Online Provider Services
Frequently Asked Questions (FAQs)
Rev. 5/19/2010

General Information

1. What is Online Provider Services (OPS)?

OPS is an Internet-based, provider self-service secure application. 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)

2. How much does Online Provider Services (OPS) cost?

OPS is a free! There is no cost to the provider for using this online tool.

3. Who can participate in 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/PTAN performs the registration process. The Provider Administrator grants permissions to additional users related to that PTAN.

4. How do I report misuse or suspicious use of the system?

If you suspect misuse or suspicious use of the system, contact the Technical Support Center (TSC) at (866) 749-430 immediately.

5. How do I contact Technical Support?

Please use these Frequently Asked Questions 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.

If you have an inquiry about the claims information, remittances, financial data displayed or eligibility information displayed, contact your Provider Contact Center (PCC).

Registration

1. How do I register for 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

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.

Note: You must register for each PTAN. If you have multiple PTAN's associated with an NPI, you must register each PTAN. Each PTAN will have a unique User ID.

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 @#$)
- 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 twice in a row

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 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.

3. Someone from my office has already registered, how do I get access?
You must Contact your Provider Administrator to request access to the system.

4. 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.

5. I am having trouble with my registration, what do I do?
Only one Provider Administrator per provider can register for Online Provider Services (OPS). If and 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.

Login

1. 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.

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 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.

2. Once I login, some of my tabs are grayed out or cannot be accessed, what do 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.

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.

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.

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. You can answer your security question correctly to reset your password.

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.

6. I am locked out of OPS, what do I do?

If you try to login to the system three times unsuccessfully, you will be locked out of the system for one (1) hour. If you are locked out three times in a row, your access will be revoked. You must contact your Provider Administrator. 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.

7. I cannot answer my security question, what do 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.

8. 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 can answer your security question correctly to reset your password.

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.

Claims Status

1. 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 are inputting 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 are smaller date range. But, you are 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.

2. 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.

3. 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 are smaller date range. But, you are cannot choose a larger date range than 45 days.

4. 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.

Remittances

1. I do not see remittances online for the date range I have chosen, what should I do?
If you have chosen to view remittances for the last 30 days, you will only see only those remittances. If no remittances are displayed, you may want to select a specific date range. f

The OPS application will default the date range to 45 days. This is the best date range to use. If you choose a larger date range, it may take significantly longer to retrieve your list of remittances. If you are requesting an unusually large date range, your browser may time out before you receive the response and your remittances will not appear.

Remittances are available 1 year. However, retrieving remittances older than 6 months may take additional time. In some cases, you may be able to retrieve remittances over 1 year old, however we do not guarantee that these are available at all times.

2. I only see remittances listed for the last 30 days, where are the rest of my remittances?
The remittances selection screen defaults to the last 30 days. If you wish to expand this date range, return to the remit entry screen and choose the option to enter a date range. Enter the date range and click submit.

3. How far back can I look for remittance information?
Remittances are available 1 year. However, retrieving remittances older than 6 months may take additional time. In some cases, you may be able to retrieve remittances over 1 year old, however we do not guarantee that these are available at all times.

4. How do I print a Remittance?
Click on the Printer icon in the Print column of the list. The remit for the date chosen will display in its own window with a printer button at the top of the screen. Click that button to print your remit.

Eligibility

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. Information is presented on the following tabs:

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

The OPS Eligibility functions are based on the HIPPA 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.

Number of psychiatric days remaining and crossover information is not available through the eligibility function of OPS. Call the IVR for this information.

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. The User should enter a beneficiary's information into the fields listed below. The following fields are required:

Subscriber[1] 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: 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 tab.

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 retrieves the beneficiary's information, all of the other tabs will display information related to that beneficiary.

For a document summarizing all OPS eligibility functions, refer to the Palmetto GBA OPS Online Eligibility User Guide.

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[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.

3. How Do I Use the date range optional fields in the Eligibility Inquiry Screen?
The "From Date" and "To Date" fields are optional fields the User 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.
A User 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. The user is prompted to correct the date and submit a new inquiry.
Based on the "From Date" and "To Date" the system will determine the beneficiary data to display. The application will display a "Beneficiary is Inactive" error message if the User enters 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 the User receives the "Beneficiary is Inactive" 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.

For a document summarizing all OPS eligibility functions, refer to the Palmetto GBA OPS Online Eligibility User Guide.

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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.

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

For a document summarizing all OPS eligibility functions, refer to the Palmetto GBA OPS Online Eligibility User Guide.

The OPS Eligibility functions are based on the HIPPA 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.

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.

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

For a document summarizing all OPS eligibility functions, refer to the Palmetto GBA OPS Online Eligibility User Guide.

The OPS Eligibility functions are based on the HIPPA 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. How Do I Use the Preventive Tab?
The Preventive Tab provides information regarding the beneficiary's Smoking Cessation and Preventive information. The information on the screen is organized into the Healthcare Common Procedure Coding System (HCPCS) categories (e.g. Cardiovascular, Colorectal, and Diabetes). The following tables provide information for the Preventive Tab.

NOTE: Only HCPCS codes for which a particular beneficiary is eligible will be displayed and grouped together under their appropriate categories.

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.

Smoking Cessation Information

Fields	Description
Sessions Remaining	Number of Smoking 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

For a document summarizing all OPS eligibility functions, refer to the Palmetto GBA OPS Online Eligibility User Guide.

The OPS Eligibility functions are based on the HIPPA 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.

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.

Part D contracts provide prescription drug coverage. Medicare claims 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.

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

For a document summarizing all OPS eligibility functions, refer to the Palmetto GBA OPS Online Eligibility User Guide.

The OPS Eligibility functions are based on the HIPPA 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.

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.

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.

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

For a document summarizing all OPS eligibility functions, refer to the Palmetto GBA OPS Online Eligibility User Guide.

The OPS Eligibility functions are based on the HIPPA 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.

9. How Do I Use the Hospice/Home Health Tab?
The Hospice/Home Health Tab includes two sections: 1) Hospice and 2) Home Health.

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.

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.

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

For a document summarizing all OPS eligibility functions, refer to the Palmetto GBA OPS Online Eligibility User Guide.

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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.

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.

The tables below descript 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

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

For a document summarizing all OPS eligibility functions, refer to the Palmetto GBA OPS Online Eligibility User Guide.

The OPS Eligibility functions are based on the HIPPA 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.

11. Is the number of psychiatric days remaining available through OPS?
Not at this time. The information is available through the IVR.

12. Is information related to the prior year or prior benefit period available?
Not at this time. The information is available through the IVR.

Financial Tools

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.

2. What is the Payment Floor Amount?
This refers to all claims in process and on the payment floor as of the date of the look-up.

Administration

1. What are the user roles?
There are two roles:

Provider Administrator
Provider User

The Provider Administrator is the Provider Representative who registered and who has the authority to add users.

The Provider User is a person who has been granted permission by the Provider Administrator to access information for that provider.

2. How Do I Administer Users?
Provider Administrators have access to the Admin Tab. Through this function, you 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
- Modifying the Provider User profile
- Terminating The 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.

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.

Palmetto GBA has the right to terminate any user's access if suspicious or improper activity is determined.

3. Who Is My Provider Administrator?
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 the Provider Administrator is.

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