PALMETTO GBA®

eServices

User Manual

Rev. December 2023

Contents

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Revision History

Date	Description
1/01/2022	2022 Version
3/15/2022	Updated section 3.5 with new preventative information
4/08/2022	Clarified verbiage in section 3.9, updated 1.11, 8.5, and 8.6
7/27/2022	Updated the Eligibility Note section with the new date range limitations. Updated the Hospice/HomeHealth tab information with NOA Indicator message. Added a new section for ADR Status Widget and Dashboard.
3/3/2023	Update with update login information and new form availability.

Glossary and Acronyms

Acronym	Description
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 eServices.
eServices	The eServices application. This application is available through the Palmetto GBA website.
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
HIPAA	The Health Insurance Portability and Accountability Act of 1996
IVR	Interactive Voice Response
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
MFA	Multi-Factor Authentication
NPI	National Provider Identifier. The NPI is a unique identification number for covered health care providers.
PHI	Protected Health Information
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.
PTAN	Provider Transaction Access Number. Also called a legacy number or Medicare PIN.
QMB	Qualified Medicare Beneficiary. Beneficiaries who are enrolled in the Qualified Medicare Beneficiary (QMB) program are dually eligible for both Medicare and Medicaid.
SNF	Skilled Nursing Facility
Tax ID	Tax Identification Number. Also called a TIN.

1.0 General Information

1.1 What is eServices?

There is no cost to the provider for registering and using eServices.

Palmetto GBA's eServices 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 website through the eServices application.

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

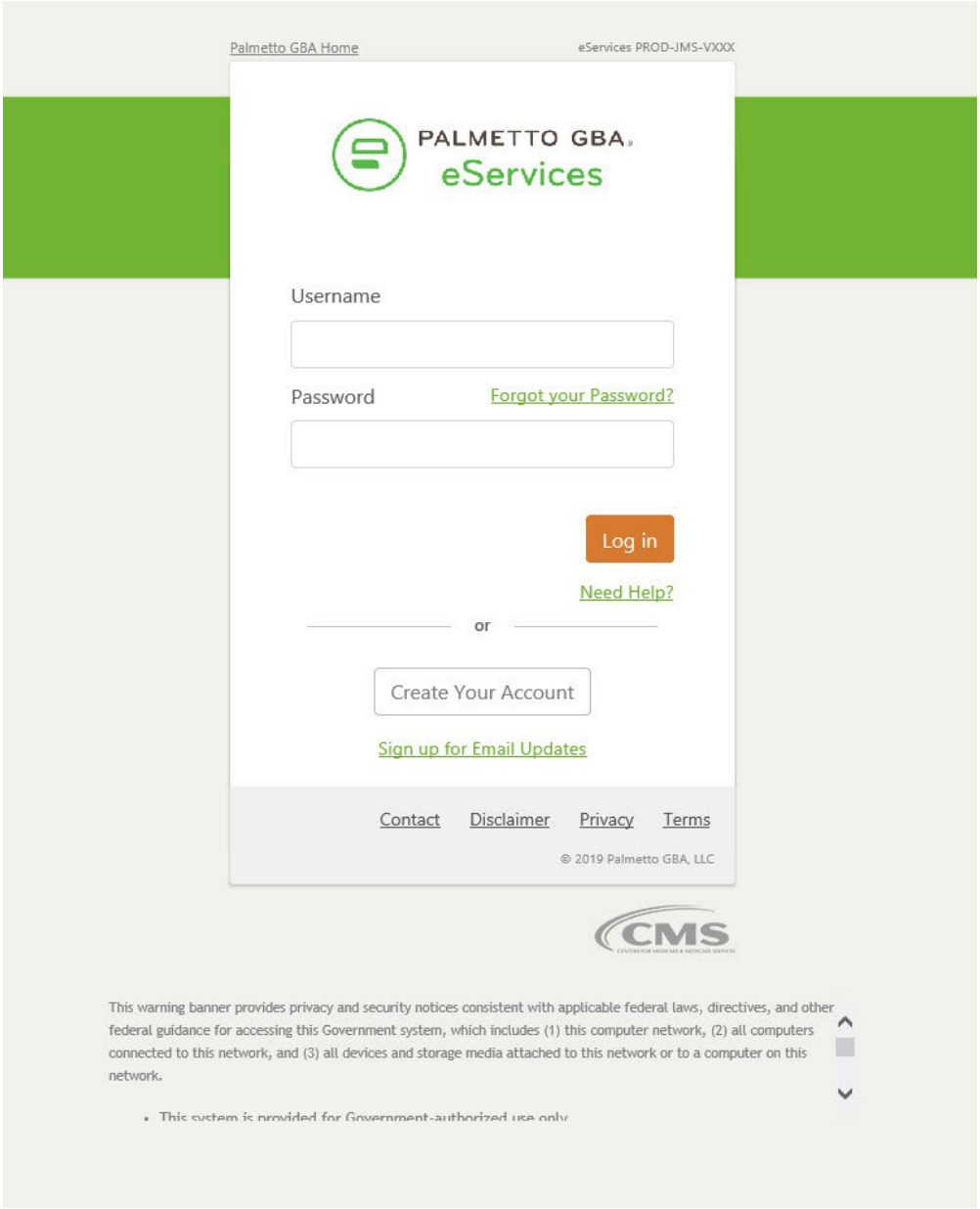
- Eligibility
- Claims Status
- eClaim Submissions - available for Part B and Railroad Medicare providers
- Clerical Error Claim Reopening Requests - available for Part B
- Remittances Online
- Financial Information - payment floor and last three checks paid
- Financial Forms - eOffset requests, eCheck payments and CMS-838 Credit Balance form (Part A and HHH only)
- Secure Forms - Appeals, Medical Review ADR Response Form, Prior Authorization Form (JM Part B only), Documentation Submission Form (Part A only), Benefit Integrity Form (RRM only), and General Inquiry Form
- eDelivery
- eReview (JM, JJ, and RRB only)
- Additional Documentation Form – available for JJ Part B and JM Part B
- MBI (Medicare Beneficiary Identifier) Lookup
- Billing Dispute Request Form (JJ Part A and JM Part A)

You can participate in eServices if you have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA and have payment amounts on file. To find instructions on how to get one, go to the EDI section for your line of business on PalmettoGBA.com.

> **NOTE**
>
> Users must have an EDI enrollment agreement on file with Palmetto GBA to participate.

The eServices home page is: www.palmettogba.com/eServices

Figure 1: Login Page



1.2 How much does eServices cost?

There is no cost to the provider for registering and using eServices.

1.3 Who can participate in eServices?

You can participate in eServices 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 select your line of business. Then, select EDI from the Topics drop-down menu. Select Enrollment 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/NPI combination.

1.4 How to report misuse or suspicious use of eServices?

If you suspect misuse or suspicious use of the system, contact your Medicare Contractor 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 application, contact your Medicare Contractor. Be prepared to provide the following information when you call:

- Provider name
- Your name, email address and telephone number
- PTAN
- NPI
- Tax ID
- Line of Business (Medicare Parts A, B, Railroad, etc.)
- eServices user ID (if one has been assigned)
- Browser type/version
- Tab and/or function you are calling about
- If calling about an error message, include the specific error message text received

You can view contact numbers via the Contact Us link on your line of business's home page on palmettogba.com or the Home tab in eServices.

1.6 How do I report a privacy incident that occurred in eServices?

If you are able to view protected health information (PHI) for an organization other than the one associated with your user ID, please contact your Medicare Contractor immediately.
Please provide the date and time the error occurred in addition to all other details of the privacy incident during your call. If the PHI has been printed or saved, please make sure these copies are properly destroyed and/or deleted.

1.7 Why can't I view or print information in eServices?

Please make sure that your system meets our minimum system requirements as outlined in Section 1.11. 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.

1.8 When is eServices available and what are the maintenance times?

eServices will generally be available 24 hours a day, seven days a week. However, access to eServices does not guarantee that all functions will be available.

Occasionally a function will temporarily be unavailable as updates are made either by the eServices team or by other systems from which eServices pulls information.

eServices scheduled maintenance will typically occur:
Monday – Friday 6:00 am to 8:00 am ET
Sunday afternoon through evening

Other systems with which eServices interacts typically undergo maintenance:
Monday – Friday late evening
Occasionally Saturdays or Sundays

Our goal is to avoid any service interruptions during normal operating hours. However, unscheduled maintenance may be necessary in order to immediately address systems security threats or performance issues. When you access the eServices website and it is not available, you should see a page that indicates maintenance is in progress.

1.9 Can I use the back button in my browser to view the previous screen in eServices?

No. When signed into eServices, users should not use the browser's back button. Using the back button will cause the user to be logged out of eServices. This security requirement ensures the safety of previously viewed/submitted data. If a user is logged out of eServices due to using the back button, the user will just need to log back in.

1.10 eServices Lockout and Logout Scenarios

The table below discusses some of the most common reasons users get locked out/logged out of eServices.

Action	Lockout/Logout Details
User attempted to log into eServices using an incorrect password or MFA code three times in a row	The user will be locked out of eServices. This is a CMS security requirement. To unlock the account, please contact your provider administrator for assistance.
User is locked out three times in a row	The user ID will remain locked until the user calls to verify their identity and have their ID unlocked. Please contact your Medicare Contractor for assistance.

Action	Lockout/Logout Details
The user has not logged into their account within the past 30 days or No provider administrators on the account have logged into their account within the past 30 days	If a provider user does not log into eServices at least once every 30 days, their account is disabled. To regain access, the user must have an active provider administrator reinstate their access. If a user does not log in after being disabled, their user ID will be permanently deactivated after 120 days of inactivity. If no provider administrators on the account log into eServices within 120 days, the entire account, including all users, are terminated. To regain access to eServices, the provider must re-register. If a provider administrator has not logged into their account in the past 120 days, but there is another active provider administrator on the account, then only their access is terminated. To regain access the user must have an active provider administrator assign them a new user ID and temporary password.
User enters registration information incorrectly eight times	If an error is encountered during the registration process, e.g., incorrect payment amount entered, the account will be locked for 60 minutes. This is a CMS security requirement. The provider may attempt to re-register after the 60 minute time period has expired. We are unable to unlock accounts that are in the 60 minute lockout period.
User tries to register eight times before the 60 minute registration lockout has expired or User tries to incorrectly register and goes through the 60 minute registration lockout two times	The provider's registration record is locked indefinitely. The user will receive a message that they need to call in and verify their identity. Please contact your Medicare Contractor for assistance.
A registered user who already has a user ID is locked out of their account because of improper log out	The user must wait for the 30 minute lockout period to expire before attempting to log in again. We are unable to unlock IDs that are in the 30 minute lockout period.
Provider administrator has not completed recertification in the past 360 days	All users are locked out of their account and must contact one of the active provider administrators on the account to complete recertification and restore access. Provider administrators are directed to the recertification screen and will be locked out of other functions of eServices until recertification is complete.
Provider user or administrator has not completed profile verification in the past 250 days	The user will be directed to their My Account tab and will be locked out of other functions of eServices until profile verification is complete.
Provider administrator failed to complete recertification within 360 days	If no provider administrators on the account complete the recertification within 360 days, the entire account, including all users, are terminated. To regain access to eServices, the provider must re-register.
Provider user or administrator has not completed profile verification in the past 260 days	If a provider user does not complete profile verification at least once every 260 days, their account is terminated. To regain access, the user must have an active provider administrator assign them a new user ID and temporary password. If no provider administrators on the account complete profile verification at least once in the past 260 days, the entire account, including all users, are terminated. To regain access to eServices, the provider must re-register.

Action	Lockout/Logout Details
User selects the browser's 'back' button	The user will be logged out of the application and redirected to the eServices login page.
User is inactive in eServices for 30 minutes	If a user becomes inactive for 30 minutes while logged into eServices, their session will timeout. If they become active again during that time, the session will remain open until activity stops again, in which case the 30 minute inactivity clock starts again. After 25 minutes of inactivity the user is prompted with a pop-up reminding them of the timeout limit and gives them 5 minutes to become active again before they are logged off.

1.11 eServices Minimum System Requirements

To optimize usability of eServices, we recommend that users verify their system adheres to the following requirements.

Operating System:

- Windows 10
- Mac OS X 11.x

Supported Internet Browsers*:

- Microsoft Edge: Version 88.x
- Google Chrome: Version 98.x

(IE 11 broswer will no longer be supported as of June 2022)

Recommended Screen Resolution: 1024 x 768

Additional Requirements:

- Adobe Acrobat Reader Version DC or Adobe Acrobat Pro Version DC
- JavaScript enabled
- Compatibility view disabled
- Pop-up blocker disabled
- Use TLS 1.2 selected in browser settings. This option is typically located on the Advanced tab under Internet Options in your browser

Please note: Although eServices may still be accessible without meeting these requirements, only the options above are supported. Failure to meet these requirements may adversely affect the functionality and layout of eServices.

*We recommend always using the most current browser version that is available.

1.12 How do I navigate the eServices calendar options using the keyboard?

To navigate the calendar options in eServices, users may utilize the following keyboard shortcuts.

- Page Up – Move to the previous month
- Page Down – Move to the next month
- Ctrl + Home – Move to the current month; Open the date selector (if closed)

- Ctrl + Page Up – Move to the previous year
- Ctrl + Page Down – Move to the next year
- Ctrl + Left – Move to the previous day
- Ctrl + Right – Move to the next day
- Ctrl + Up – Move to the previous week
- Ctrl + Down – Move to the next week
- Enter – Select the focused date
- Ctrl + End – Close the date selector and erase the date
- Esc – Close the date selector without selection

2.0 Registration

2.1 How do providers register for eServices?

You can participate in eServices 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 eServices. The provider administrator may then grant access to the different features of the application to their associates, who are provider users. The provider administrator also has the ability to assign additional provider administrators by selecting the Admin permission for the user. 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 eServices link from PalmettoGBA.com. You'll see the eServices introduction screen.

You must enter the information listed below to register:

- Provider name
- Contact name (The person assigned to this user ID)
- Email address
- Phone number
- Extension
- Provider, billing service or clearinghouse indicator
- PTAN
- NPI
- Tax ID
- Most recent Medicare payment amount received or access code. 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
- Billing service/clearinghouse information, if required

You must also agree to the Terms of Use to register. If you have entered registration information in an incorrect format, the eServices application will display an error message in red at the top of the screen. Carefully read that error message and enter the information again. If the information you enter matches the information on file with Palmetto GBA, you will be able to choose a password and security questions and answers.

Once this is completed, you will receive an email at the email address you registered. You must access the email and click on the validation link. If you do not click on the validation link and you try to log in, you will see the profile screen where you can update or correct your email address and submit. If your email address is correct, you may click on the link to request a new email. Please make sure your email address is correct on your profile before calling Palmetto GBA for assistance.

