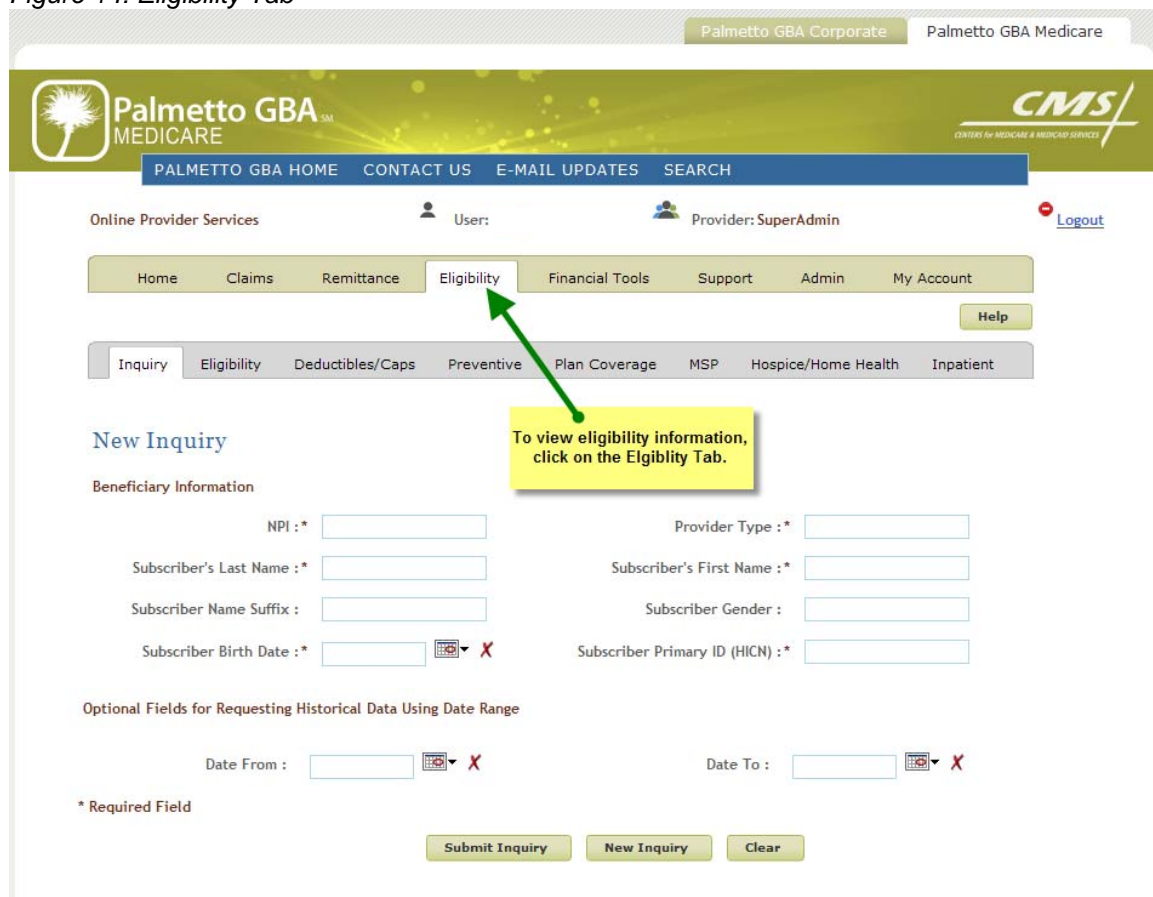
6.0 Eligibility

6.1 How do I use the eligibility function?

When you choose the Eligibility Tab you will see a new set of tabs to display information related to your inquiry. See *Figure 14*. Information is presented on the following tabs:

- Inquiry
- Eligibility
- Deductibles/Caps
- Preventive
- Plan Coverage
- MSP
- Hospice/Home Health
- Inpatient

Figure 14: Eligibility Tab



The screenshot shows the Palmetto GBA Medicare online provider services interface. At the top, there are navigation tabs for "Palmetto GBA Corporate" and "Palmetto GBA Medicare". Below this is a header with the Palmetto GBA Medicare logo and the CMS logo. A navigation bar contains links for "PALMETTO GBA HOME", "CONTACT US", "E-MAIL UPDATES", and "SEARCH".

The main content area shows "Online Provider Services" with a user profile for "User:" and "Provider: SuperAdmin". A "Logout" link is visible. Below this is a horizontal menu with tabs: "Home", "Claims", "Remittance", "Eligibility", "Financial Tools", "Support", "Admin", and "My Account". A "Help" button is also present. Underneath, a secondary menu shows "Inquiry", "Eligibility", "Deductibles/Caps", "Preventive", "Plan Coverage", "MSP", "Hospice/Home Health", and "Inpatient". A green arrow points to the "Eligibility" tab in this secondary menu.

A yellow callout box with the text "To view eligibility information, click on the Eligibility Tab." is positioned over the arrow. Below the callout is the "New Inquiry" form, which includes fields for "Beneficiary Information" (NPI, Subscriber's Last Name, Subscriber Name Suffix, Subscriber Birth Date, Provider Type, Subscriber's First Name, Subscriber Gender, Subscriber Primary ID (HICN)) and "Optional Fields for Requesting Historical Data Using Date Range" (Date From, Date To). A legend indicates that an asterisk (*) denotes a required field. At the bottom of the form are three buttons: "Submit Inquiry", "New Inquiry", and "Clear".

The OPS Eligibility functions are based on the HIPAA Eligibility Transaction System (HETS) and information is retrieved and displayed to mirror the HETS User interface designed by CMS. For more information about the CMS HETS User interface and eligibility guidelines, refer to the Internet [User Guide](#) on CMS' Web site.

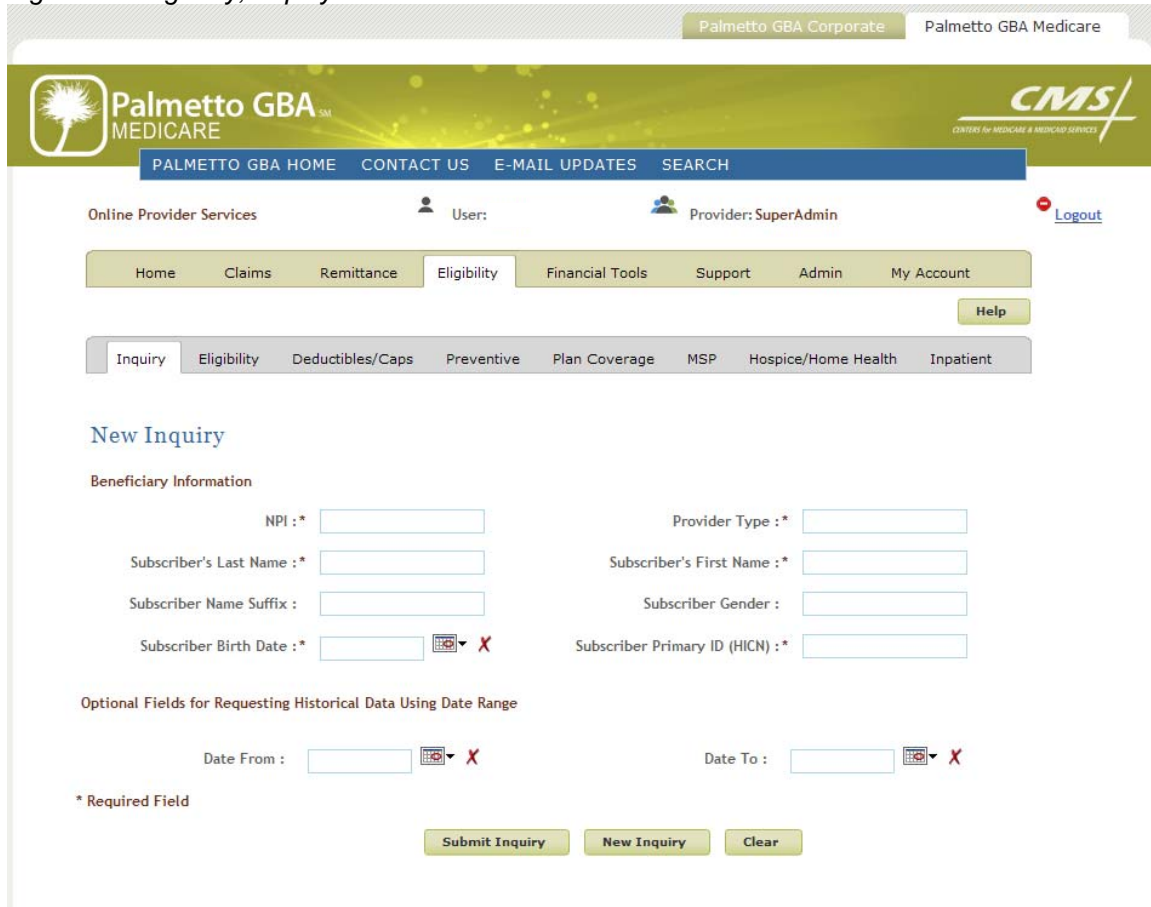
Note: OPS retrieves and displays information from the HETS 270/271 transaction provided by CMS. The Interactive Voice Response unit (IVR) receives data directly from the Medicare Common Working File (CWF). It is possible that the IVR could be updated 24 hours earlier than OPS.

The number of psychiatric days remaining and crossover information are not available through the eligibility function of OPS. Call the IVR for this information.

6.2 How do I successfully perform an eligibility inquiry?

The first step is to perform the inquiry. When you click on the Eligibility Tab, you will be directed to the Inquiry Sub-tab first. You can use the Inquiry Tab to enter beneficiary information and submit a Medicare Beneficiary eligibility request. See *Figure 15*.