If you are sure your email address is correct, but you do not receive your email, your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The

email address you will be receiving the validation email from is:

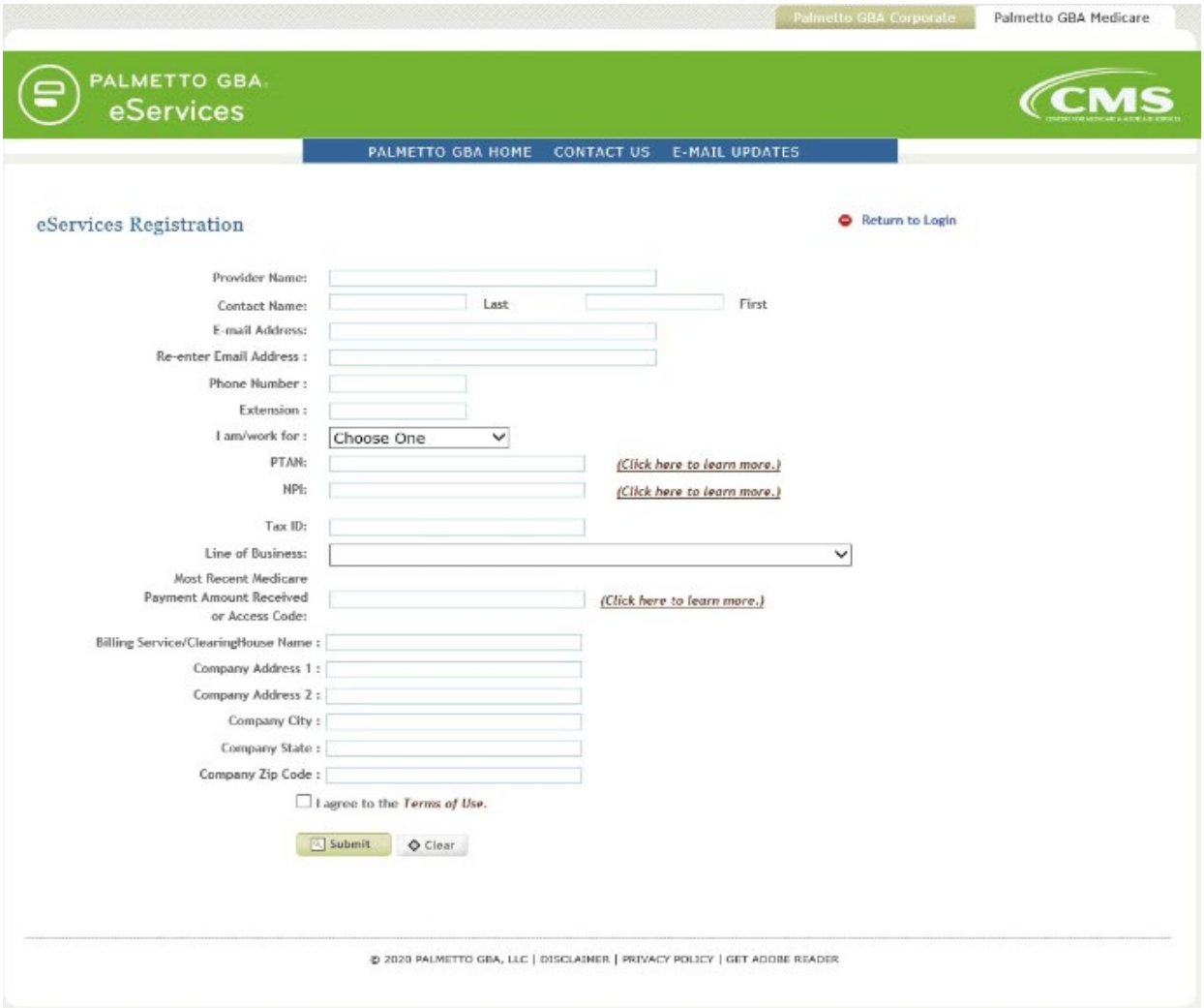
ops.no.reply@palmettogba.com

Generic user names are ***not*** permitted. Each user of eServices must have a unique user ID and password. This means that we expect each user to have a legitimate first and last name. Generic first and last names are not permitted. Examples of generic user names are: Front Desk, Account Coordinator, Billing Department, User A, or the name of your provider office. No sharing of user IDs and passwords is permitted. Palmetto GBA will delete, without notice, any user names we find that are generic.

NOTE

You must register each PTAN/NPI combination separately. 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: eServices Registration Screen



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 meet certain format criteria which will be displayed when creating your password.

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

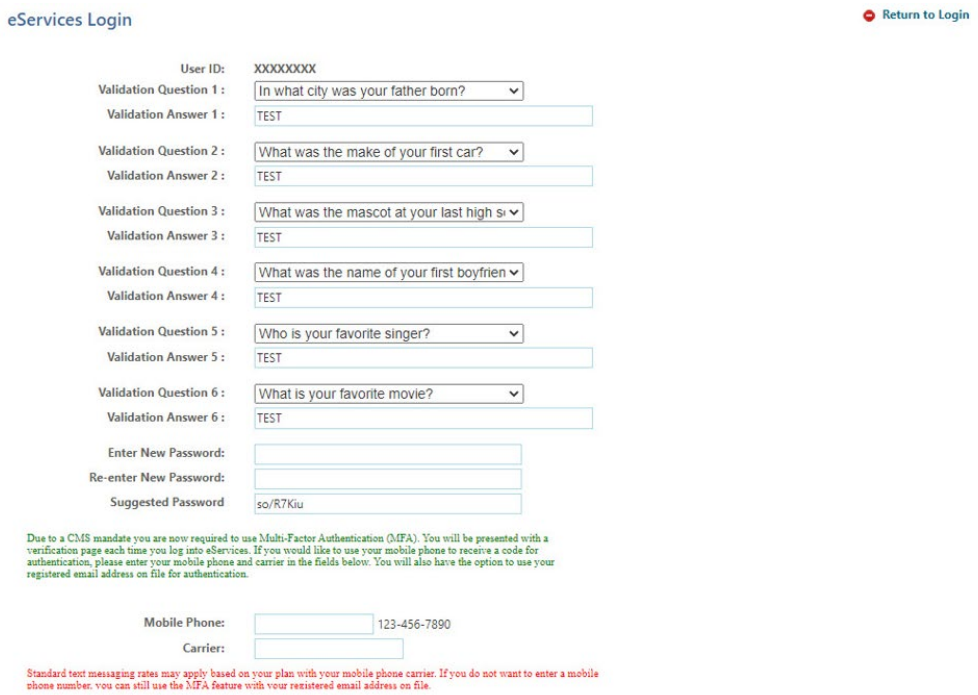
Use the following guidelines to protect your password and your information:

- Must be at least 8 characters long (at least 15 characters for Super Admin users)
- Must start with a letter
- Must contain an uppercase letter
- Must contain a lowercase letter
- Must contain at least one number
- Must have at least one of the following special characters @#$!%&)(*-.,:][+;<=>?^_`~}{|/\'"
- Must contain a minimum number of 75% changed characters from the previous password. Examples:
    - If current and new passwords are 8 characters long then 6 characters must be different
    - If current and new passwords are 12 characters long then 9 characters must be different
    - If current password is 15 characters and the new password is 20 characters, at least 11 characters must be different
    - If current password is 20 characters and the new password is 23 characters, at least 15 characters must be different
- Must be changed every 60 days
- May contain spaces in the middle of a password. Spaces are not allowed in the first or last character space
- Cannot contain leading portion of the first or last name
- Cannot use the same password as the previous 13 passwords

2.3 How do I choose my security questions?

You have several questions from which to choose. Answers to your security questions are case sensitive and include spaces. Enter your answers carefully. You must answer these questions exactly as they were entered to change your password or reset your password if you cannot remember it. You can verify or change your security questions and answers through your My Account tab once you are logged in.

Figure 3: Password and Validation Questions Choice Screen



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 else 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 eServices. If an administrator from your office has already registered, please contact that person for access to eServices.

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

Providers who have a Do Not Forward (DNF) on file with Palmetto GBA will not be able to register until the DNF is lifted.

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 contact your Medicare Contractor.

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 separately. 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 eServices. 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.

For Railroad Medicare: If you do not know your Railroad Medicare PTAN, you can visit our PTAN Lookup & Request Tool. This tool allows you to lookup an existing PTAN, as well as to request a new PTAN for new providers who have seen a Railroad Medicare patient and are ready to submit a claim. If you need assistance using the tool, you may call our Provider Contact Center at 888-355-9165 and select Option 3. Customer Service Representitives are available Monday – Friday, from 8:30 a.m. to 4:00 p.m. in all time zones, with the exception of Pacific Time, which receives service from 8:00 a.m. to 4:30 p.m.

2.8 How do I find out my NPI?

You must have a National Provider Identifier (NPI) to register for eServices. 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 eServices. 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 eServices. 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.

Providers who have a Do Not Forward (DNF) on file with Palmetto GBA will not be able to register until the DNF is listed.

2.11 How do I obtain my access code?

Brand new providers who submit a current EDI enrollment agreement will receive an email with the access code upon processing the EDI agreement. The access code may be used to complete the registration in the eServices portal. On the Registration page, providers can either register with the last Medicare check amount received or access code. Once the access code is validated along with the provider information, users may continue the registration process.

2.12 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 eServices 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/Medicare.

2.13 I am a new Medicare provider. When can I register?

New providers must have an Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA and wait until they receive a payment from Medicare to register for eServices. If you are new to Medicare and you call technical support for registration assistance, you will be asked to wait until your first Medicare payment is issued to enroll.

2.14 What do I do if I did not receive my validation email?

Once you register or update your profile, you will receive an email with a link to validate your access. Make sure that you log out of your profile update before clicking on the link in your email. Once this is completed, you will be able to log in to eServices. If you do not click on the validation link and you try to log in, you will see your profile screen where you can update or correct your email address and submit. If your email address is correct, you may click on the link to request a new email. Please make sure your email address is correct on your profile before calling Palmetto GBA for assistance.

If you are sure your email address is correct, but you do not receive your email, your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email address you will be receiving the validation email from is:

ops.no.reply@palmettogba.com

If you experience password errors during the above process, please use the 'Forgot or Change Your Password?' link on the login page to reset your password.

3.0 Login

3.1 How do I log in to eServices?

You must have either registered for eServices or been given access to eServices by a provider administrator for your provider. If you have completed these steps, you will have a user ID.

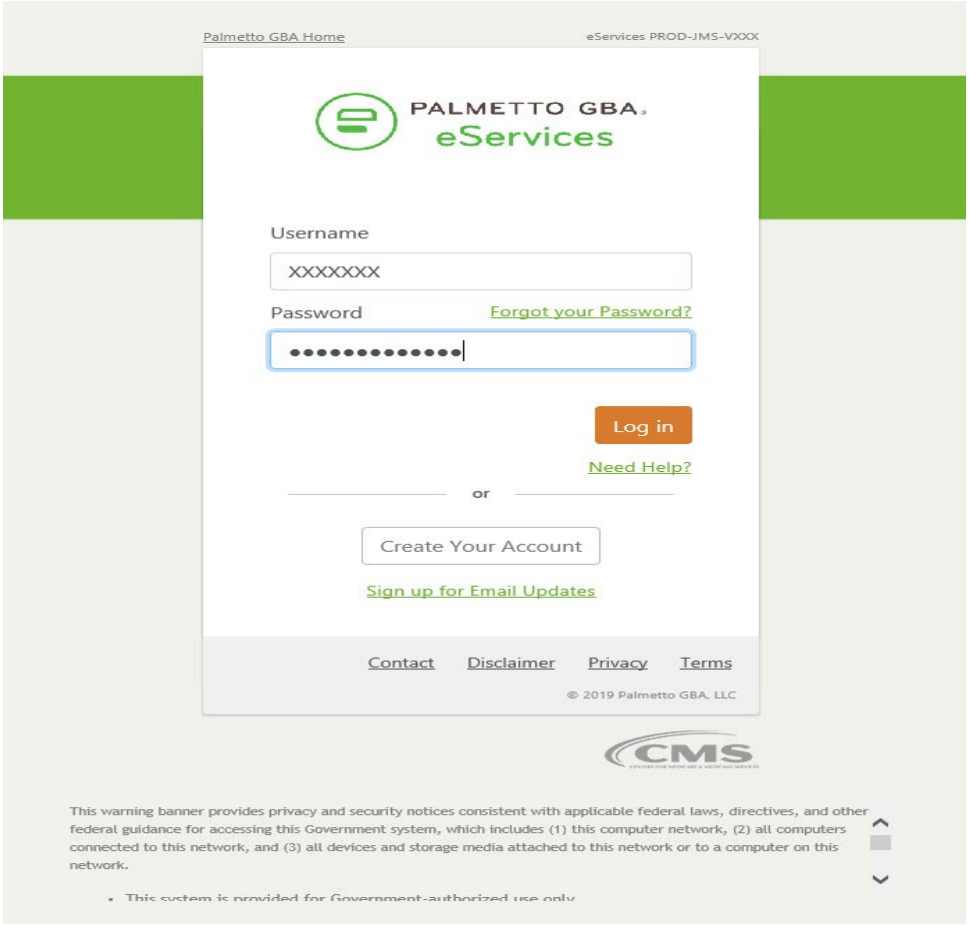
Access our eServices introduction screen and enter your user ID and password.

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 agree to the terms of use, change your password and choose your security questions and answers. Once you have successfully completed these steps, you will be given access to eServices.

NOTE

A log out link is located in the upper right of each screen, once you have logged in. You must log out to end your session. If you do not log out, your user ID will be locked for one hour.

Figure 4: eServices Registration and Log in Screen



3.2 Once I log in, 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 contact your Medicare Contractor.

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 contact your Medicare Contractor.

3.5 What happens if I cannot log into eServices?

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 eServices introduction screen. You will receive an email with a secure link to then answer two security questions. You must answer both security questions correctly to reset your password.

If you attempt to log in incorrectly three times in a 120 minute period, you will be locked out of eServices. To unlock your account, you must contact your Medicare contractor to verify your identity and regain access.

You can verify or change your security questions and answers 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 that if you are logged into eServices and you want to exit, click on the log out link in the upper right of every page. If you do not do this, you will be locked out for one hour. We do not unlock accounts that are in the one hour lockout period.