Figure 15: Eligibility, Inquiry Tab



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PALMETTO GBA HOME CONTACT US E-MAIL UPDATES SEARCH

Online Provider Services User: Provider: SuperAdmin Logout

Home Claims Remittance Eligibility Financial Tools Support Admin My Account Help

Inquiry Eligibility Deductibles/Caps Preventive Plan Coverage MSP Hospice/Home Health Inpatient

New Inquiry

Beneficiary Information

NPI : * Provider Type : *

Subscriber's Last Name : * Subscriber's First Name : *

Subscriber Name Suffix : Subscriber Gender :

Subscriber Birth Date : * Subscriber Primary ID (HICN) : *

Optional Fields for Requesting Historical Data Using Date Range

Date From : Date To :

* Required Field

Submit Inquiry New Inquiry Clear

The following fields are required:

Subscriber¹ Last Name

Subscriber First Name

Subscriber Birth Date

Subscriber Primary ID (HICN)²

You may enter data into optional fields, but the fields are not required to receive a valid Medicare Beneficiary Eligibility benefit response. The optional fields are as follows:

Subscriber Name Suffix – Even though the suffix is not a required field, the suffix field should be entered if the beneficiary has a suffix printed on their Medicare Health Insurance card. The suffix may be necessary to receive a valid Eligibility response.

Subscriber Gender

Optional Fields for Requesting Historical Data Using Date Range

Note: To retrieve all information available, you should enter a date range. The HETS 270/271 system we are required to access for eligibility allows allow date requests up to 27 months in the past. This matches the timely claim filing limit. In cases of claim appeals or other scenarios which may involve the need for eligibility information older than 27 months, please contact your provider service center. If data entered into an optional field does not match the beneficiary's data maintained by Medicare, eligibility data will not be returned on the eligibility response tabs.

To protect the privacy of beneficiary data, Subscriber last name, Subscriber first name, Subscriber primary ID (HICN), and Subscriber birth date must match the beneficiary's data maintained by Medicare; otherwise, eligibility data will not be returned.

Once you have successfully retrieved the beneficiary's information, all of the other tabs will display information related to that beneficiary.

The OPS Eligibility functions are based on the HIPAA Eligibility Transaction System (HETS) and information is retrieved and displayed to mirror the HETS User interface designed by CMS. For more information about the CMS HETS User interface and eligibility guidelines, refer to the Internet [User Guide](#) on CMS' Web site.

¹ The Subscriber is the patient. The patient is also referred to as a beneficiary by Medicare.

² The Health Insurance Claim Number (HICN) is the Medicare beneficiary identifier assigned by Medicare. When looking at the Medicare Health Insurance card, the HICN is the Medicare Claim Number displayed on the card.

6.3 How do I use the date range optional fields in the Eligibility Inquiry Tab?

The “From Date” and “To Date” fields are optional fields you can input to request beneficiary eligibility data for a specific time period. If no “From Date” or “To Date” is entered, the system will automatically use the current calendar date for the inquiry. You will receive the “Invalid 'From Date' Format” error message when an invalid character or an invalid date is entered on the Medicare Eligibility Benefit Inquiry screen. You are prompted to correct the date and submit a new inquiry.

To make sure you see all of the information, enter a date range. The HETS 270/271 system we are required to access for eligibility allows allow date requests up to 27 months in the past. This matches the timely claim filing limit. In cases of claim appeals or other scenarios which may involve the need for eligibility information older than 27 months, please contact your provider service center.

Based on the “From Date” and “To Date” the system will determine the beneficiary data to display. The application will display an error message if you enter a date and/or date range within one of the following scenarios:

- A “From Date” that is before the date of eligibility and no “To Date” is entered
- A “From Date” that is after the date of termination or date of death
- A specified date range(s) that is outside of the date(s) of eligibility

If you receive the error message because of one of the above scenarios, they should retry the Inquiry leaving the date range fields blank. If the beneficiary is currently eligible for Medicare benefits and the User leaves the date range fields blank, the User will see the Effective and Termination (if applicable) dates of eligibility based on the current calendar date.

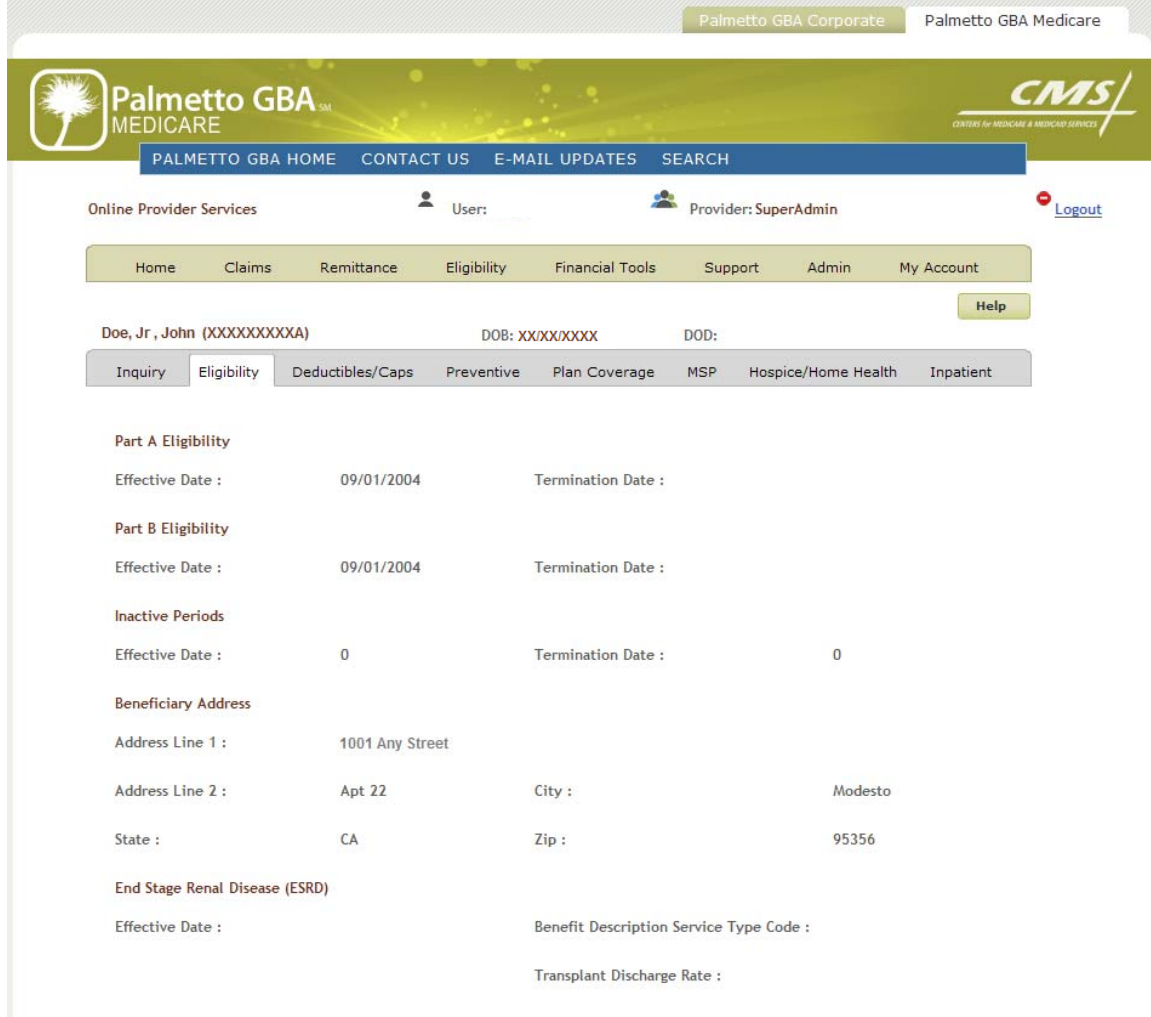
All information provided in the Eligibility tabs is based on what is or is not entered in the date range fields. If you are looking for prior year information, adjust your date ranges accordingly. Information is available for 24 months from the current date.

The OPS Eligibility functions are based on the HIPAA Eligibility Transaction System (HETS) and information is retrieved and displayed to mirror the HETS user interface designed by CMS. For more information about the CMS HETS User interface and eligibility guidelines, refer to the Internet [User Guide](#) on CMS' Web site.

6.4 How do I use the Eligibility Tab?

The Eligibility Tab provides information regarding the beneficiary's Part A and Part B Eligibility, Inactive Periods (e.g. unlawful, deported, and incarcerated), Beneficiary Address, and ESRD. If this tab is available, it indicates that the beneficiary has some type of Medicare Eligibility. If eligible for Medicare benefits, the beneficiary will qualify for either a Part A or a Part B Eligibility period. The ESRD section provides information regarding a beneficiary's eligibility to receive Medicare benefits based on permanent kidney failure requiring dialysis or a kidney transplant. See *Figure 16*.

Figure 16: Eligibility, Eligibility Tab



The screenshot shows the Palmetto GBA Medicare Online Provider Services interface. At the top, there are tabs for 'Palmetto GBA Corporate' and 'Palmetto GBA Medicare'. The main header includes the Palmetto GBA Medicare logo and the CMS logo. Below the header is a navigation bar with links for 'PALMETTO GBA HOME', 'CONTACT US', 'E-MAIL UPDATES', and 'SEARCH'. The user is logged in as 'User: [redacted]' and 'Provider: SuperAdmin'. A 'Logout' link is visible. The main menu includes 'Home', 'Claims', 'Remittance', 'Eligibility', 'Financial Tools', 'Support', 'Admin', and 'My Account'. A 'Help' button is also present. The beneficiary information is displayed as 'Doe, Jr, John (XXXXXXXXXX)' with 'DOB: XX/XX/XXXX' and 'DOD:'. Below this is a sub-menu with 'Inquiry', 'Eligibility', 'Deductibles/Caps', 'Preventive', 'Plan Coverage', 'MSP', 'Hospice/Home Health', and 'Inpatient'. The 'Eligibility' sub-tab is active, showing the following information:

- Part A Eligibility**
 - Effective Date : 09/01/2004
 - Termination Date :
- Part B Eligibility**
 - Effective Date : 09/01/2004
 - Termination Date :
- Inactive Periods**
 - Effective Date : 0
 - Termination Date : 0
- Beneficiary Address**
 - Address Line 1 : 1001 Any Street
 - Address Line 2 : Apt 22
 - City : Modesto
 - State : CA
 - Zip : 95356
- End Stage Renal Disease (ESRD)**
 - Effective Date :
 - Benefit Description Service Type Code :
 - Transplant Discharge Rate :

Note: If either the “Part A Eligibility Benefit” information or “Part B Eligibility Benefit” information does not contain data, it means the beneficiary is not eligible to receive Medicare benefits for the requested period on the inquiry screen. The ESRD section only displays active ESRD data and will not be available if notification has not been received by CMS indicating an ESRD period is active and in effect per the date(s) requested.