Figure 5: Request to Reset Password

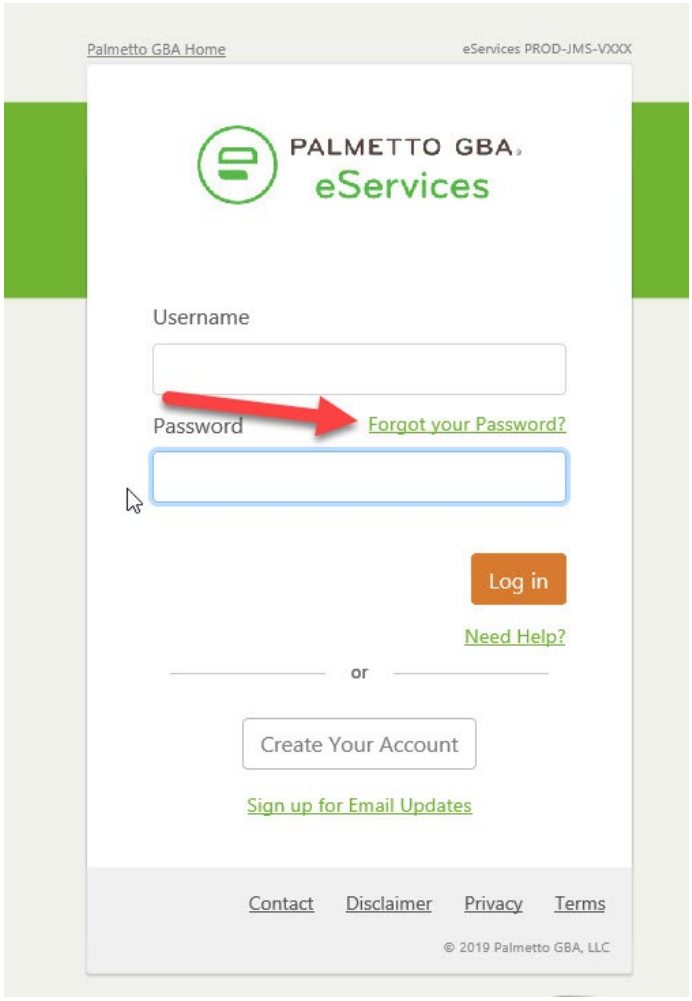


Figure 6: Password Reset, Enter User ID

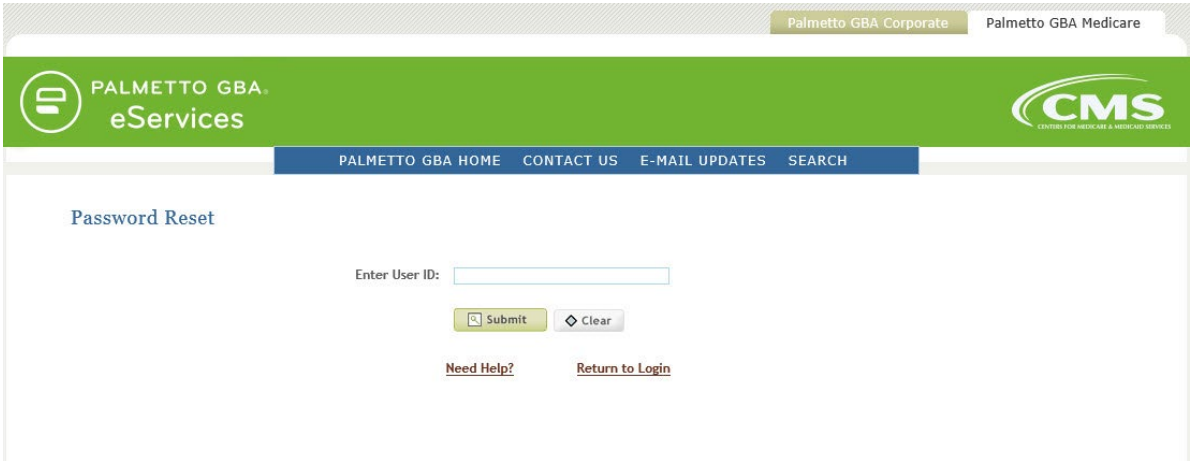
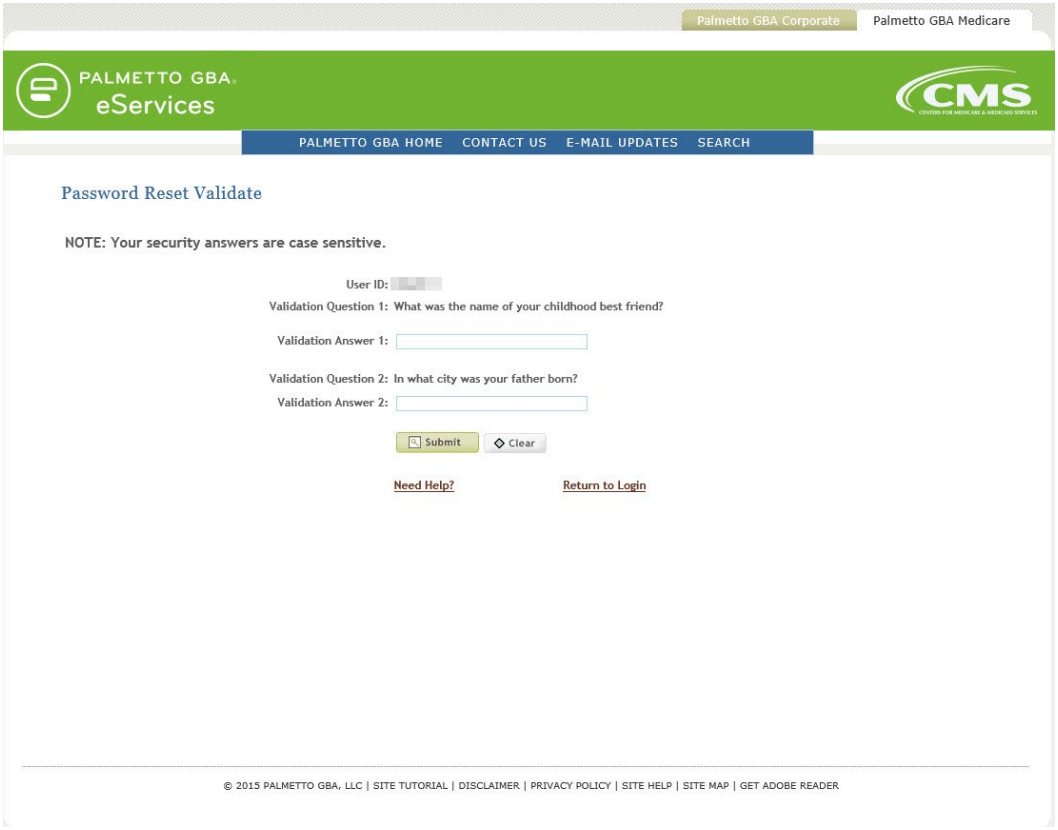


Figure 7: Password Reset Validate, Answering Validation Questions



3.6 I cannot answer my security questions. What should I do?

When you opt to reset your password, you will be randomly presented with two of your security questions. You must answer both questions correctly to reset your password.

If you cannot reset your password 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 and you cannot answer your security questions, please contact your Medicare Contractor. Keep in mind that you can update your security questions 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 eServices introduction screen. You will receive an email with a secure link to answer two security questions. You must answer both questions correctly to reset your password. If you want to change or verify your security questions and answers, you can update it through your My Account tab once you are logged in.

Keep in mind that if you attempt to login incorrectly three times in a 120 minute period, you will be locked out of eServices. To unlock your account, you must contact your Medicare Contractor to verify your identity and regain access.

NOTE

If your organization requires you to confirm or acknowledge the link in the Forgot Password email is a valid and secure link, you may need to copy and paste the link from the email into a browser.

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

A log out link is located in the upper right of each screen, once you have logged in. You must log out to end your session. If you do not log out, your user ID will be locked for one 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 contact your Medicare Contractor to verify your identity and regain access.

3.9 Can my eServices access expire?

Palmetto GBA and CMS are dedicated to keeping your information safe. To achieve this, access to eServices must be limited to users who use the system on a regular basis. Palmetto GBA will disable any user ID that has not been used in 30 days per CMS security requirements. If you are a provider user and have been given access to eServices by the provider administrator in your office, your user ID will be disabled if you or your provider administrator have not logged in within the last 30 days. If you are a provider administrator and you have not logged in within the last 30 days, your user ID and the user IDs of your provider users will be disabled.

To keep your eServices access current, please log in to eServices with your user ID and password. If you have forgotten your password, please use the 'Forgot or Change Your Password?' link on the returning user screen.

If you are a provider administrator, please log in to make sure the access for your provider users is not disabled.

When the user has not successfully logged in for 120 days, the user ID will be deactivated indefinitey. If you have been deactivated, you will receive the following error message:

“Your eServices access has expired and your user ID is now invalid. If you are a provider administrator, please register again. If you are a provider user, please contact your provider administrator for access.”

If you receive this error message and you are a provider user, your provider administrator must add you again as a new user. You will receive a new user ID from your provider administrator.

If you receive this error message, and you are the only provider administrator on the account, you must register again. You will receive a new eServices user ID. You must also add any provider users to eServices as new users.

If you are a provider administrator, but there are other active provider administrators on your account, you must contact one of the active provider administrators. The active provider administrator must add you again as a new user. You will receive a new user ID for the active provider administrator.

It is recommended that all users and provider administrators log into their account at least once every 30 days to keep their access current.

3.10 Disabled User Status

This functuality will disable users instead of deactivating them if they have not logged in within the 30 day window. The users will be placed in the disabled status for an additional 90 days after the 30 day period of login inactivity. After 120 days, the user ID will be deactivated indefinitey. This means that a user can reactivate their account within the 90 day window and essentially has 120 (30+90) full days before being terminated.

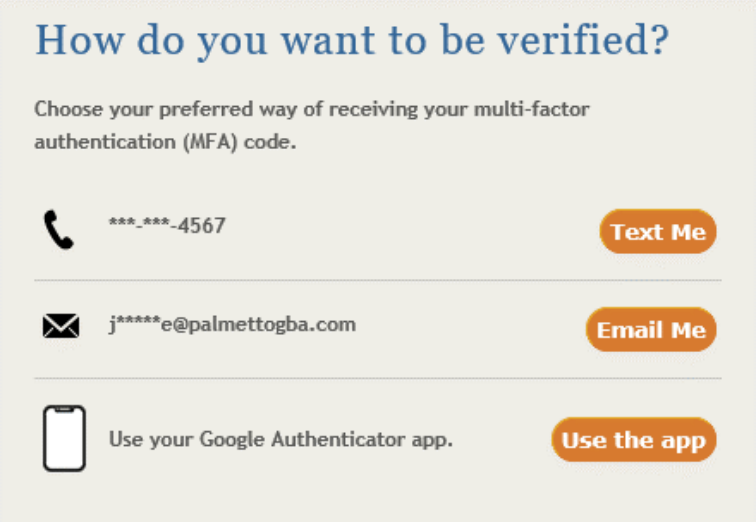
3.11 Will my eServices session timeout?

Yes. To be in compliance with CMS security requirements, your eServices session will timeout after 30 minutes of inactivity. A notification box will display when you are approaching your inactivity limit. Users should not use the portal in multiple tabs as this could cause you to get locked out.

3.12 Multi-Factor Authentication (MFA)

To enhance the security of Medicare data, CMS requires the use of multi-factor authentication (MFA) in eServices. After successfully entering your user name and password, you will be directed to the MFA verification screen where you will need to enter an MFA verification code to complete the login process. Once on this screen you will be prompted to select a method to receive your MFA code. You may elect to either receive a text (if the mobile phone number was entered on the My Account tab), an email message, or utilize a code via Google Authenticator. All users will have the option to receive their code via email by default.

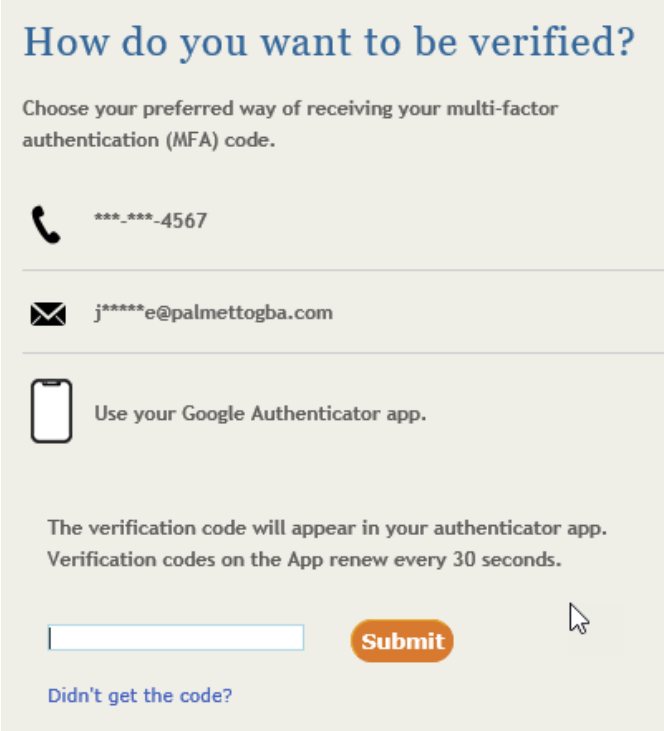
Figure 8: MFA Verification Screen, Method Selection



After you have made your selection you will be sent either a text or email message with an eight digit verification code or you can utilize the current six digit code in your Google Authenticator app. Enter

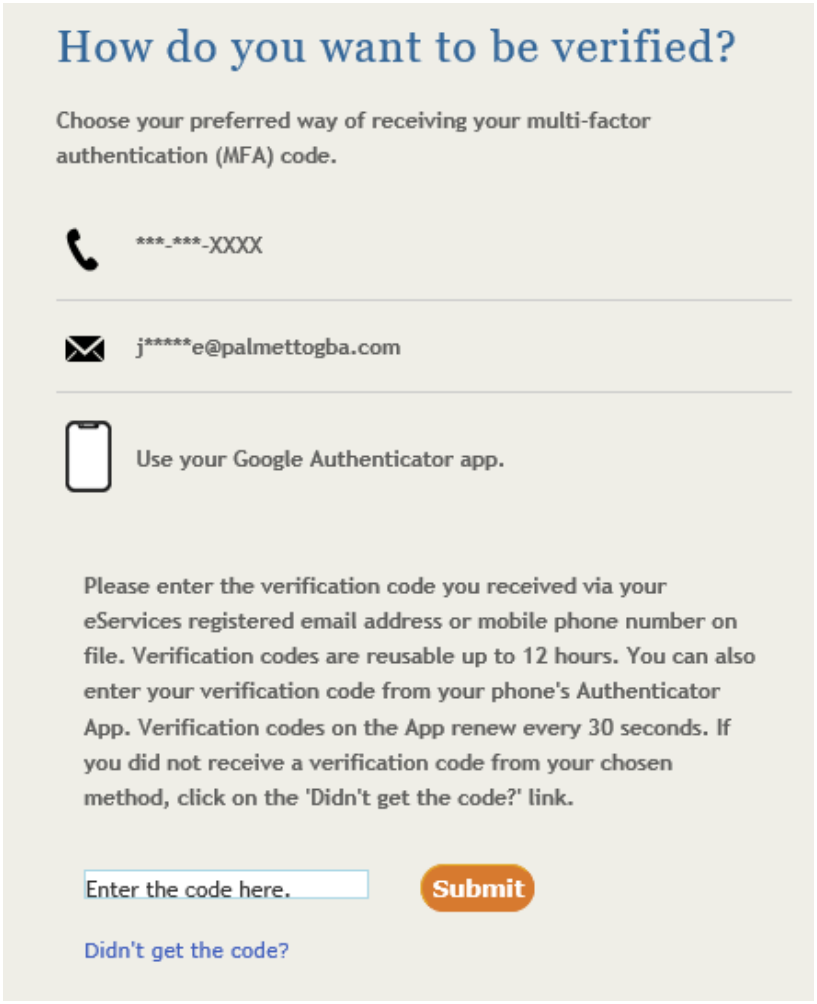
the code in the field provided on the verification page. Upon successful validation of the verification code, you will be able to access the portal.

Figure 9: MFA Verification Screen, Verification Code Entry



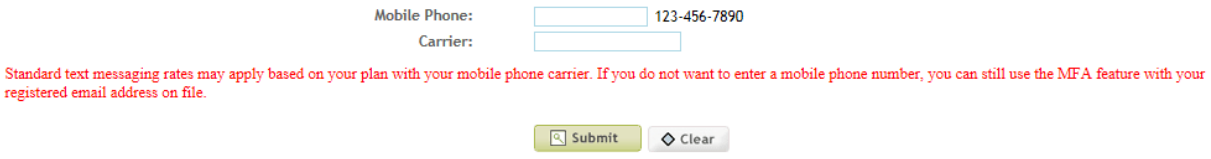
Your text or email verification code can be reused repeatedly for up to 12 hours from the time the code was requested. If you are reusing your verification code, enter the code in the box on the 'How do you want to be verified' screen. You may still request a new MFA code at any time. Simply use the 'Didn't get the code' link to begin the request. Once a new MFA code is generated, the previously generated MFA code cannot be used. Google Authenticator codes change automatically every 30 seconds. If logging in with a Google Authenticator code, you must always use the current code to log in.

Figure 10: MFA Verification Screen, Reuse Verification Code



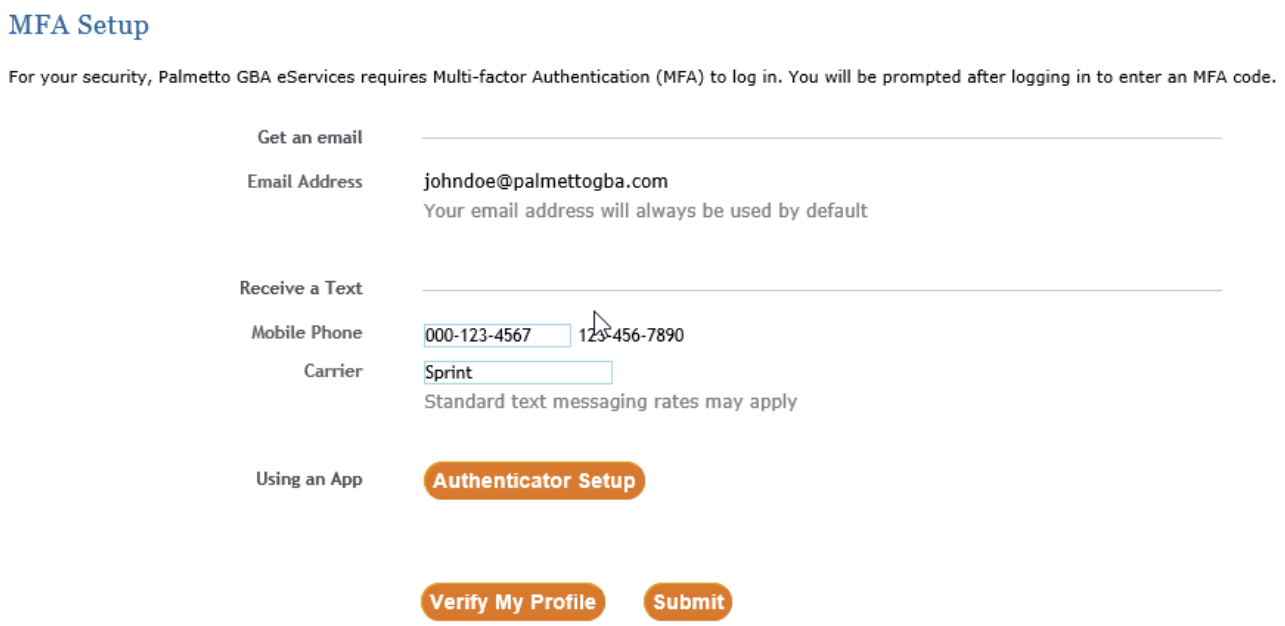
Once logged into eServices, you may access the My Account tab to add mobile number information for the additional option to receive your MFA verification code via text message (standard messaging rates may apply). You may also add the additional option to utilize a Google Authenticator code from this tab.