The following tables provide information for the Eligibility Benefit tab.

Part A Eligibility Benefit Information

Field Name	Description
Effective Date	A date that indicates the start of eligibility for Medicare Part A benefits
Termination Date	A date that indicates the termination of eligibility for Medicare Part A benefits. No date in this field means Medicare Part A eligibility has not terminated

Part B Eligibility Benefit Information

Field Name	Description
Effective Date	A date that indicates the start of eligibility for Medicare Part B benefits
Termination Date	A date that indicates the termination of eligibility for Medicare Part B benefits. No date in this field means Medicare Part B eligibility has not terminated

Inactive Periods

Field Name	Description
Effective Date	A date that indicates the start of an inactive period due to unlawful, deported, or incarcerated reasons
Termination Date	A date that indicates the end of an inactive period due to unlawful, deported, or incarcerated reasons

Beneficiary Address

Field Name	Description
Address Line 1	The address line 1 of the beneficiary, if available
Address Line 2	The address line 2 of the beneficiary, if available
City	The city of the beneficiary, if available
State	The state of the beneficiary, if available
ZIP	The ZIP code of the beneficiary, if available

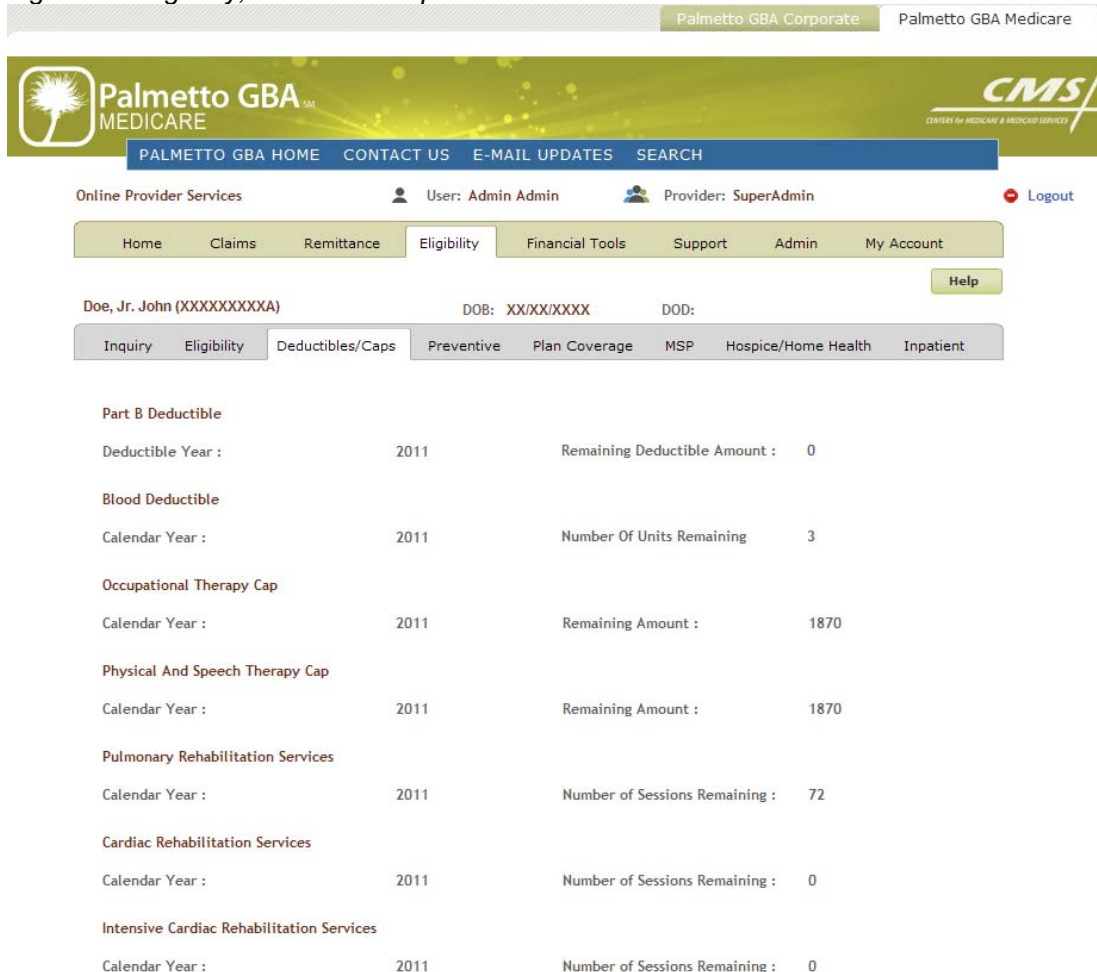
End Stage Renal Disease (ESRD) Information

Field Name	Description
Effective Date	The date that indicates the start of eligibility for ESRD services
Benefit Description Service Type Code	The Type of Dialysis (14 or 15) services that are being rendered
Transplant Discharge Date	The Date the Transplant services were discharged

The OPS Eligibility functions are based on the HIPAA Eligibility Transaction System (HETS) and information is retrieved and displayed to mirror the HETS User interface designed by CMS. For more information about the CMS HETS User interface and eligibility guidelines, refer to the Internet [User Guide](#) on CMS' Web site.

6.5 How do I use the Deductible/Caps Tab?

The Deductibles/Caps tab provides information regarding the beneficiary's Part B Deductibles, Blood Deductibles, Occupational Therapy Cap, and Physical and Speech Therapy Caps. The following tables provide information for the Deductible/Caps Tab. See *Figure 17*.

Figure 17: Eligibility, Deductible/Caps Tab


The screenshot shows the Palmetto GBA Medicare Online Provider Services interface. At the top, there are navigation tabs for "Palmetto GBA Corporate" and "Palmetto GBA Medicare". Below this is a header with the Palmetto GBA Medicare logo and the CMS logo. A navigation bar contains links for "PALMETTO GBA HOME", "CONTACT US", "E-MAIL UPDATES", and "SEARCH".

The main content area shows the user's profile: "User: Admin Admin" and "Provider: SuperAdmin". Below this is a navigation menu with tabs for "Home", "Claims", "Remittance", "Eligibility", "Financial Tools", "Support", "Admin", and "My Account". The "Eligibility" tab is selected, and within it, the "Deductibles/Caps" sub-tab is active.

The "Deductibles/Caps" section displays the following information for beneficiary "Doe, Jr. John (XXXXXXXXXA)":

Service Category	Calendar Year	Remaining Amount / Number of Sessions Remaining
Part B Deductible	2011	Remaining Deductible Amount : 0
Blood Deductible	2011	Number Of Units Remaining : 3
Occupational Therapy Cap	2011	Remaining Amount : 1870
Physical And Speech Therapy Cap	2011	Remaining Amount : 1870
Pulmonary Rehabilitation Services	2011	Number of Sessions Remaining : 72
Cardiac Rehabilitation Services	2011	Number of Sessions Remaining : 0
Intensive Cardiac Rehabilitation Services	2011	Number of Sessions Remaining : 0

The following tables provide information for the Deductible/Caps Tab.

Part B Deductible Information

Field Name	Description
Deductible Year	The calendar year associated with the remaining deductible amount
Remaining Deductible Amount	Medicare Part B remaining deductible amount associated with the calendar year indicated

Blood Deductible Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining deductible amount
Number of Units Remaining	The remaining Blood Deductible units remaining associated with the calendar year indicated

Occupational Therapy Cap Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining capitation amount
Remaining Amount	Occupational Therapy remaining amount associated with the calendar year indicated

Physical and Speech Therapy Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining capitation amount
Remaining Amount	Physical and Speech Therapy remaining amount associated with the calendar year indicated

Pulmonary Rehabilitation Information

Calendar Year	The calendar year associated with the remaining capitation amount
Remaining Amount	Pulmonary rehabilitation services remaining amount associated with the calendar year indicated

Cardiac Rehabilitation Information

Calendar Year	The calendar year associated with the remaining capitation amount
Remaining Amount	Cardiac rehabilitation services remaining amount associated with the calendar year indicated

Intensive Cardiac Rehabilitation Information

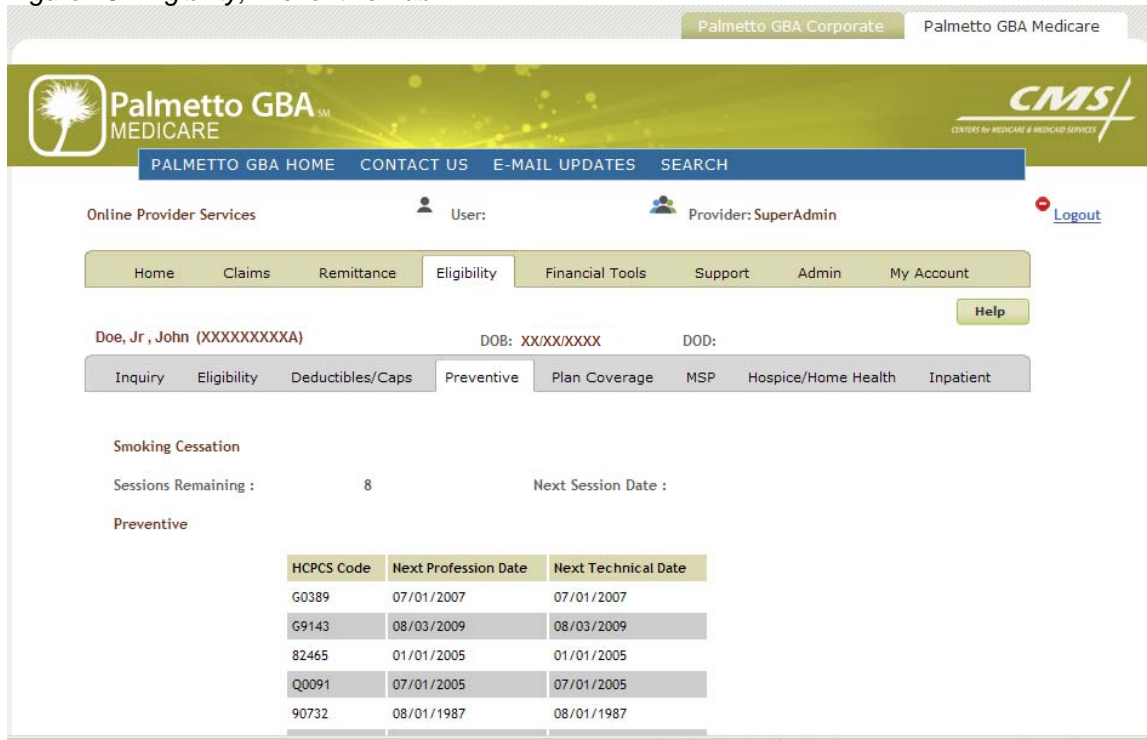
Calendar Year	The calendar year associated with the remaining capitation amount
Remaining Amount	Intensive cardiac rehabilitation services remaining amount associated with the calendar year indicated