Figure 11: My Account Tab, MFA Mobile Opt In



To set up the Google Authenicator option, begin by clicking the ‘Authenticator Setup’ button under the MFA Setup section of your My Account tab.

Figure 12: My Account Tab, MFA Google Authenticator Opt In



Then, follow the instructions for your mobile device type (iPhone or Android). Once you have completed this setup, you will be able to access the MFA code for the associated user ID from the Google Authenticator app on your device going forward. You will not be required to perform the setup steps at each log in.

Figure 13: MFA, Google Authenticator Setup

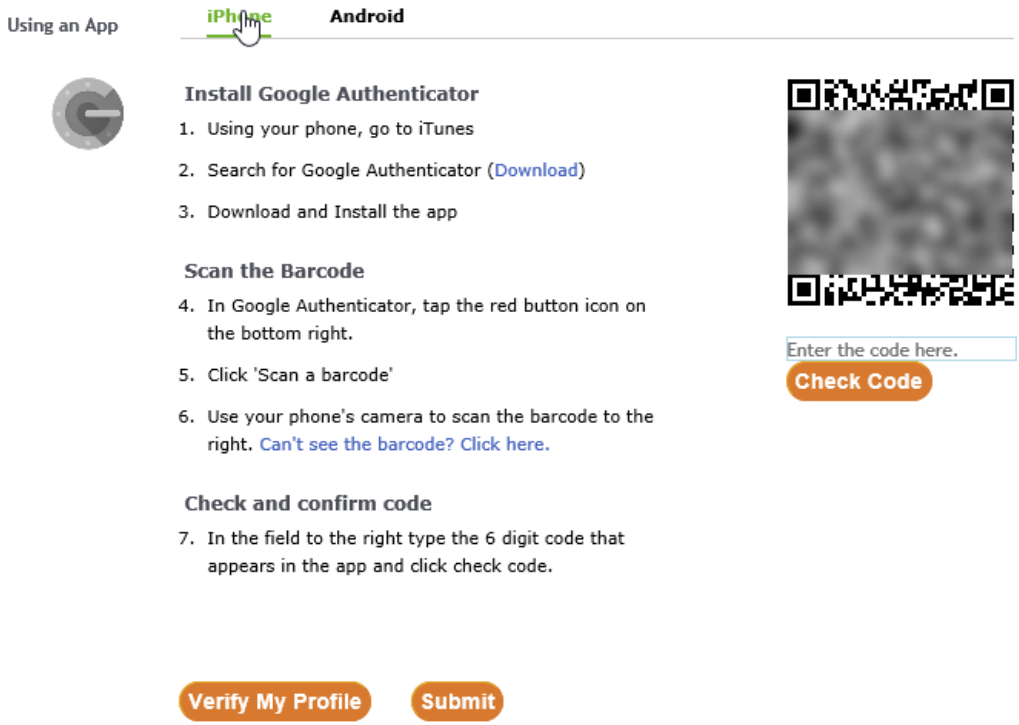


Figure 14: MFA, Google Authenticator Setup Confirmation

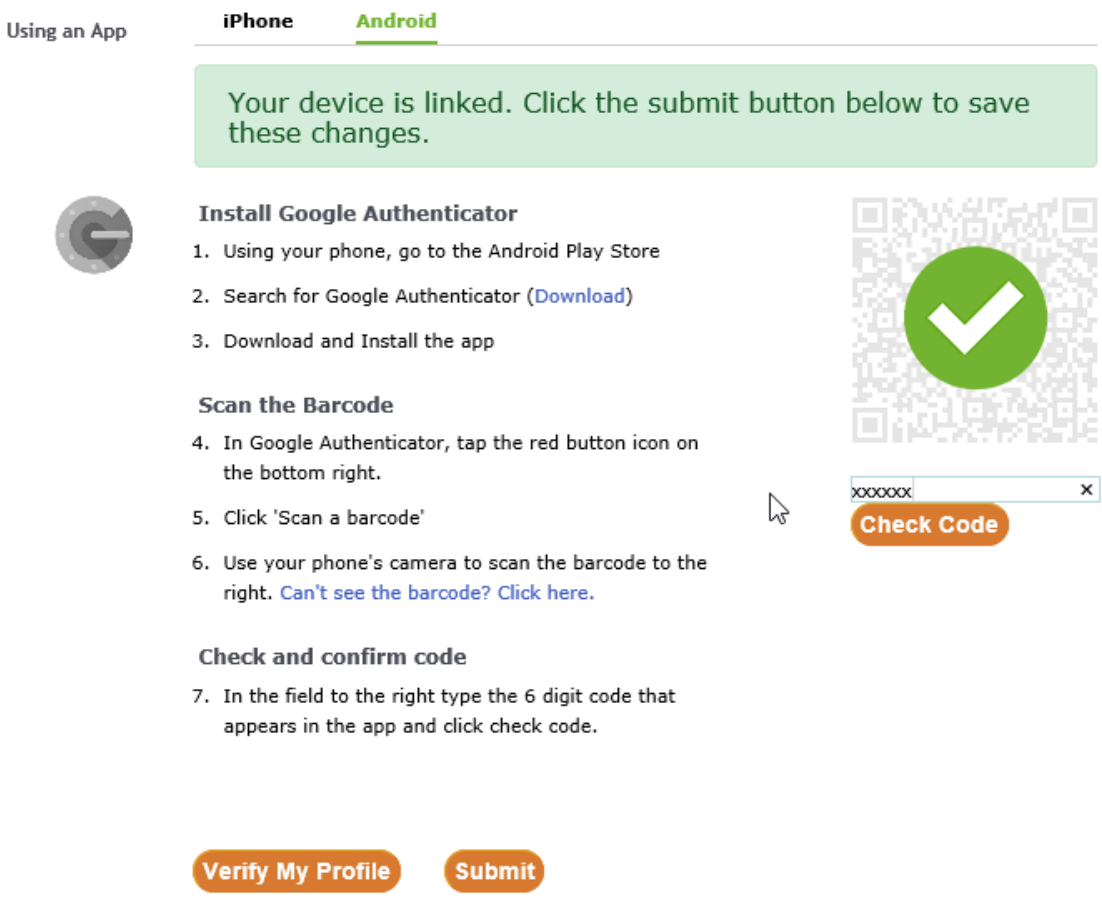


Figure 15: Google Authenticator Duplicate Setup Confirmation

If the user has setup google authenticator for the user ID, they will receive a pop-up message indicating the feature has already been setup. If the user clicks ok, a new QR code will be generated. Users will need to scan code before clicking on verify my profile or submit buttons. The user will receive a pop-up message indicating they need to scan code before using either button when trying to reset the google authenticator feature.

Figure 16: Scan Code, Google Authenticator

4.0 Claims Status/Claims Submission

4.1 How do I use the claims status feature?

If you have access to claims status and are successfully logged in, click on the Claims tab. The claims status screen will appear. The few required fields are marked as required. Other fields are optional.

If your search is for a specific claim number, the details on that claim will appear. If you search using other criteria a list of claims matching your search criteria will display. You may click a link to view the details of any claims in the list.

Searches for long periods of time may take longer to return results. In addition, offline claims will not be displayed. Many claims are offline after three years, sometimes earlier.

Figure 17: Claims Tab

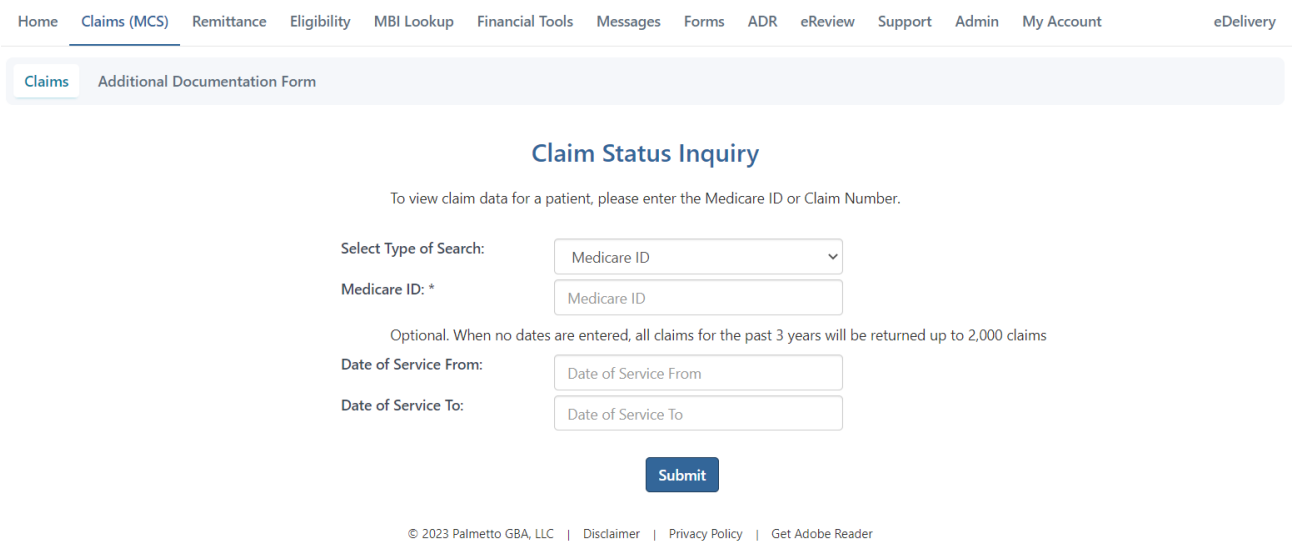


Figure 18: List of Claims Status Information

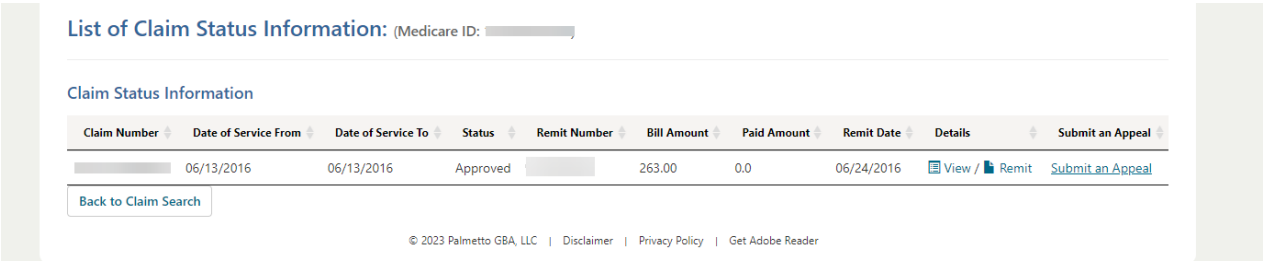
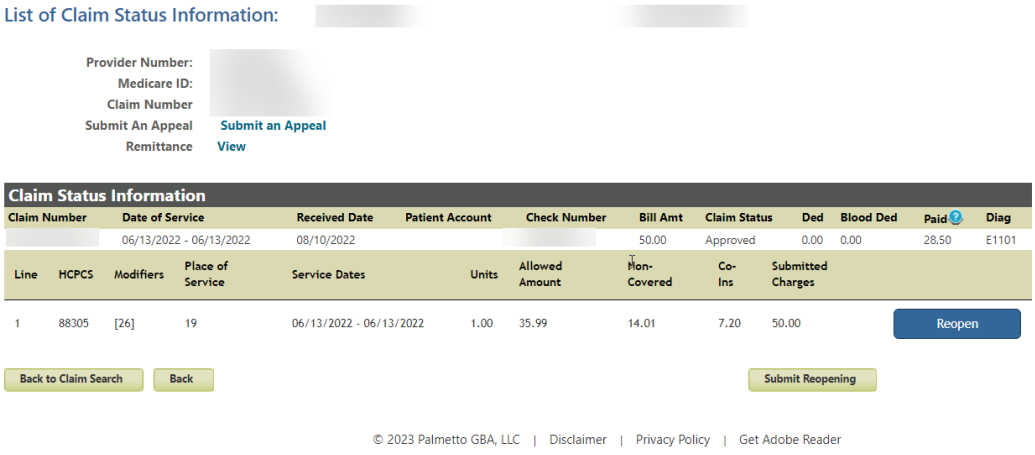


Figure 19: Claim Line Details



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 Medicare ID. 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.

Retrieving claims information older than six months may take additional time. In addition, offline claims will not be displayed. Many claims are offline after three 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 Medicare Contractor. Telephone numbers are listed in the Contact Us pages of PalmettoGBA.com/Medicare.

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

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

4.5 I am being told I have entered an invalid Medicare ID. What do I do?

You must double-check the Medicare ID. It should be entered without spaces, dashes or any other special characters.

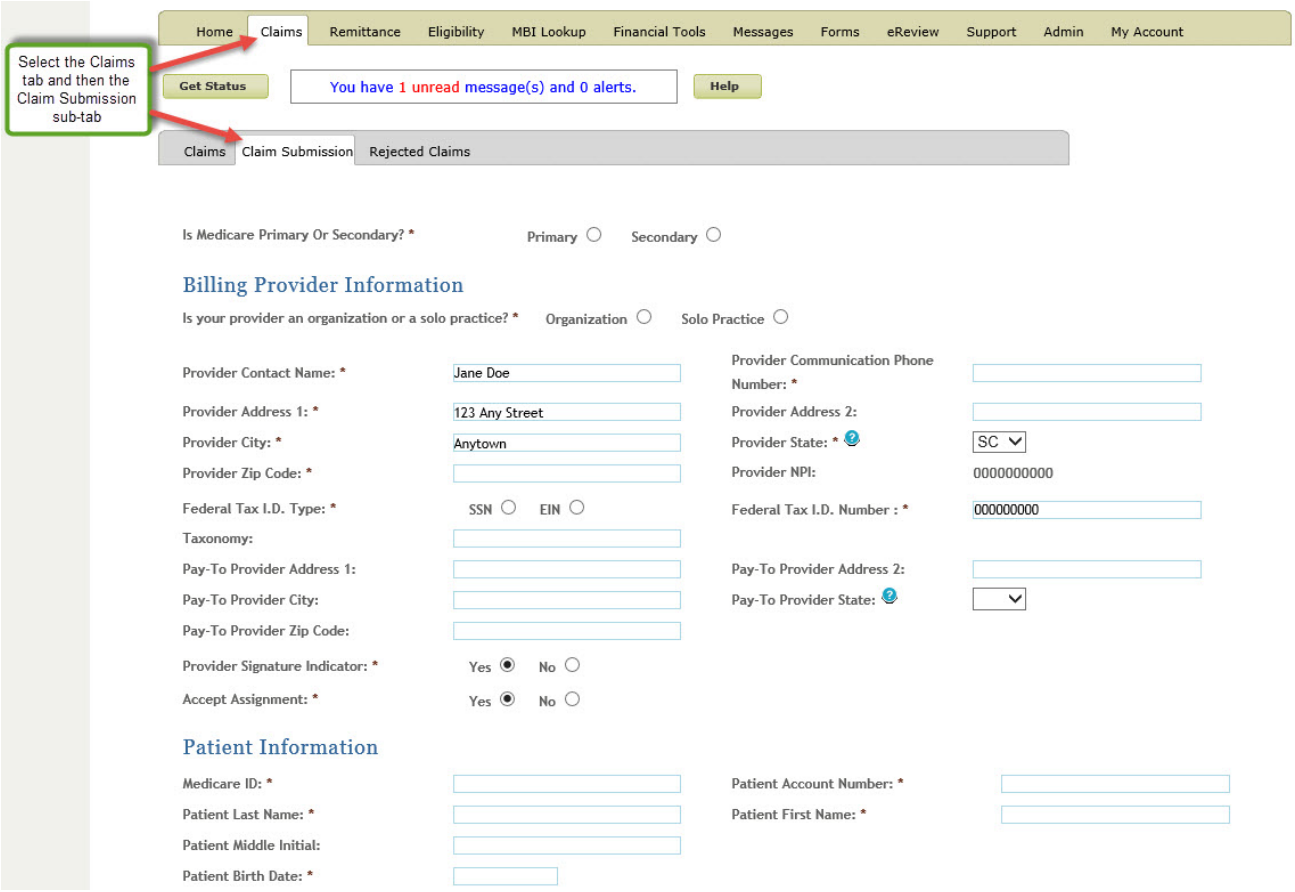
4.6 Claims Submission

Part B users can access the electronic claim submission (eClaim) feature by accessing the Claim Submission sub-tab located under the Claims tab. If the Claim Submission sub-tab is not displaying, the user may not have access to this feature yet.