The OPS Eligibility functions are based on the HIPAA Eligibility Transaction System (HETS) and information is retrieved and displayed to mirror the HETS User interface designed by CMS. For more information about the CMS HETS User interface and eligibility guidelines, refer to the Internet [User Guide](#) on CMS' Web site.

6.6 How do I use the Preventive Tab?

The Preventive Tab provides information regarding the beneficiary's claims history for Smoking Cessation and Preventive services. The information on the screen is organized into the Healthcare Common Procedure Coding System (HCPCS) categories (e.g. Cardiovascular, Colorectal and Diabetes). See *Figure 18*:

Figure 18: Eligibility, Preventive Tab



The screenshot shows the Palmetto GBA Medicare online provider services interface. The user is logged in as 'SuperAdmin'. The 'Eligibility' tab is selected, and the 'Preventive' sub-tab is active. The interface displays the following information:

- Beneficiary Name: Doe, Jr, John (XXXXXXXXXA)
- DOB: XX/XX/XXXX
- DOD:
- Smoking Cessation: Sessions Remaining: 8, Next Session Date:
- Preventive Services Table:

HCPCS Code	Next Profession Date	Next Technical Date
G0389	07/01/2007	07/01/2007
G9143	08/03/2009	08/03/2009
82465	01/01/2005	01/01/2005
Q0091	07/01/2005	07/01/2005
90732	08/01/1987	08/01/1987

Note: Only HCPCS codes for which a particular beneficiary is eligible will be displayed and grouped together under their appropriate categories. If a service has been rendered, it is removed from the list until closer to the time the beneficiary is eligible to receive the service again. The new preventive codes for annual visits and the welcome to Medicare visit are now available and will display in the list if the beneficiary is eligible for the service.

The Preventive tab also contains a special category called "Unclassified." This category will display any newly added HCPCS code that has not yet been defined.

The following tables provide information for the Preventive Tab.

Smoking Cessation Information

Fields	Description
Sessions Remaining	Number of Smoking Cessation Sessions remaining for a beneficiary
Next Session Date	The next available begin date for Smoking Session program if there are no sessions remaining in their current period

Preventive Information

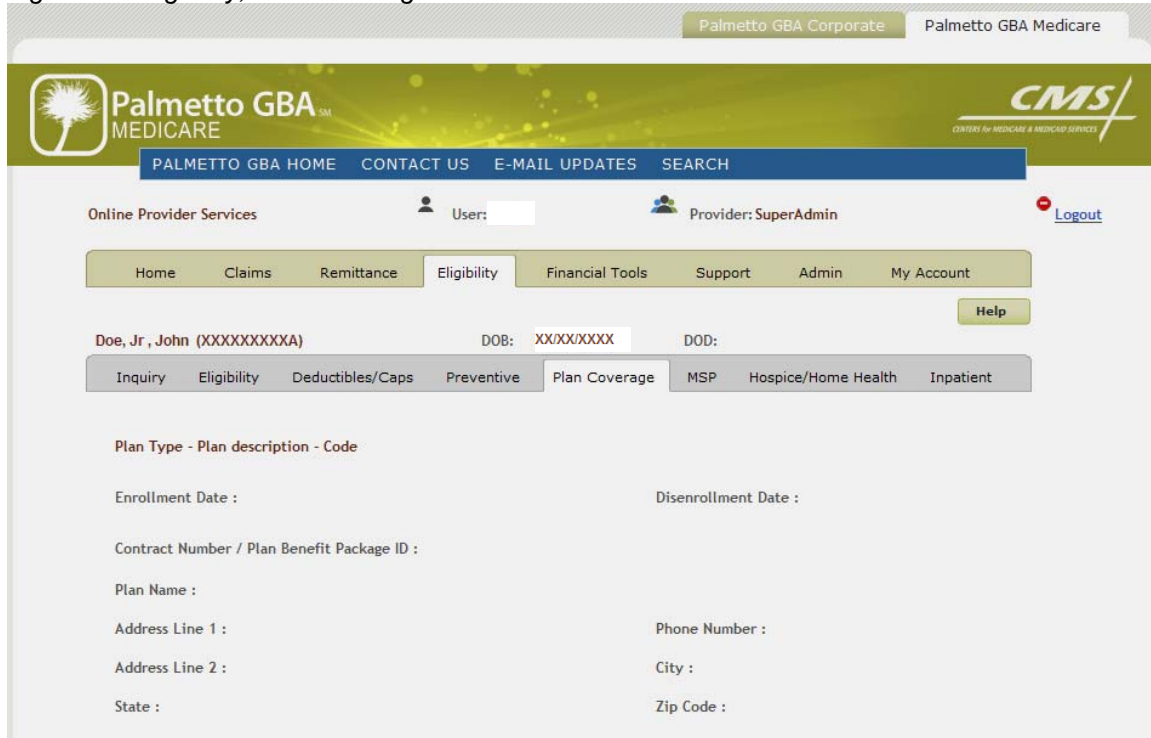
Field Name	Description
HCPCS Code	A Healthcare Common Procedure Coding System (HCPCS) code
Next Professional Date	The date a beneficiary is next eligible for professional services associated with the indicated HCPCS code
Next Technical Date	The date a beneficiary is next eligible for technical services associated with the indicated HCPCS code

The OPS Eligibility functions are based on the HIPAA Eligibility Transaction System (HETS) and information is retrieved and displayed to mirror the HETS User interface designed by CMS. For more information about the CMS HETS User interface and eligibility guidelines, refer to the Internet [User Guide](#) on CMS' Web site.

6.7 How do I use the Plan Coverage Tab?

The Plan Coverage tab provides information regarding the beneficiary's enrollment under MA and Part D contracts and/or MA Managed Care Plans (Part C contracts) that provide Part A and B benefits for beneficiaries enrolled under a contract. See *Figure 19*.

Figure 19: Eligibility, Plan Coverage Tab



The screenshot shows the Palmetto GBA Medicare website interface. At the top, there are tabs for 'Palmetto GBA Corporate' and 'Palmetto GBA Medicare'. Below this is a green header with the Palmetto GBA logo and the CMS logo. A blue navigation bar contains links for 'PALMETTO GBA HOME', 'CONTACT US', 'E-MAIL UPDATES', and 'SEARCH'. The main content area is titled 'Online Provider Services' and includes a user profile section with 'User: [redacted]' and 'Provider: SuperAdmin'. A secondary navigation bar has tabs for 'Home', 'Claims', 'Remittance', 'Eligibility' (which is selected), 'Financial Tools', 'Support', 'Admin', and 'My Account'. Below this, there is a 'Help' button and a section for beneficiary information: 'Doe, Jr, John (XXXXXXXXXA)', 'DOB: XX/XX/XXXX', and 'DOD:'. A third navigation bar has tabs for 'Inquiry', 'Eligibility', 'Deductibles/Caps', 'Preventive', 'Plan Coverage' (which is selected), 'MSP', 'Hospice/Home Health', and 'Inpatient'. The main content area contains several fields for plan information: 'Plan Type - Plan description - Code', 'Enrollment Date :', 'Disenrollment Date :', 'Contract Number / Plan Benefit Package ID :', 'Plan Name :', 'Address Line 1 :', 'Phone Number :', 'Address Line 2 :', 'City :', 'State :', and 'Zip Code :'. Each field is currently empty.

Part D contracts provide prescription drug coverage. Medicare claims for Part D should not be submitted to the fee-for-service Medicare contractor for the period a beneficiary is enrolled under an MA plan because the MA Organization receives capitation payments from Medicare for the beneficiary's medical services.

Note: Whenever the HETS-UI Internet application indicates that a beneficiary has coverage through a non-Medicare entity (MA or Medicare Drug Benefit plans) the inquiring provider should always contact the non-Medicare entity for complete beneficiary entitlement information. All information provided in the Plan Coverage Tab is based on what is or is not entered in the date range fields in the Inquiry Tab. If you are looking for prior year information, adjust your date ranges accordingly. Information is available for 24 months from the current date.

Part C contracts will return whether the MA is a Health Maintenance Organization Medicare Non Risk (HM), a Health Maintenance Organization Medicare Risk (HN), an Indemnity (IN), a Point of Service (PS), a Preferred Provider Organization (PR), or a Pharmacy (Part D). The response will display only the most current plan description (HM, HN, IN, PS, PR, Part D) and Plan Type Code for a contract. This may happen if a contract's plan description and Plan Type Code has changed since the beneficiary originally enrolled. Providers are advised to contact the plans if there is any question about the plan's terms and conditions.

The table below describes the Plan Coverage fields.