NOTE

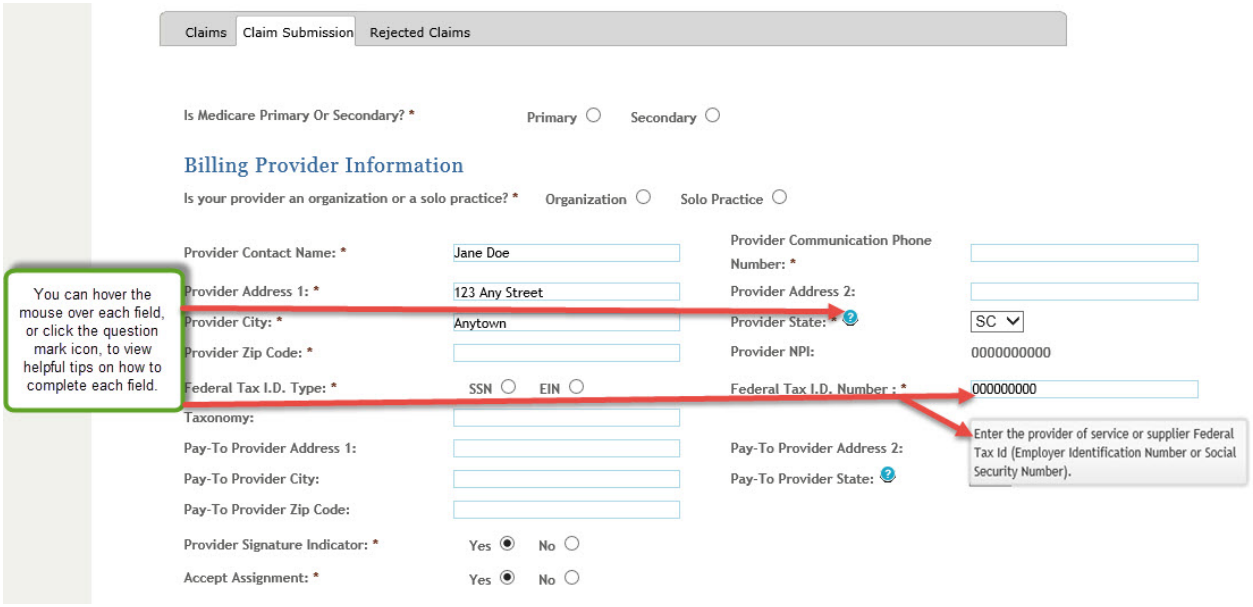
While eServices provider administrators will have access to the feature by default, provider users must be granted permission by an active provider administrator on their account. Additionally, new registrants must wait 48–72 hours (not including weekends and holidays) before the Claim Submission feature is available. If the provider administrator still cannot access the Claim Submission sub-tab after the 72 hours they will need to contact their Medicare Contractor for assistance.

Figure 20: Claim Submission Sub-tab



The eClaim form is dynamic so the fields that display will vary based on the data that is entered on the form. All required fields will be marked with a red asterisk. There are also tool tips that will display as users hover on the field, or question mark icon, to help them determine how to complete the field.

Figure 21: Claim Submission Tool Tips



Users may attach PDF files; up to 40 MB in size each, to their claim. While there is no longer a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB. The attachments must be in PDF format and created using appropriate PDF creation software. Failure to create the PDF correctly can result in a corrupt file that could prevent the user from successfully submitting their eClaim.

Once the user successfully submits their eClaim form, they will be directed to a Claim Submission Summary page that will provide them with the eServices Transaction ID for this eClaim submission. The eServices transaction ID will serve as a confirmation number for the eClaim submission until the submission is accepted. Rejected claims will not receive an ICN.

Figure 22: Claim Submission Summary

Users will receive messages and updates regarding their eClaim submission in their eServices Notification Center. This can be accessed by selecting the Messages tab. The message details will contain history of the eClaim submission. Detailed History will include the Submission Confirmation and when the eClaim submission was accepted or rejected. This may take 24–48 hours (not including weekends or holidays) to receive. If the submission is accepted, an ICN and DCN (if attachments are submitted) will be provided in the message.

NOTE

Receiving an accepted message does not mean that the claim was approved to be paid. Once the claim is processed, the approval or denial information will be on the remittance.

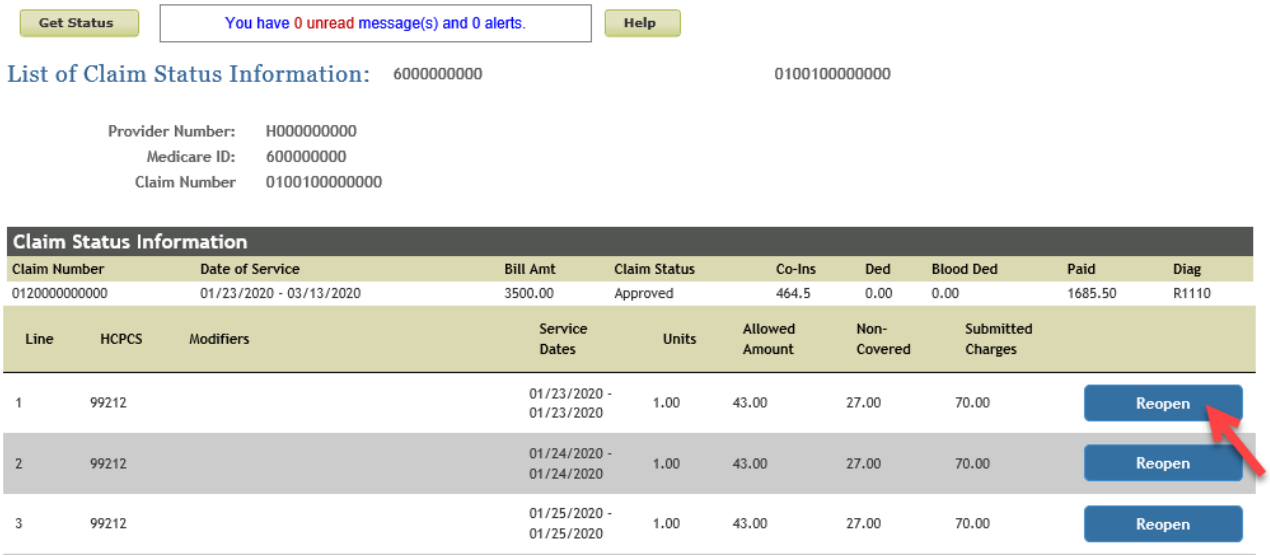
A rejected status will include the corresponding error messages, informing the user what to correct. If the user needs to contact their Medicare Contractor regarding questions about a rejected claim, they must provide the file name listed in the rejected inbox message.

4.7 Claims Reopenings

Claims Reopenings Part B users can request some clerical error reopenings directly from the MCS Claims tab in eServices. Search for the claim using the claim status feature on the Claims tab. Click the word 'link' under the Details column for the claim you wish to view. This will redirect you to a detailed list of the claim's line items.

When performing a Reopening Request, select Reopen on the Claim Status Detail Screen beside the claim line that you want to reopen.

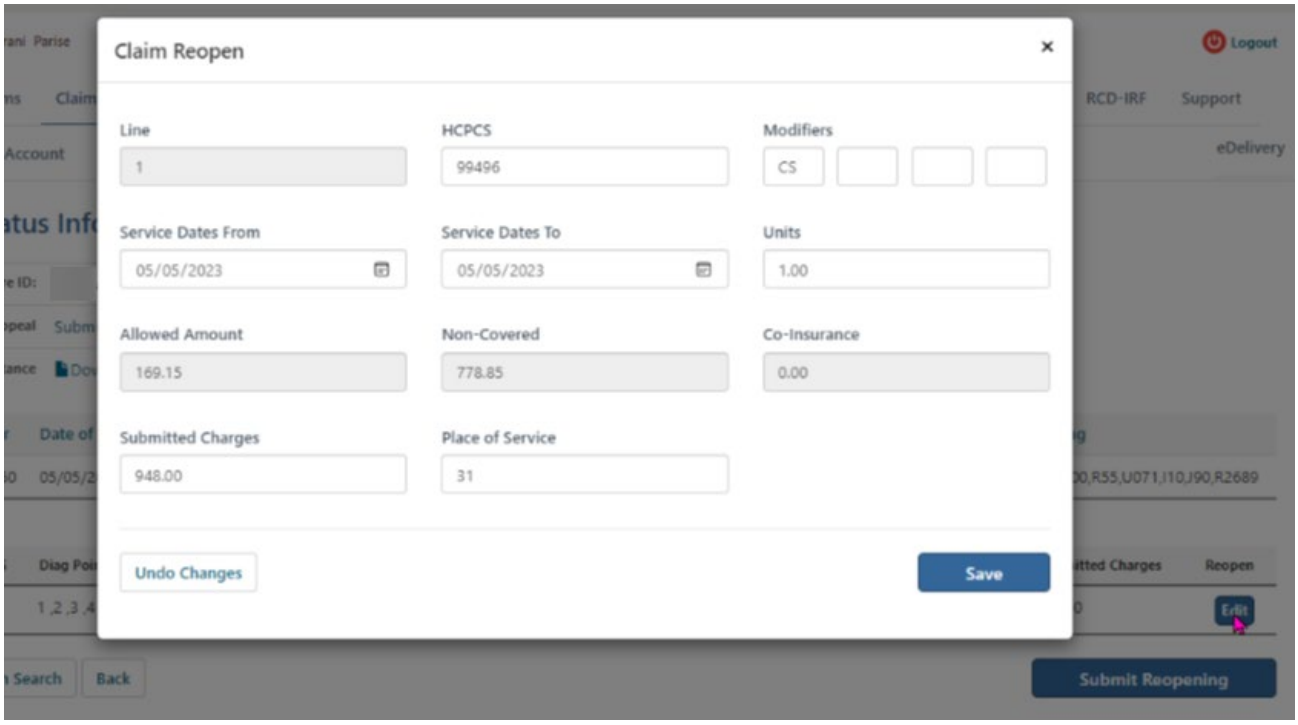
Figure 23: Reopening Request



Claim line detail displays. Updates can be made to the following fields:

- HCPCS Code field
- 4 Modifier fields
- Number of units
- Place of service
- Dates of service
- Submitted charges

Figure 24: Claim Status Information



Closing the window before saving will cancel out any changes on the screen and take you back to the Claim Status Detail Information Screen.

The Save button saves any changes and takes you back to the Claim Status Detail Information Screen.

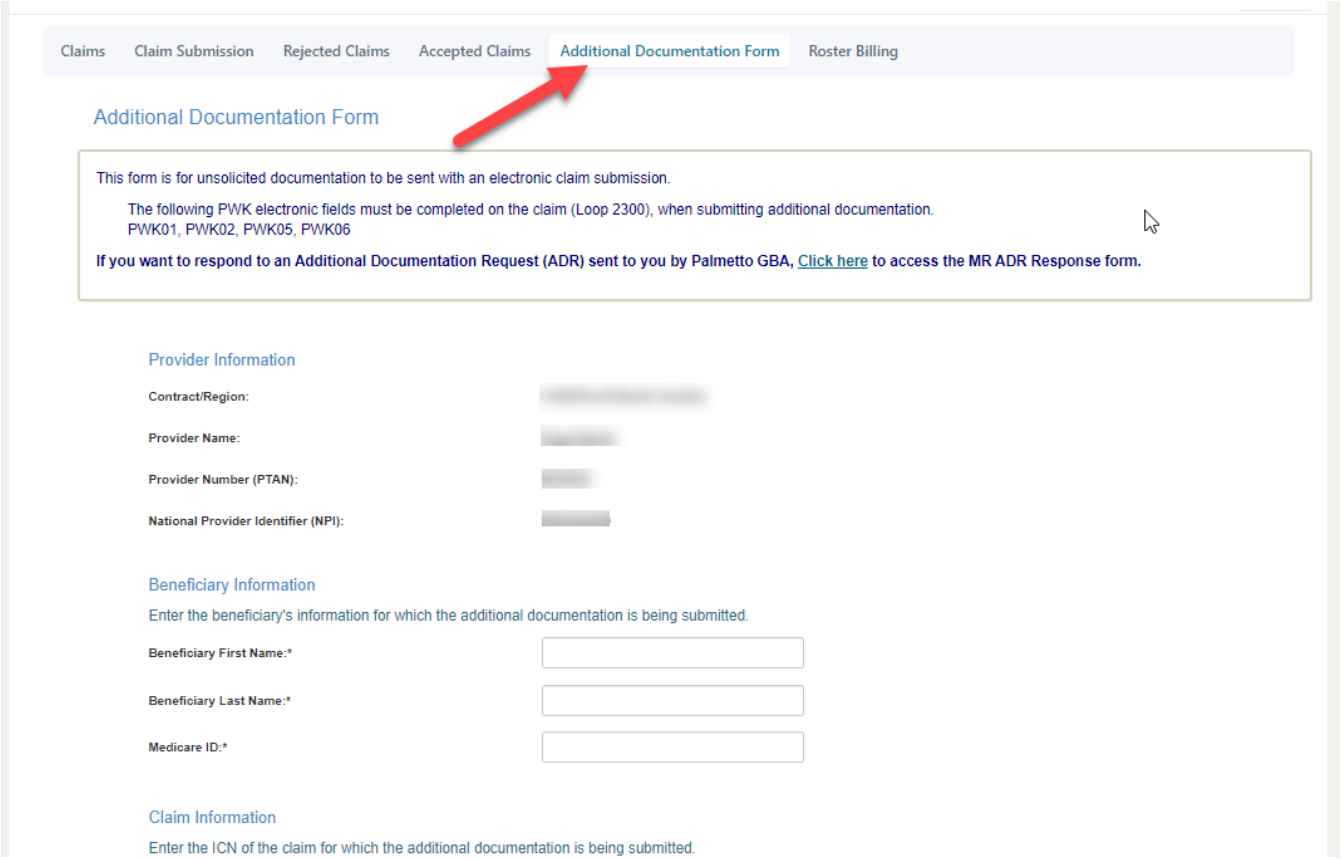
Undo Changes will undo any changes and takes you back to the Claim Status Detail Information Screen.