Plan Coverage Information

Field Name	Description
Plan Type	A full plan description followed by Plan Type Code: Health Maintenance Organization Medicare Non Risk – HM Health Maintenance Organization Medicare Risk – HN Indemnity – IN Preferred Provider Organization – PR Point of Service – PS Pharmacy – Part D
Enrollment Date	The date that indicates the start of enrollment to the coverage plan
Disenrollment Date	The date that indicates the termination of enrollment to the coverage. No date in this field means the plan enrollment has not terminated.
Contract Number/Plan Benefit Package ID	The contract number followed by the plan number (if on file)

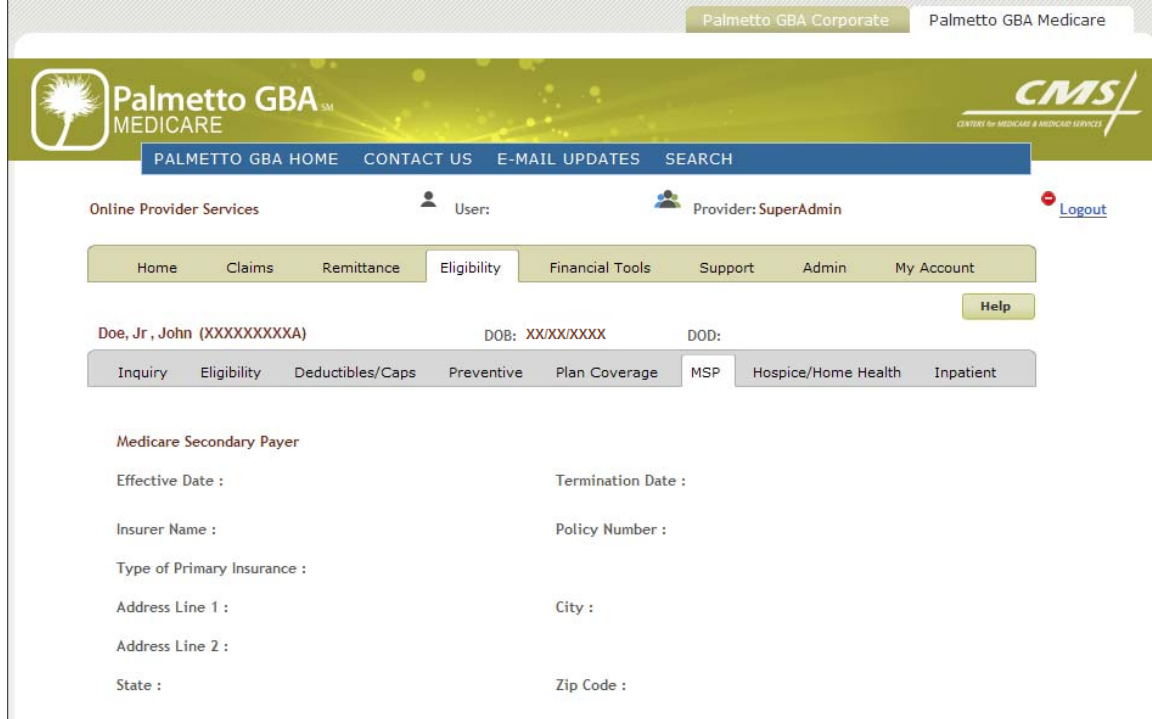
Plan Name	A descriptive name of the beneficiary's insurance coverage organization
Address Line 1	The Coverage Plan's Address Line 1
Phone Number	The Coverage Plan's Contract Telephone Number (if on file) displayed as XXX-XXX-XXXX
Address Line 2	The Coverage Plan's Address Line 2
City	The Coverage Plan's City Address
State	The Coverage Plan's State Address
ZIP Code	The Coverage Plan's ZIP Code

The OPS Eligibility functions are based on the HIPAA Eligibility Transaction System (HETS) and information is retrieved and displayed to mirror the HETS User interface designed by CMS. For more information about the CMS HETS User interface and eligibility guidelines, refer to the Internet [User Guide](#) on CMS' Web site.

6.8 How do I use the MSP Tab?

When a beneficiary has a primary payer other than Medicare, the Medicare Secondary Payer (MSP) Tab provides the beneficiary's primary insurance information. See *Figure 20*.

Figure 20: Eligibility, MSP Tab



The screenshot shows the Palmetto GBA Medicare website interface. At the top, there are tabs for 'Palmetto GBA Corporate' and 'Palmetto GBA Medicare'. Below this is a green header with the Palmetto GBA Medicare logo and the CMS logo. A navigation bar contains links for 'PALMETTO GBA HOME', 'CONTACT US', 'E-MAIL UPDATES', and 'SEARCH'. Below the navigation bar, there are user-related links: 'Online Provider Services', 'User:', 'Provider: SuperAdmin', and a 'Logout' button. A secondary navigation bar includes 'Home', 'Claims', 'Remittance', 'Eligibility', 'Financial Tools', 'Support', 'Admin', and 'My Account'. A 'Help' button is also present. The main content area shows a beneficiary name 'Doe, Jr, John (XXXXXXXXXA)', 'DOB: XXXXXXXX', and 'DOD:'. Below this is a tabbed menu with 'MSP' selected. The MSP section is titled 'Medicare Secondary Payer' and contains several fields for data entry: 'Effective Date', 'Termination Date', 'Insurer Name', 'Policy Number', 'Type of Primary Insurance', 'Address Line 1', 'City', 'Address Line 2', 'State', and 'Zip Code'.

Note: The MSP tab only displays active MSP data per the date(s) requested and will not be accessible if there is no MSP data or if notification of coverage primary to Medicare has not been received by CMS. To make sure you see all of the information, enter a date range in the inquiry screen. The HETS 270/271 system we are required to access for eligibility allows allow date requests up to 27 months in the past. This matches the timely claim filing limit. In cases of claim appeals or other scenarios which may involve the need for eligibility information older than 27 months, please contact your provider service center.

The following table describes the MSP fields.

MSP Information

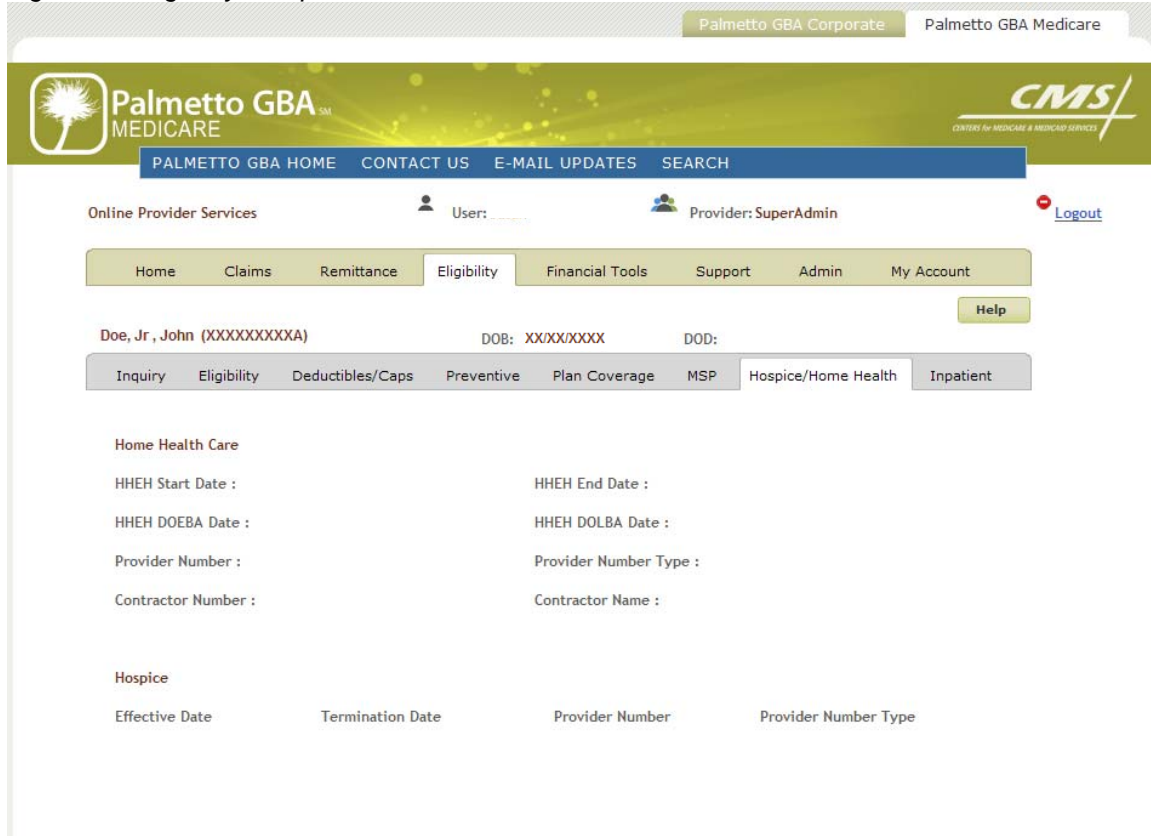
Field Name	Description
Effective Date	The date that indicates the start of the primary insurer's coverage
Termination Date	The date that indicates the termination of the primary insurer's coverage. No date in this field means primary insurance coverage has not terminated
Insurer Name	The name of the insurance company
Policy Number	The primary insuring organization's policy number for the Medicare beneficiary
Type of Primary Insurance	12 = Medicare Secondary Working Aged Beneficiary or spouse with Employer Group Health Plan 13 = Medicare Secondary End Stage Renal Disease Beneficiary in the 12 month coordination period with an Employer Group Health Plan 14 = Medicare Secondary No-Fault insurance including auto is primary 15 = Medicare Secondary Workers' Compensation 16 = Medicare Secondary Public Health Service (PHS) or other Federal Agency 41 = Medicare Secondary Black Lung 42 = Medicare Secondary Veteran's Administration 43 = Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan 47 = Medicare Secondary other liability insurance is primary WC = Workers' Compensation Medicare Set-aside Arrangement
Address Line 1	The address Line 1 of the insurance company
Address Line 2	The address Line 2 of the insurance company
City	The city of the insurance company
State	The state of the insurance company
ZIP Code	The ZIP code of the insurance company

The OPS Eligibility functions are based on the HIPAA Eligibility Transaction System (HETS) and information is retrieved and displayed to mirror the HETS User interface designed by CMS. For more information about the CMS HETS User interface and eligibility guidelines, refer to the Internet [User Guide](#) on CMS' Web site.