4.8 Submitting an Additional Documentation form

JJ Part B and JM Part B users can access the additional documentation form from the Additional Documentation Form sub-tab located under the Claims tab. This form is used to attach documents when submitting a claim. If the sub-tab is not displaying, you may not have

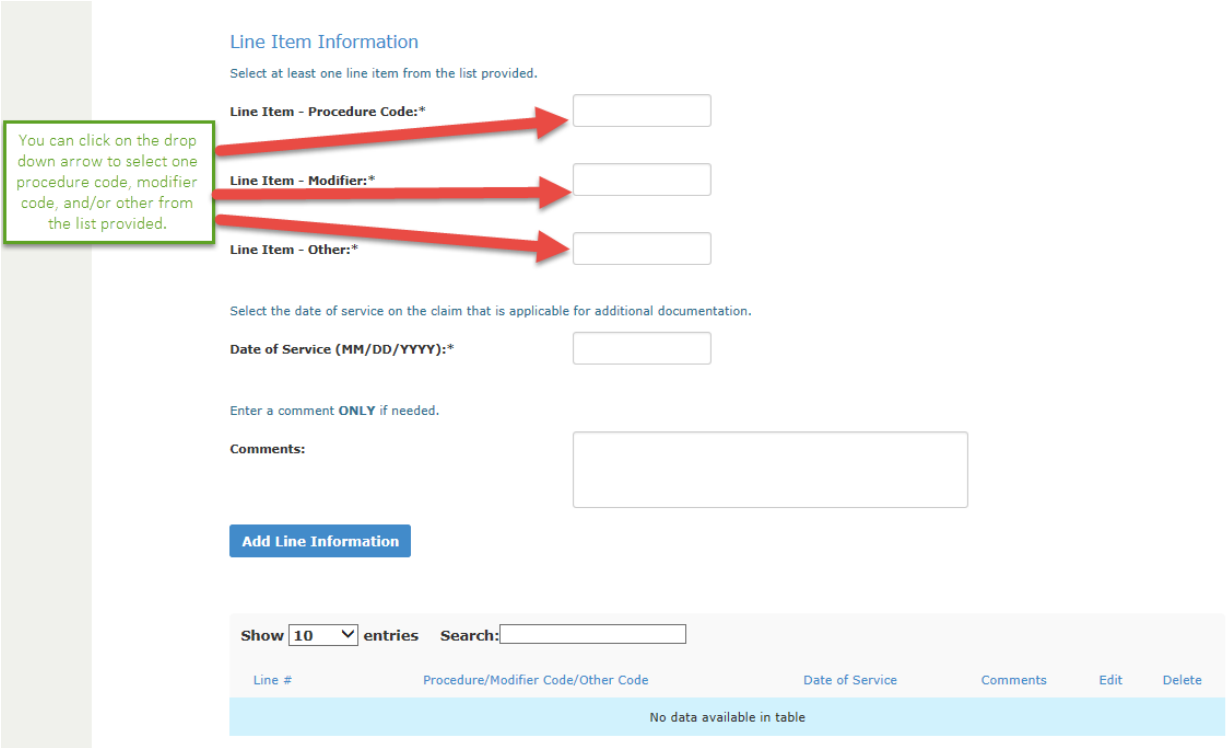
access to this feature.

Figure 25: Additional Documentation Form Navigation



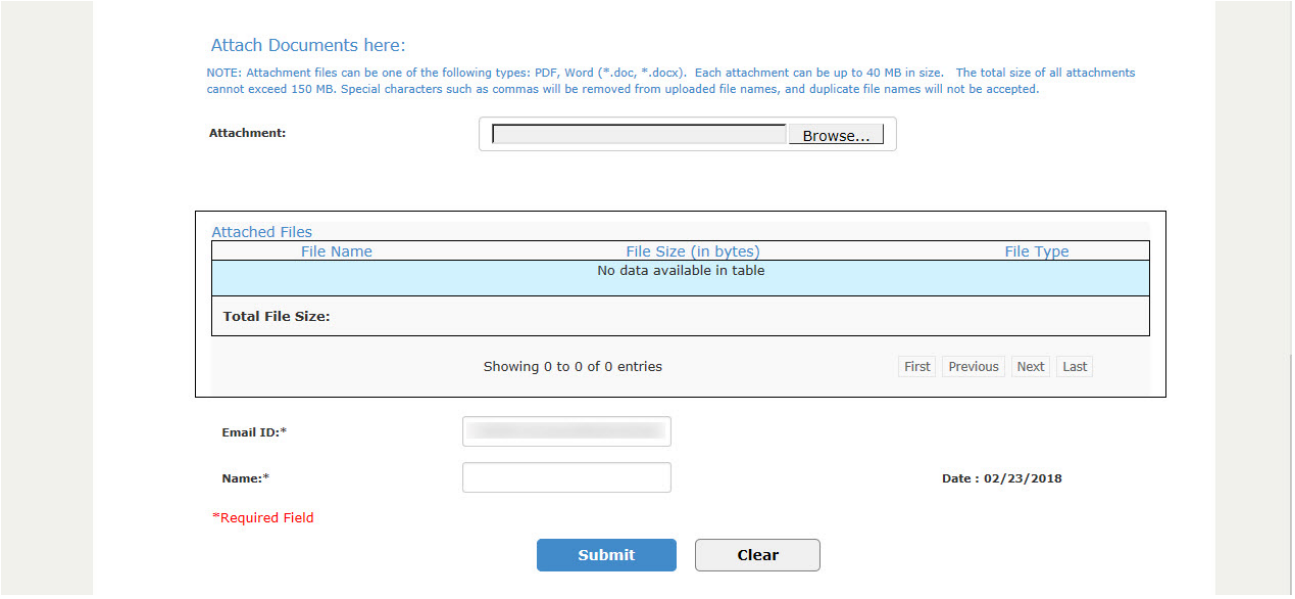
The form is prepopulated with the information we know from your registration record. This will save you several steps. Complete all of the required information. In the Line Item Information section, you must select a procedure code, modifier code, and/or other from the list provided. After completing this section, use the Add Line Information button to add the information to the form. You may then choose to add additional line items following the same process. Each Additional Documentation form may contain up to five line items total.

Figure 26: Additional Documentation Form - Line Item Information



Users may submit attachments up to 40 megabytes (MB) in size. While there is not a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB in size. Files must be either PDF or Word format. Special characters, such as commas, will be removed from uploaded file names; and duplicate file names will not be accepted.

Figure 27: Additional Documentation Form - Attachments



4.9 Submitting a Level 2 Appeal Form

JJ Part A, JM Part A and HHH users can access appeals data from the Claims Lookup feature located under the Claims tab.

Figure 28: Claims Lookup Inquiry

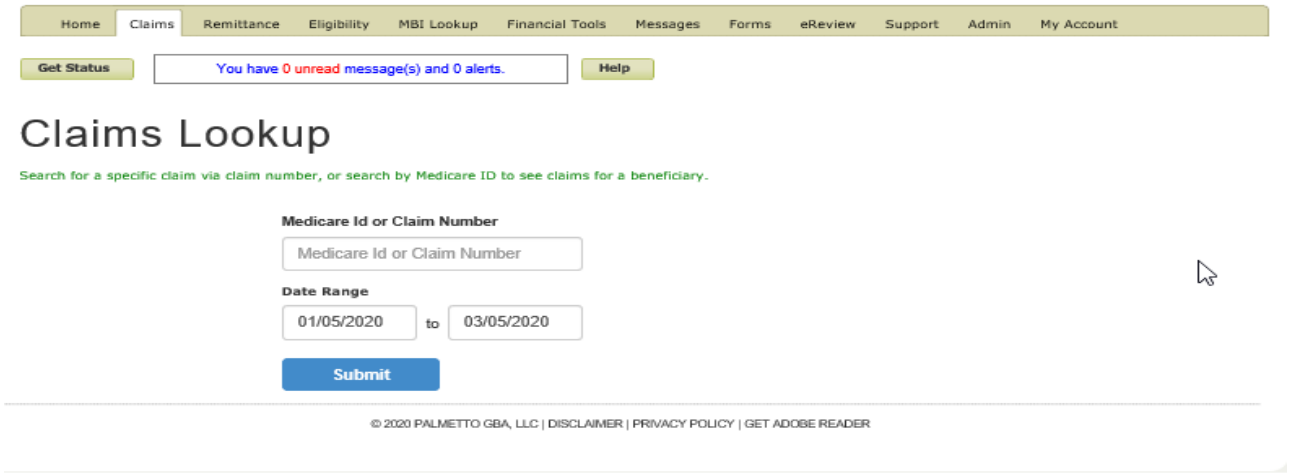
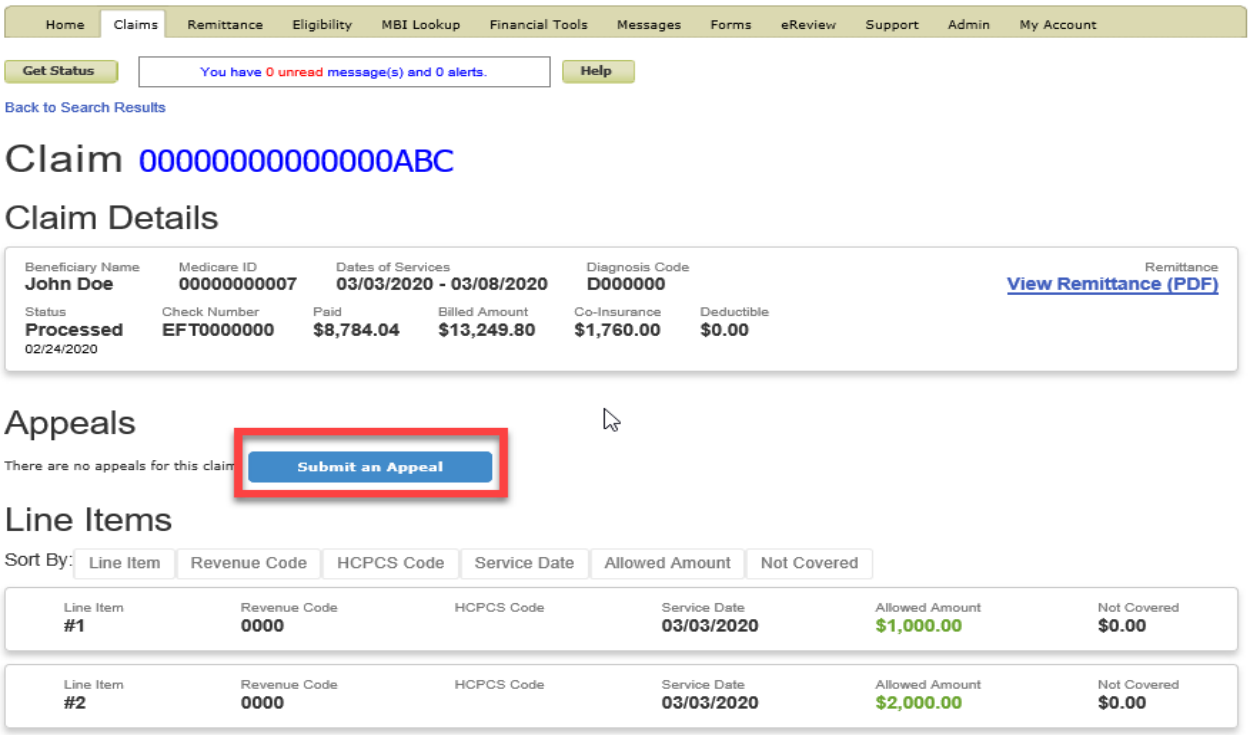
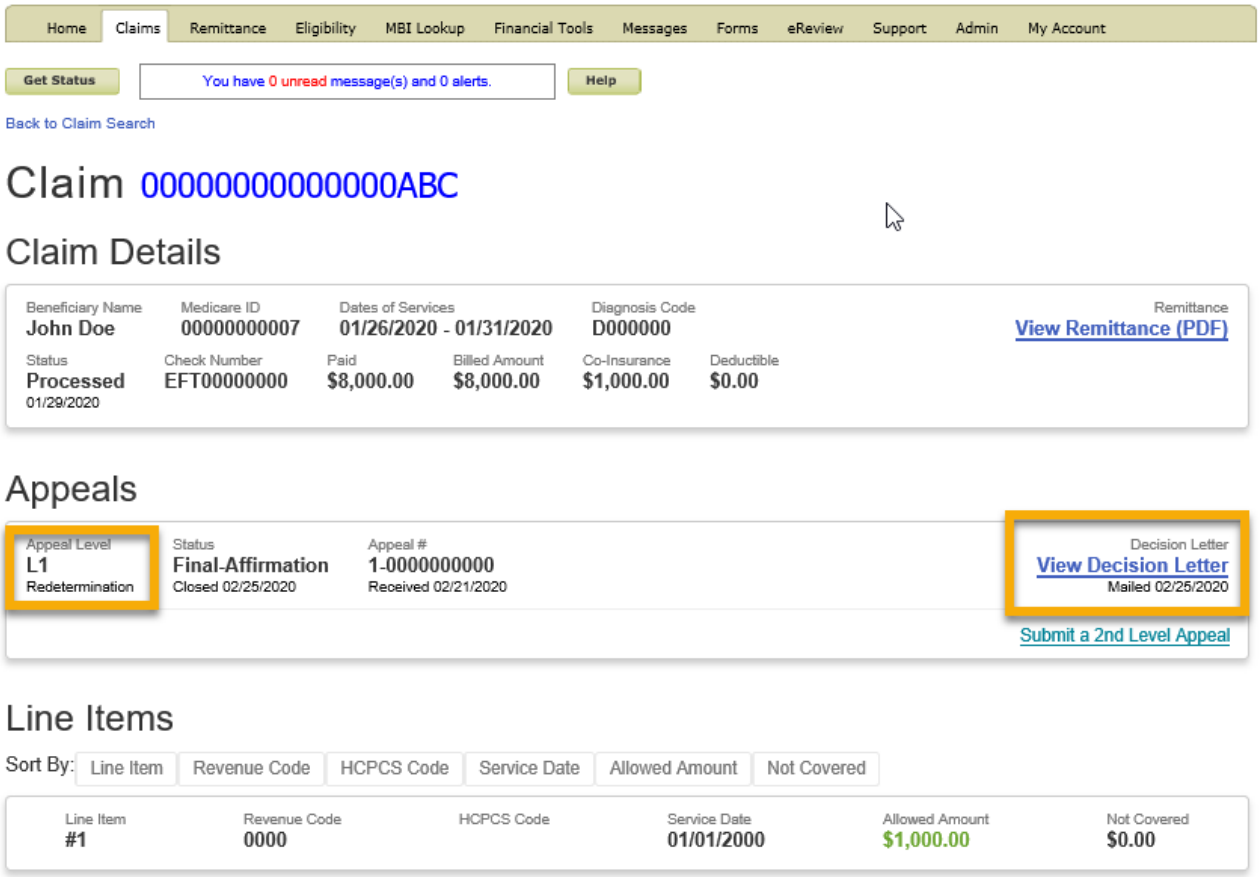


Figure 29: Submitting An Appeal



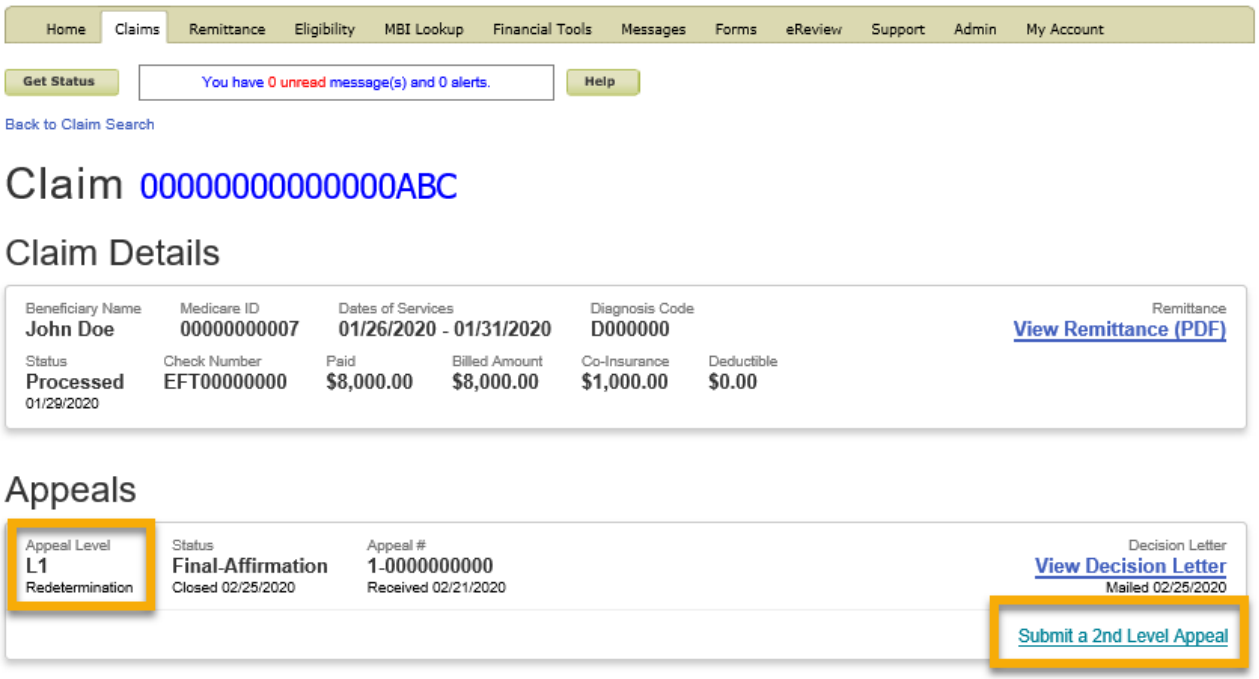
If no appeals are found, “Submit an Appeal” button will be displayed. Users will be redirected to the Redetermination form after confirming whether the appeal is late (over 120 days).

Figure 30: Level 1 Appeal - View Decision Letter



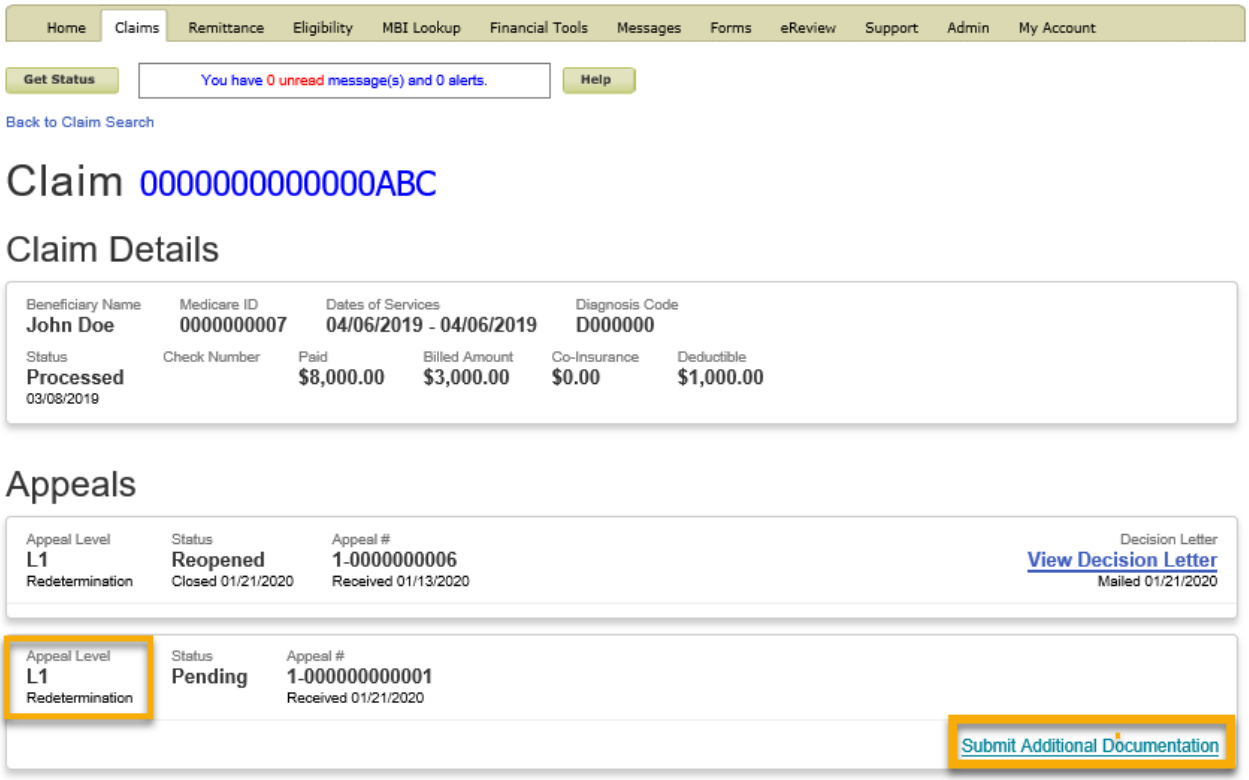
If a Level 1 appeal is found, the status of the appeal will be provided. Multiple links are available for Level 1 Appeals. The links are made available based on the status of the appeal. View Decision Letter link will allow users to download and view the decision letter of the appeal.

Figure 31: Submitting 2nd Level Appeal



If a Level 1 appeal is found, the status of the appeal will be provided. Multiple links are available for Level 1 Appeals. The links are made available based on the status of the appeal. Submit a 2nd level Appeal link redirects the user to complete and submit the Level 2 appeal form. The form can only be submitted if the date of submission is less than 186 days from the date the decision letter was mailed.

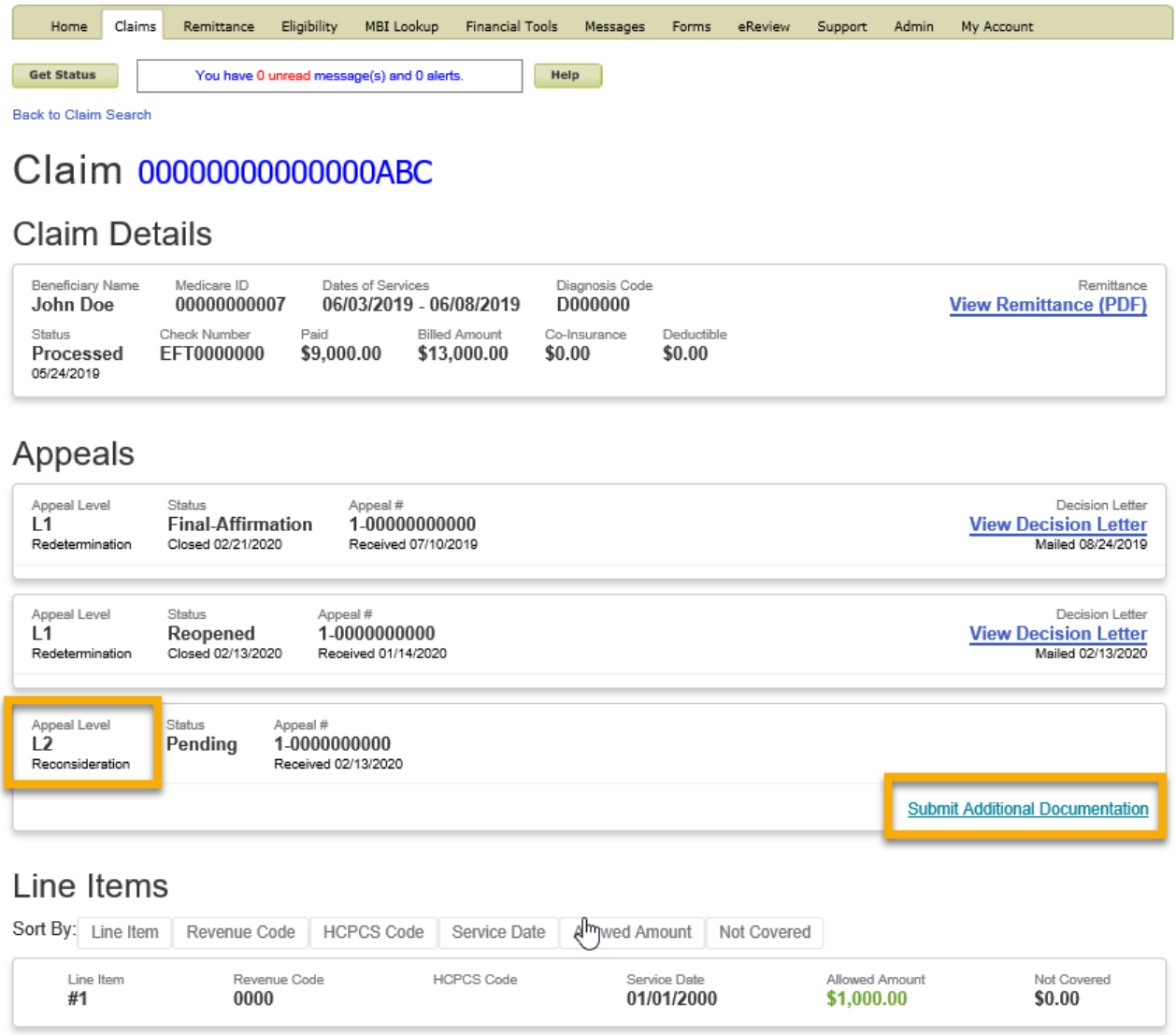
Figure 32: Level 1 Appeal – Submitting Additional Documentation



If a Level 1 appeal is found, the status of the appeal will be provided. Multiple links are available for Level 1 Appeals. The links are made available based on the status of the appeal. Submit Additional Documentation link will redirect users to complete and submit additional documents that can be reviewed as part of the appeal.

Note: Submission of additional documentation for an appeal does not guarantee the inclusion of the documents for review. Normal business practices for reviewing additional documentation are not changed with this new function.

Figure 33: Level 2 Appeal



If a Level 2 appeal is found, the status of the appeal will be provided. Submit Additional Documentation link will redirect users to complete and submit additional documents that can be reviewed as part of the appeal.

Note: Submission of additional documentation for an appeal does not guarantee the inclusion of the documents for review. Normal business practices for reviewing additional documentation are not changed with this new function.

4.10 Submitting a Roster Bill

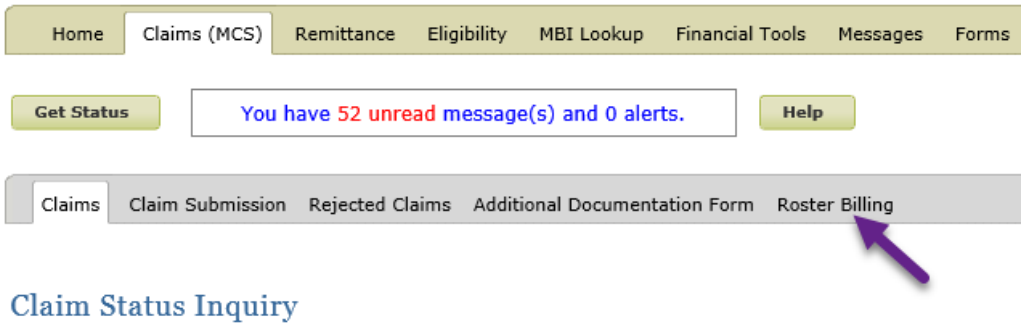
Part B providers, particularly mass immunizers, can create electronic claims for immunization services for up to fifty patients using the roster billing feature. If you need to submit an invoice for pricing with the claim, please use the single eClaim submission feature and not Roster Bill.

Note: If you just registered your eServices account please allow 72 hours before trying to submit your first roster bill.

Users must have the claim submission permission to submit a Roster Bill.

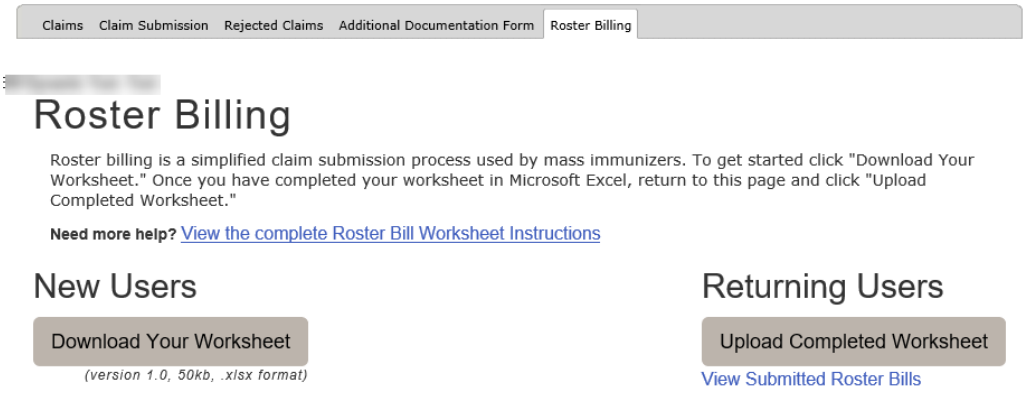
Navigate to the Claims tab and look for the Roster Billing sub-tab.

Figure 34: Roster Billing Subtab



Click on Roster Billing. The Roster Billing home page will display.

Figure 35: Submitting a Roster Bill

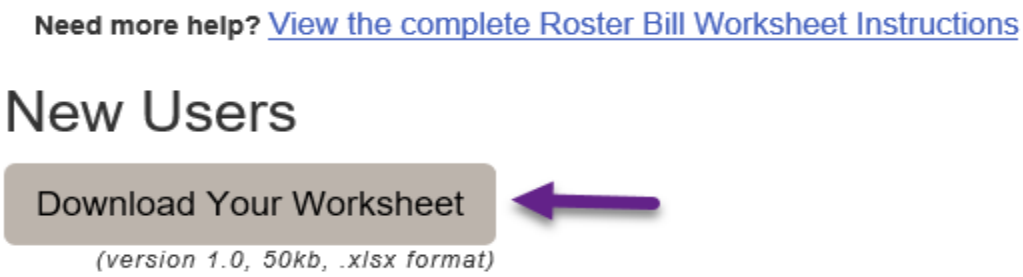


Complete Worksheet:

If you are new to Roster Billing or want a new blank worksheet:

Download a worksheet to enter the claim data and the patients' information. The worksheet will be a blank Excel document.

Figure 36: Roster Bill Worksheet



If you are not new to Roster Billing, complete a worksheet previously downloaded.

The worksheet will be an Excel document with two sections to complete. The first step is the claim information and the next step is the roster information.

Required fields will have an asterisk.

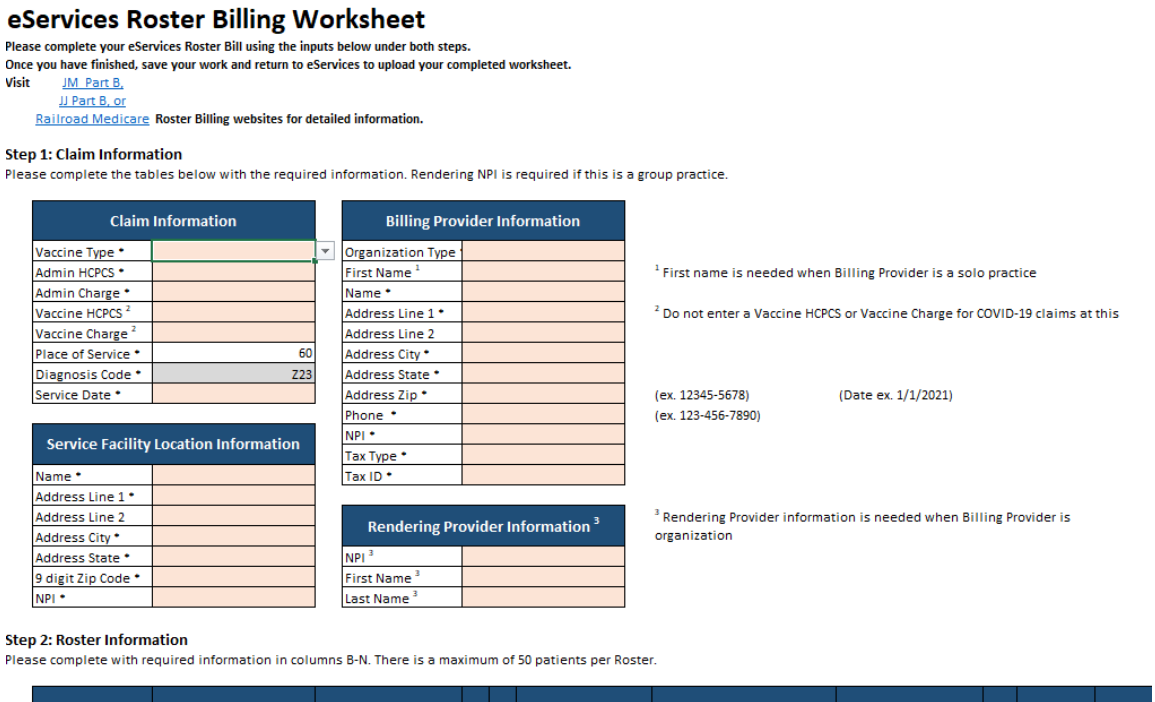
Default or unavailable fields will be grayed out.

For guidance in completing the worksheet see the Roster Bill Worksheet Instructions on the Roster Bill home page and see the links to jurisdiction websites at the top of the worksheet.