6.9 How do I use the Hospice/Home Health Tab?

The Hospice/Home Health Tab includes two sections: 1) Hospice and 2) Home Health. See Figure 21.

Figure 21: Eligibility, Hospice/Home Health Tab



The screenshot displays the Palmetto GBA Medicare online provider services interface. At the top, there are links for 'Palmetto GBA Corporate' and 'Palmetto GBA Medicare'. The main header includes the Palmetto GBA Medicare logo and the CMS logo. Below the header is a navigation bar with links for 'PALMETTO GBA HOME', 'CONTACT US', 'E-MAIL UPDATES', and 'SEARCH'. The user is logged in as 'SuperAdmin'. The 'Eligibility' tab is selected, showing a patient profile for 'Doe, Jr, John' with fields for 'DOB: XX/XX/XXXX' and 'DOD:'. Below the profile, there are tabs for 'Inquiry', 'Eligibility', 'Deductibles/Caps', 'Preventive', 'Plan Coverage', 'MSP', 'Hospice/Home Health', and 'Inpatient'. The 'Hospice/Home Health' tab is active, showing two sections: 'Home Health Care' and 'Hospice'. The 'Home Health Care' section has fields for 'HHEH Start Date', 'HHEH End Date', 'HHEH DOEBA Date', 'HHEH DOLBA Date', 'Provider Number', 'Provider Number Type', 'Contractor Number', and 'Contractor Name'. The 'Hospice' section has a table with columns for 'Effective Date', 'Termination Date', 'Provider Number', and 'Provider Number Type'.

The Home Health section provides information for each episode start and end date and the corresponding billing activity dates. Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing of all Home Health services while a beneficiary is under a Home Health plan of care authorized by a physician. Consequently, Medicare payment for all such items and services must be made to a single Home Health Agency (HHA) overseeing that plan. This HHA is known as the primary HHA for Home Health Prospective Payment System (HHPPS) billing purposes. There is no limit to the number of non-overlapping episodes a beneficiary who remains eligible for the Home Health benefit can receive.

The Hospice section provides eligibility information when the hospice benefit is effective and when it terminates. When Hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of their terminal illness during any period their hospice benefit election is in effect, except for professional services of an attending physician, which may include a nurse practitioner. If the attending physician, who may be a nurse practitioner, is an employee of the designated hospice provider, they may not receive compensation from the Hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the Hospice.

Keep in mind that all individual hospice episode periods under the same provider for a given patient are concatenated together. This means you will see only one effective date for that period, regardless of the individual episode dates under that provider. If the patient has any gap in their episode of care or changes providers at any time, or if their hospice provider has sent the final claim revoking hospice care, you will see more than just a single effective date being returned. Once the final claim has been submitted, the hospice termination (or revocation) date is returned. If the patient is still in hospice care, but has changed providers, the start and termination date with each provider will be returned. Therefore, if no termination date is returned it is to be assumed that the patient is still under hospice care as no claim has yet been processed that revokes that period of care.

These physician professional services are billed to Medicare Part A by the Hospice. The HETS-UI system will return separate Hospice Periods if a Medicare beneficiary had two (or more) periods at different Hospice Providers on contiguous days. Each Hospice Period will be returned separately, including the unique Hospice Provider Number.

Note: The Hospice/Home Health tab only displays active Hospice and/or Home Health data and will not be accessible when there have been no claims received by CMS indicating Hospice or Home Health coverage is active and is in effect per the date(s) requested. To make sure you see all of the information, enter a date range in the inquiry screen. The HETS 270/271 system we are required to access for eligibility allows allow date requests up to 27 months in the past. This matches the timely claim filing limit. In cases of claim appeals or other scenarios which may involve the need for eligibility information older than 27 months, please contact your provider service center.

The tables below describe the Home Health and Hospice Information fields.

Home Health Information

Field Name	Description
HHEH Start Date	The date the 60-day Home Health episode period started
HHEH End Date	The date that the Home Health episode terminated.
HHEH DOEBA Start Date	The date of earliest billing activity for spell of illness
HHEH DOLBA End Date	The date of latest billing activity for spell of illness
Provider Number	The NPI or Legacy Provider Number of the Home Health Facility
Provider Number Type	A display of "Legacy" or "NPI" depending on the source of the provider number
Contract Name	A display of the Contract name

Hospice Information

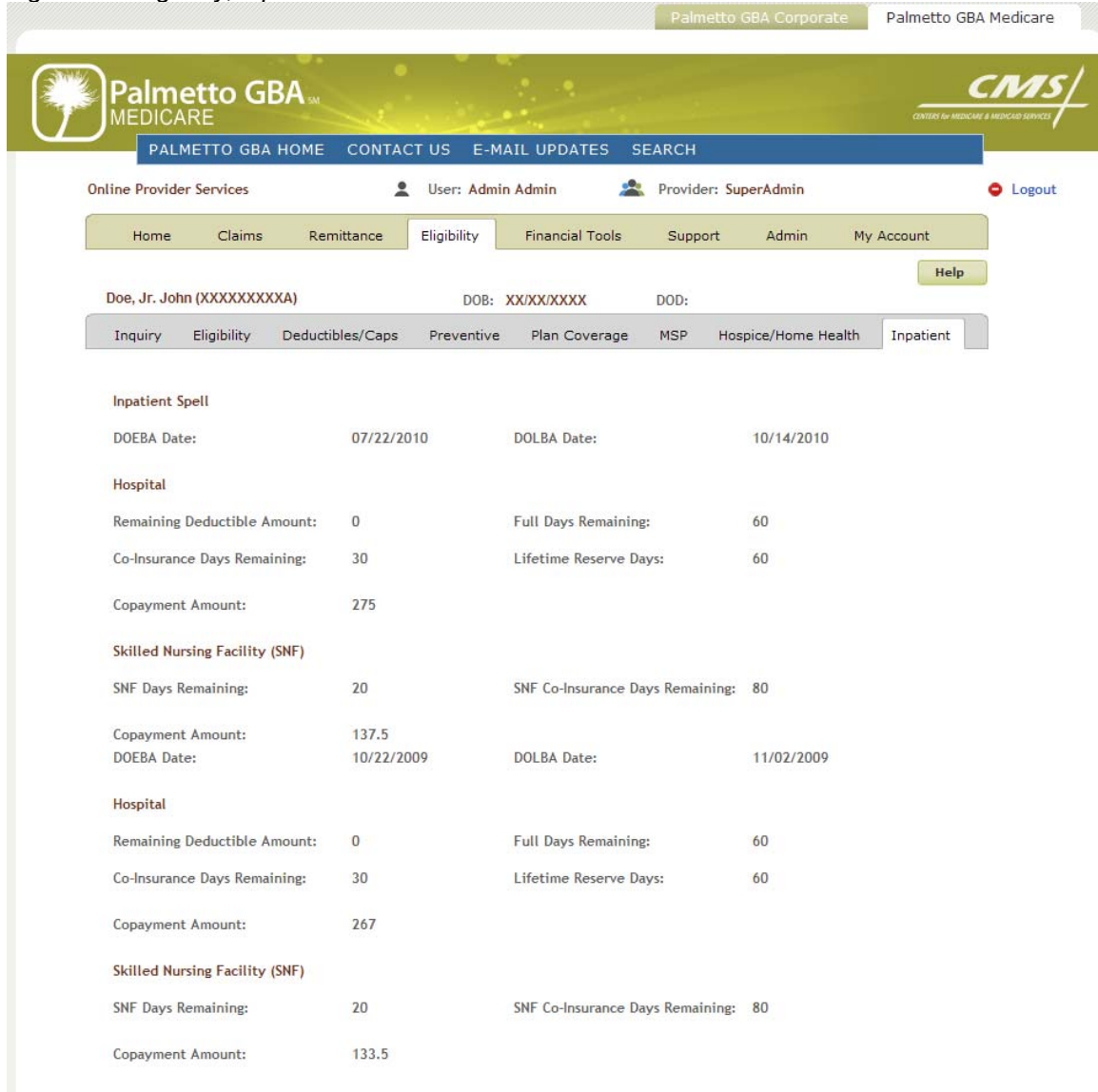
Field Name	Description
Effective Date	The start date of a beneficiary's elected period of Hospice coverage
Termination Date	The termination date of a beneficiary's elected Hospice coverage. No date in this field means the beneficiary's elected period of Hospice coverage has not terminated
Provider Number	The NPI or Legacy provider number of the Hospice Facility
Provider Number Type	A display of "Legacy" or "NPI" depending on the source of the provider number

The OPS Eligibility functions are based on the HIPAA Eligibility Transaction System (HETS) and information is retrieved and displayed to mirror the HETS User interface designed by CMS. For more information about the CMS HETS User interface and eligibility guidelines, refer to the Internet [User Guide](#) on CMS' Web site.

6.10 How do I use the Inpatient Tab?

The Inpatient Tab includes Hospital and Skilled Nursing Facility (SNF) sections. The Hospital section provides hospital benefit and billing information. The SNF section provides SNF benefit and billing information.
See *Figure 22*.

Figure 22: Eligibility, Inpatient Tab



The screenshot displays the Palmetto GBA Medicare online provider services interface. At the top, there are tabs for 'Palmetto GBA Corporate' and 'Palmetto GBA Medicare'. The main header features the Palmetto GBA Medicare logo and the CMS logo. Below the header is a navigation bar with links for 'PALMETTO GBA HOME', 'CONTACT US', 'E-MAIL UPDATES', and 'SEARCH'. The user is logged in as 'Admin Admin' with the role of 'SuperAdmin'. The 'Eligibility' tab is selected, and the 'Inpatient' sub-tab is active. The interface shows details for 'Doe, Jr. John (XXXXXXXXXX)' with a DOB of 'XX/XX/XXXX'. The 'Inpatient Spell' section displays the following information:

Section	Item	Value	Item	Value
Inpatient Spell	DOEBA Date:	07/22/2010	DOLBA Date:	10/14/2010
	Hospital			
Hospital	Remaining Deductible Amount:	0	Full Days Remaining:	60
	Co-Insurance Days Remaining:	30	Lifetime Reserve Days:	60
	Copayment Amount:	275		
Skilled Nursing Facility (SNF)				
Skilled Nursing Facility (SNF)	SNF Days Remaining:	20	SNF Co-Insurance Days Remaining:	80
	Copayment Amount:	137.5		
	DOEBA Date:	10/22/2009	DOLBA Date:	11/02/2009
Hospital				
Hospital	Remaining Deductible Amount:	0	Full Days Remaining:	60
	Co-Insurance Days Remaining:	30	Lifetime Reserve Days:	60
	Copayment Amount:	267		
Skilled Nursing Facility (SNF)				
Skilled Nursing Facility (SNF)	SNF Days Remaining:	20	SNF Co-Insurance Days Remaining:	80
	Copayment Amount:	133.5		

The system will return Hospital default deductibles based on the request start year when the following occurs:

- No Inpatient Spell data returned from the database overlaps or falls within 60 days of the requested date (range)
- Entitlement period and request date period overlap
- Part A Entitlement start year is less than the requested start year

In addition, the system will continue to return the Hospital Inpatient Default Deductible Remaining amounts, Hospital Co-Payment days, and SNF (Skilled Nursing Facility) Co-Payment days based on the beneficiary's Part A Entitlement start year when the following occurs:

- No Inpatient Spell data returned from the database overlaps or falls within 60 days of the requested date (range)
- Entitlement period and request date period overlap
- Part A Entitlement start year is greater than or equal to the requested start year

Note: Depending on the date(s) range requested, multiple Hospital and SNF spells might be displayed. The data returned on this screen is directly impacted by timely submission of claims by the provider. The data returned is compiled from claims that have been processed by CWF. To make sure you see all of the information, enter a date range in the inquiry screen. The HETS 270/271 system we are required to access for eligibility allows allow date requests up to 27 months in the past. This matches the timely claim filing limit. In cases of claim appeals or other scenarios which may involve the need for eligibility information older than 27 months, please contact your provider service center.

If a single Hospital/SNF spell spans more than one calendar year, OPS will return the daily copayment amounts associated with the beginning year of the spell.

If there is no Hospital/SNF spell within 60 days of the requested date(s) of service, OPS will return default values for Part A Spell data.

The tables below describe the Inpatient Tab fields.

Inpatient Spell Information

Field Name	Description
DOEBA Date	The date of earliest billing activity for the spell of illness
DOLBA Date	The date of latest billing activity for spell of illness

Hospital Information

Field Name	Description
Remaining Deductible Amount	The amount of the inpatient deductible remaining to be met
Full Days Remaining	The full Hospital inpatient days remaining in the spell
Co-Payment Days Remaining	The Hospital inpatient co-payment days remaining
Lifetime Reserve Days	The number of lifetime reserve days remaining
Copayment Amount	Copayment amount remaining

SNF Information

Field Name	Description
SNF Days Remaining	The number of SNF days remaining
SNF Co-Payment Days Remaining	The number of SNF co-payment days remaining
Copayment Amount	Copayment amount remaining

The OPS Eligibility functions are based on the HIPAA Eligibility Transaction System (HETS) and information is retrieved and displayed to mirror the HETS User interface designed by CMS. For more information about the CMS HETS User interface and eligibility guidelines, refer to the Internet [User Guide](#) on CMS' Web site.

6.11 When to Call the IVR

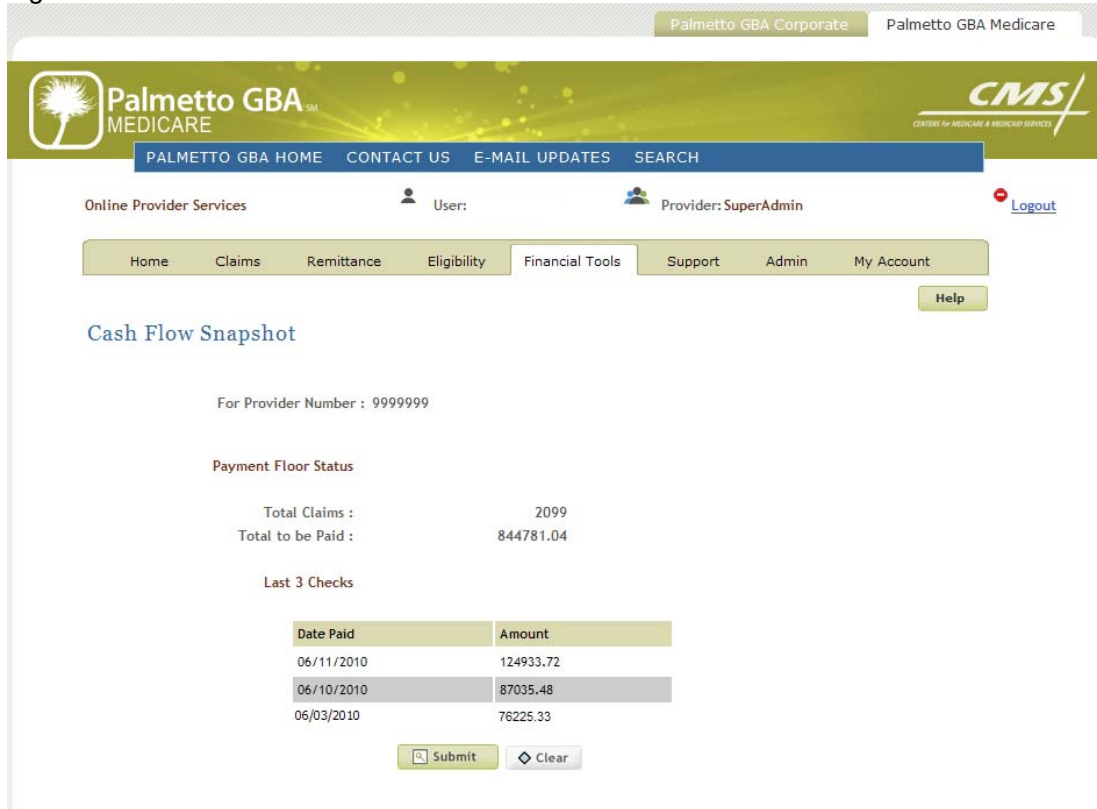
The number of psychiatric days remaining and crossover information are not available through the eligibility function of OPS. Call the IVR for this information.

7.0 Financial Tools

7.1 How do I use the Financial Tools Tab?

Click on the Financial Tools Tab to inquire about your Payment Floor Status and Last 3 Checks paid. When you first access the screen there will be no information. Click Submit and information will be retrieved. See *Figure 23*.

Figure 23: Financial Tools Tab



Palmetto GBA Corporate Palmetto GBA Medicare

Palmetto GBA
 MEDICARE

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PALMETTO GBA HOME CONTACT US E-MAIL UPDATES SEARCH

Online Provider Services User: Provider: SuperAdmin Logout

Home Claims Remittance Eligibility **Financial Tools** Support Admin My Account Help

Cash Flow Snapshot

For Provider Number : 9999999

Payment Floor Status

Total Claims : 2099
 Total to be Paid : 844781.04

Last 3 Checks

Date Paid	Amount
06/11/2010	124933.72
06/10/2010	87035.48
06/03/2010	76225.33

Submit Clear

Virginia Part B providers will see the last three checks received, which are approximately 90 prior to March 19, 2011. This view will include only the checks received during that time.

7.2 What is the payment floor amount?

Medicare contractors are required to hold payments for a minimum predetermined number of days. The payment floor for electronic claims is 14 days, and the payment floor for paper claims is 29 days. This tab refers to all claims in process and awaiting the payment floor as of the date of the look-up. These are payments that have been approved but have not yet been released for payment.

9.0 Administration

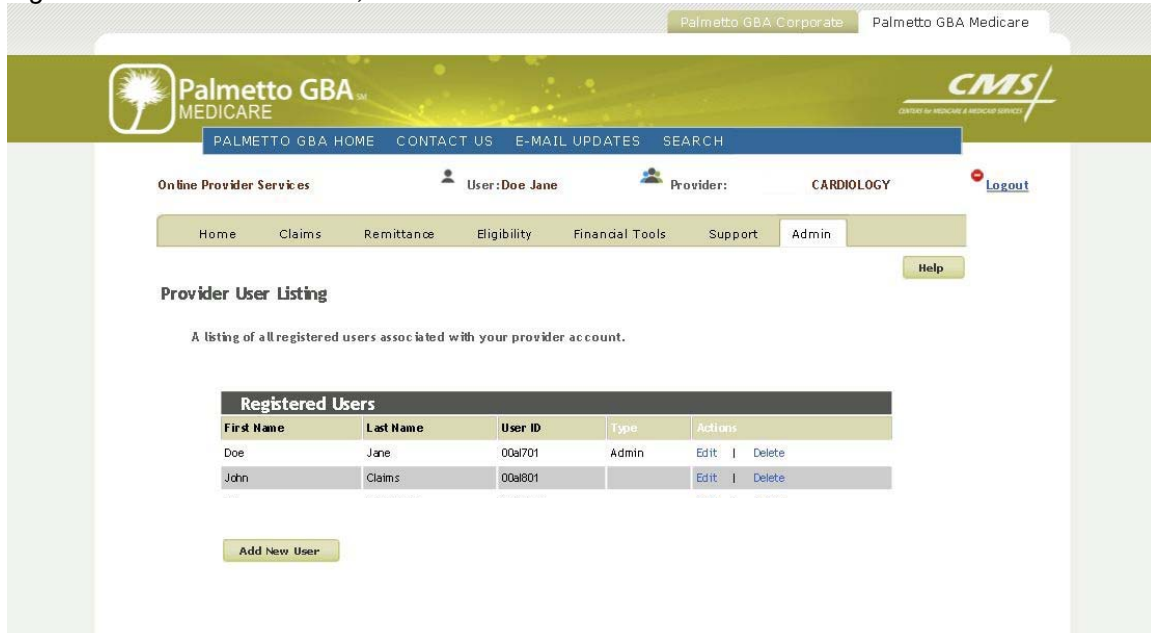
9.1 User Administration Tab Information

The person who registers is the Provider Administrator. ONLY ONE Provider Administrator can register per NPI/PTAN. Provider Administrators have access to the Admin Tab. Through this function, they can administer users. The Provider Administrator grants access for users (Provider Users) to access, view and print from this Web site the information related to said Provider. This includes the following:

- Creating the Provider User
- Assigning a temporary password to the Provider User
- Assigning application permissions to the Provider User
- Creating additional Provider Administrators
- Modifying the Provider User profile
- Terminating the Provider User or additional Provider Administrator

Any access granted and maintained by the Provider Administrator is the sole responsibility of that Provider Administrator. Palmetto GBA has no responsibility for maintaining Provider User access and permission to the data assigned to them by the Provider Administrator. See *Figures 24, 25 and 26.*

Figure 24: Administration Tab, List of Provider Users

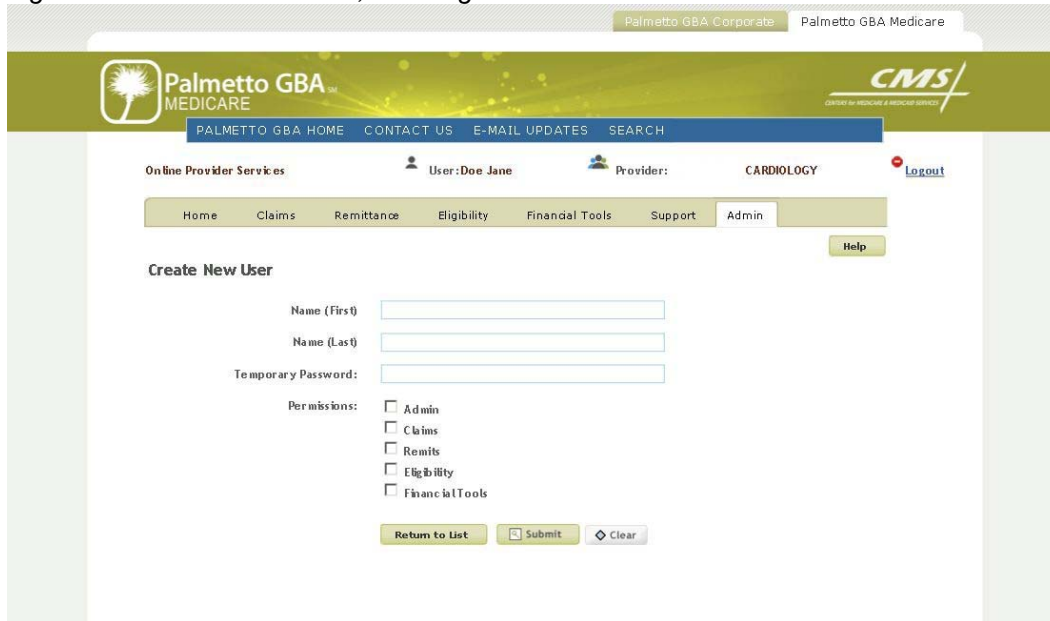


The screenshot shows the Palmetto GBA Medicare Administration interface. At the top, there are tabs for 'Palmetto GBA Corporate' and 'Palmetto GBA Medicare'. The main header includes the Palmetto GBA Medicare logo and the CMS logo. Below the header is a navigation bar with links for 'PALMETTO GBA HOME', 'CONTACT US', 'E-MAIL UPDATES', and 'SEARCH'. The user is logged in as 'User: Doe Jane' and is viewing the 'Admin' tab. The 'Admin' tab has sub-links for 'Home', 'Claims', 'Remittance', 'Eligibility', 'Financial Tools', 'Support', and 'Admin'. A 'Help' button is also visible. The main content area is titled 'Provider User Listing' and contains the text: 'A listing of all registered users associated with your provider account.' Below this text is a table titled 'Registered Users' with the following data:

First Name	Last Name	User ID	Type	Actions
Doe	Jane	00a1701	Admin	Edit Delete
John	Claims	00a1801		Edit Delete

Below the table is an 'Add New User' button.

Figure 24: Administration Tab, Creating a New User

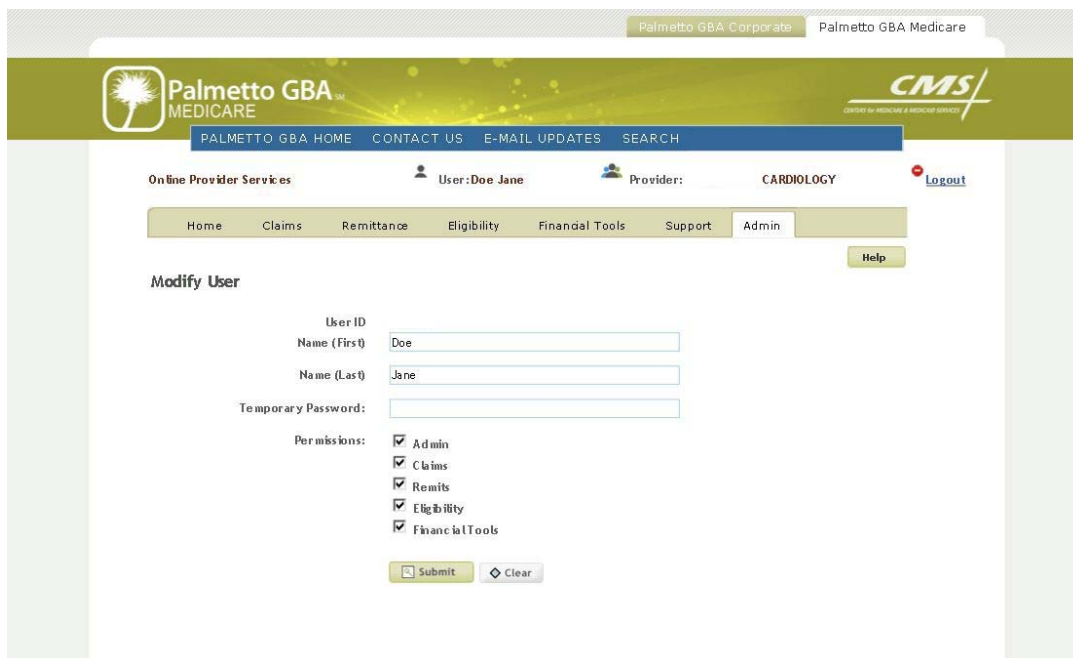


The screenshot shows the 'Create New User' form in the Palmetto GBA Medicare Administration Tab. The page header includes the Palmetto GBA Medicare logo and the CMS logo. The navigation bar contains links for Home, Claims, Remittance, Eligibility, Financial Tools, Support, Admin, and Help. The user is logged in as 'User: Doe Jane' with a provider of 'CARDIOLOGY'. The form fields are:

- Name (First): [Text Input]
- Name (Last): [Text Input]
- Temporary Password: [Text Input]
- Permissions:
 - Admin
 - Claims
 - Remits
 - Eligibility
 - Financial Tools

Buttons at the bottom include 'Return to List', 'Submit', and 'Clear'.

Figure 25: Administration Tab, Modifying a User



The screenshot shows the 'Modify User' form in the Palmetto GBA Medicare Administration Tab. The page header and navigation bar are identical to Figure 24. The user is logged in as 'User: Doe Jane' with a provider of 'CARDIOLOGY'. The form fields are:

- User ID: [Text Input]
- Name (First): [Text Input] (value: Doe)
- Name (Last): [Text Input] (value: Jane)
- Temporary Password: [Text Input]
- Permissions:
 - Admin
 - Claims
 - Remits
 - Eligibility
 - Financial Tools

Buttons at the bottom include 'Submit' and 'Clear'.

A Provider User may be granted administrative access by the Provider Administrator. Keep in mind that Provider Administrators have access to all functions of Online Provider Services. Granting administrative access to a Provider User also gives them access to all functions, including the ability to delete the original Provider Administrator. The Provider Administrator will receive the Provider User's User ID and create a temporary password for the Provider User. The Provider Administrator is responsible for giving the Provider User their User ID password.

If a user does not know who their Provider Administrator is, they need to contact your Provider's staff to find out if they have registered to the system and who is designated as the provider administrator.

Provider Administrators can create and delete additional Provider Administrators. These administrators have access to all functions of the application, including the ability to modify or delete the original Provider Administrator. Provider Administrators can see who is designated as Provider Administrators on the Admin Tab.

If you are a provider administrator and are leaving the office, or are no longer functioning as the provider administrator, you must assign an additional provider administrator before leaving the role. Once a new provider administrator is assigned, he or she can login and delete the old provider administrator or change the provider administrator to a provider user by deselecting the Admin box in the role selections of the user's profile. Do not delete the provider administrator before assigning an additional provider administrator. If you do this, your record must be removed and you must register again. If your provider administrator has left and you did not designate a new provider administrator, your registration record will be removed and you must register again. To request that your record be removed, please contact the TSC at (866) 749-4301.

Palmetto GBA has the right to terminate any user's access if suspicious or improper activity is determined. Access may be terminated without notice.

9.2 Who is my Provider Administrator?

If you do not know who your Provider Administrator is, contact your Provider's staff to find out if they have registered to the system and who is designated as the provider administrator.

If you are a Provider Administrator, you can see who is designated as Provider Administrators on the Admin Tab.

Palmetto GBA has the right to terminate any user's access if suspicious or improper activity is suspected or determined. Access may be terminated without notice.

9.3 How do I change the Provider Administrator?

If you are a Provider Administrator and are leaving the office, or are no longer functioning as the Provider Administrator, you must assign an additional Provider Administrator before leaving the role. Once a new Provider Administrator is assigned, he or she can login and delete the old Provider Administrator or change the Provider Administrator to a Provider User by deselecting the Admin box in the role selections of the user's profile.

Do not delete the Provider Administrator before assigning an additional Provider Administrator. If you do this, your record must be removed and you must register again. If your Provider Administrator is no longer available and you did not designate a new Provider Administrator, your registration record will be removed and you must register again.

To request that your record be removed, please contact the TSC at (866) 749-4301.