You can currently submit claims for influenza, pneumococcal and COVID-19 (vaccine and monoclonal antibody infusion).

Note: *If you are mass immunizer such as a pharmacy with one NPI, please select the organization type of Solo.*

Figure 37: Roster Billing Worksheet Example



eServices Roster Billing Worksheet

Please complete your eServices Roster Bill using the inputs below under both steps.
Once you have finished, save your work and return to eServices to upload your completed worksheet.
Visit JM Part B, JJ Part B, or Railroad Medicare **Roster Billing websites for detailed information.**

Step 1: Claim Information
Please complete the tables below with the required information. Rendering NPI is required if this is a group practice.

Claim Information	
Vaccine Type *	
Admin HCPCS *	
Admin Charge *	
Vaccine HCPCS [2]	
Vaccine Charge [2]	
Place of Service *	60
Diagnosis Code *	Z23
Service Date *	

Billing Provider Information	
Organization Type [1]	
First Name [1]	
Name *	
Address Line 1 *	
Address Line 2	
Address City *	
Address State *	
Address Zip *	
Phone *	
NPI *	
Tax Type *	
Tax ID *	

[1] First name is needed when Billing Provider is a solo practice

[2] Do not enter a Vaccine HCPCS or Vaccine Charge for COVID-19 claims at this

(ex. 12345-5678) (Date ex. 1/1/2021)
(ex. 123-456-7890)

Service Facility Location Information	
Name *	
Address Line 1 *	
Address Line 2	
Address City *	
Address State *	
9 digit Zip Code *	
NPI *	

Rendering Provider Information [3]	
NPI [3]	
First Name [3]	
Last Name [3]	

[3] Rendering Provider information is needed when Billing Provider is organization

Step 2: Roster Information
Please complete with required information in columns B-N. There is a maximum of 50 patients per Roster.

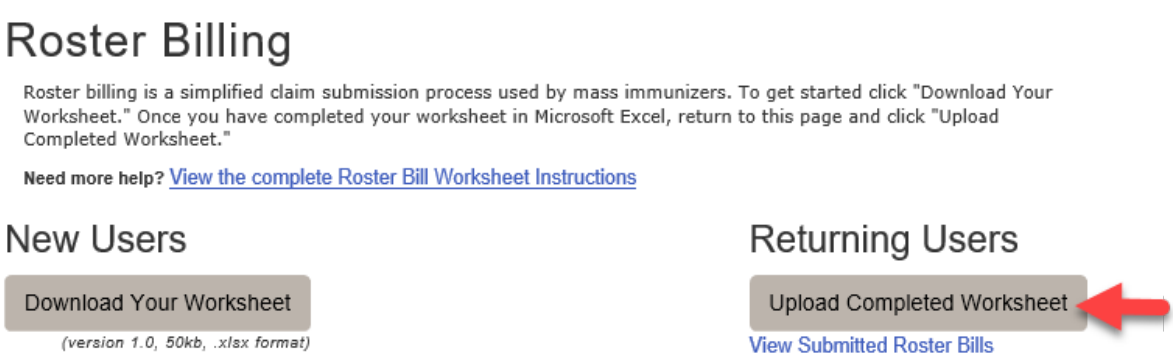
	Medicare ID *	Last Name *	First Name *	MI	Sex *	Date of Birth *	Address Line 1 *	City *	State *	Zip Code *	Signature on File *
1											
2											
3											

Once you fill out the worksheet, you will want to save a copy for your records.

Upload/ Drag Completed Worksheet:

Click the Upload Completed Worksheet button.

Figure 38: Roster Billing Existing Users



Roster Billing

Roster billing is a simplified claim submission process used by mass immunizers. To get started click "Download Your Worksheet." Once you have completed your worksheet in Microsoft Excel, return to this page and click "Upload Completed Worksheet."

Need more help? View the complete Roster Bill Worksheet Instructions

New Users

Download Your Worksheet

(version 1.0, 50kb, .xlsx format)

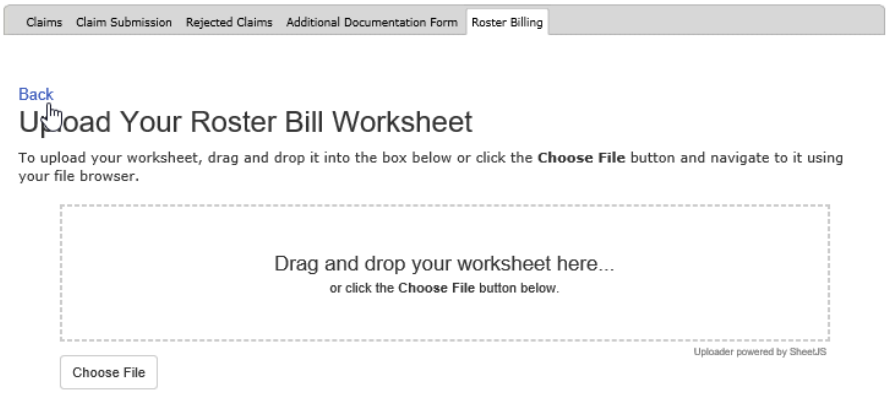
Returning Users

Upload Completed Worksheet

View Submitted Roster Bills

The following page will appear.

Figure 39: Worksheet Upload



Choose a file or drag and drop your worksheet.

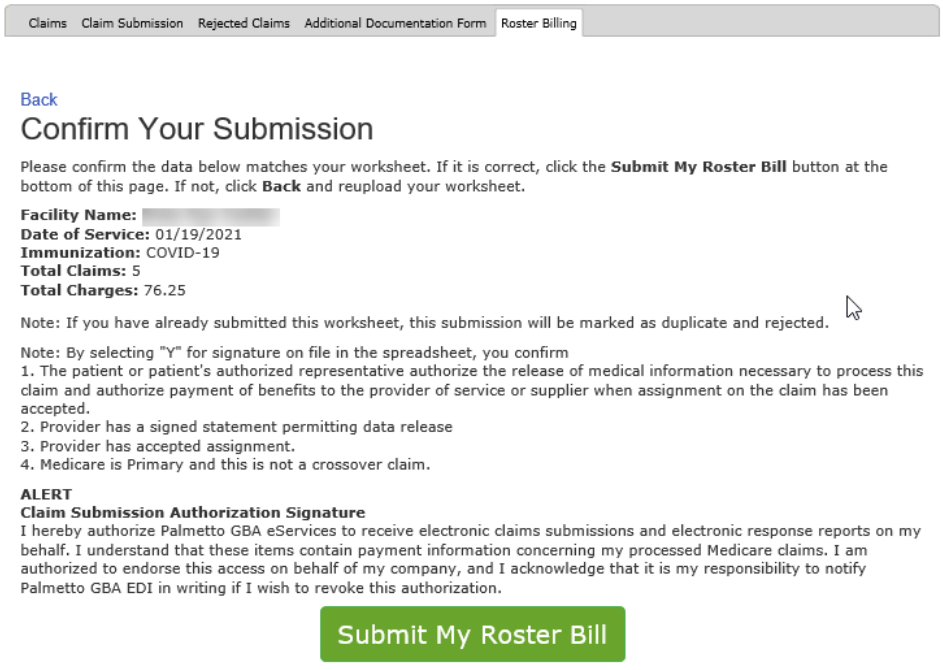
Submit Worksheet:

Once the worksheet is added the following page will appear.

Read over the worksheet summary and if everything is correct.

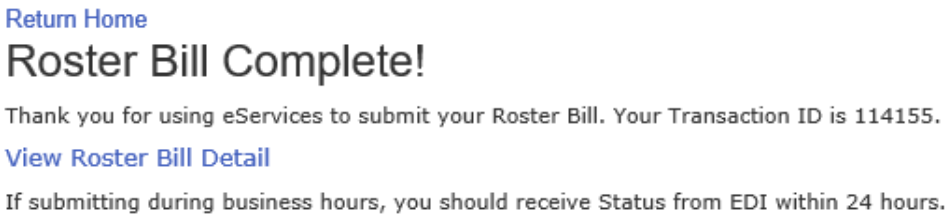
Click the confirm/ submit button.

Figure 40: Roster Bill Confirmation



The following confirmation page will display.

Figure 41: Roster Bill Completion



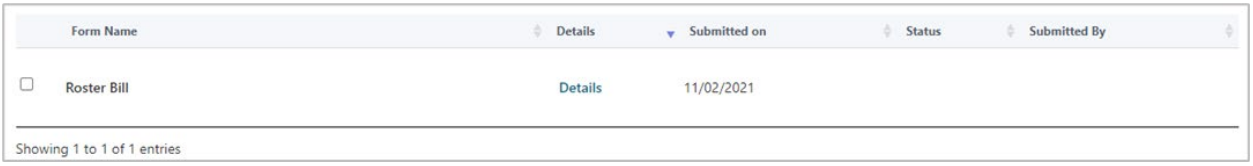
Note: If there are any validation errors with the data entered in the worksheet an error will appear.

4.11 Checking the Status of Roster Bills

Inbox Message

Within an hour you will receive a message in your inbox.

Figure 42: Inbox Message



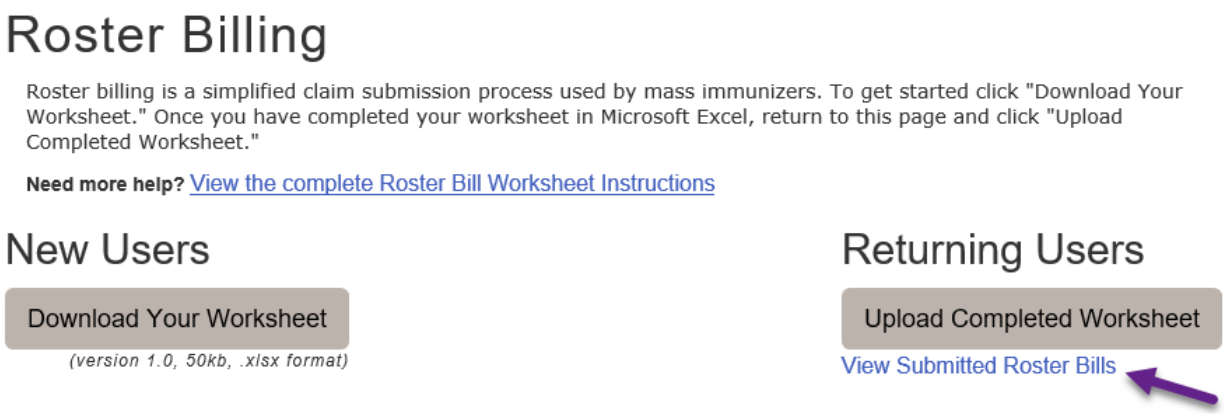
Within two to three days your Detail History will be updated with additional information.

Figure 43: Detail History Information

View list of submissions

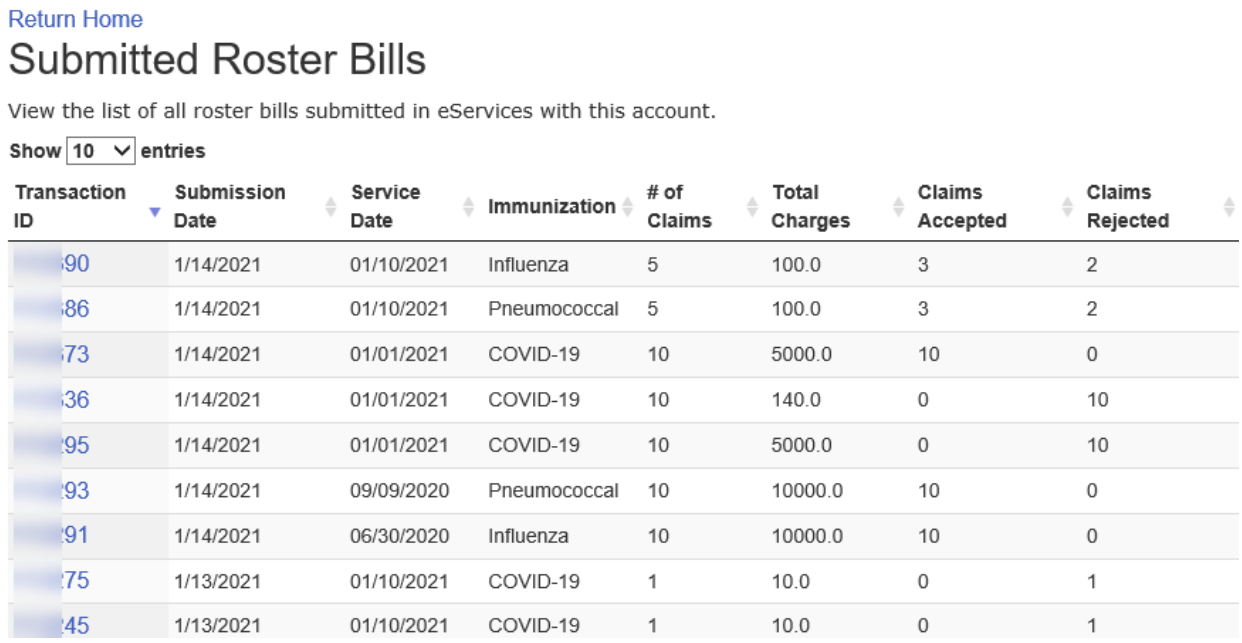
Click on View Submitted Roster Bills link.

Figure 44: View Submitted Roster Bills



A list of all the roster bills submitted will display. You can sort the rows by the data column of your choice. The default sort is by Submission Date with the most current submission being at the top.

Figure 45: Submitted Roster Bills

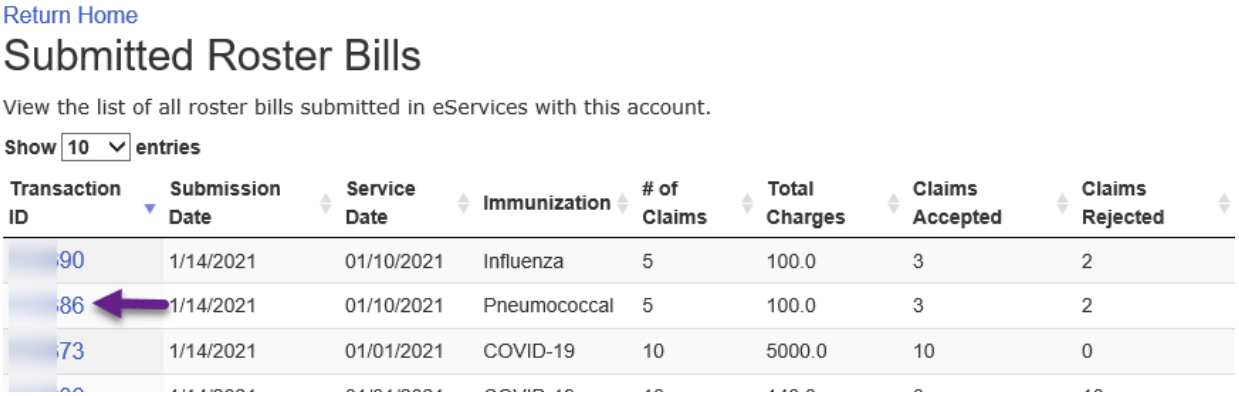


Transaction ID	Submission Date	Service Date	Immunization	# of Claims	Total Charges	Claims Accepted	Claims Rejected
[redacted]90	1/14/2021	01/10/2021	Influenza	5	100.0	3	2
[redacted]86	1/14/2021	01/10/2021	Pneumococcal	5	100.0	3	2
[redacted]73	1/14/2021	01/01/2021	COVID-19	10	5000.0	10	0
[redacted]36	1/14/2021	01/01/2021	COVID-19	10	140.0	0	10
[redacted]95	1/14/2021	01/01/2021	COVID-19	10	5000.0	0	10
[redacted]93	1/14/2021	09/09/2020	Pneumococcal	10	10000.0	10	0
[redacted]91	1/14/2021	06/30/2020	Influenza	10	10000.0	10	0
[redacted]75	1/13/2021	01/10/2021	COVID-19	1	10.0	0	1
[redacted]45	1/13/2021	01/10/2021	COVID-19	1	10.0	0	1

View details of specific submission

Click on the transaction ID to view the details of the specific Roster Bill.

Figure 46: Specific Roster Bill

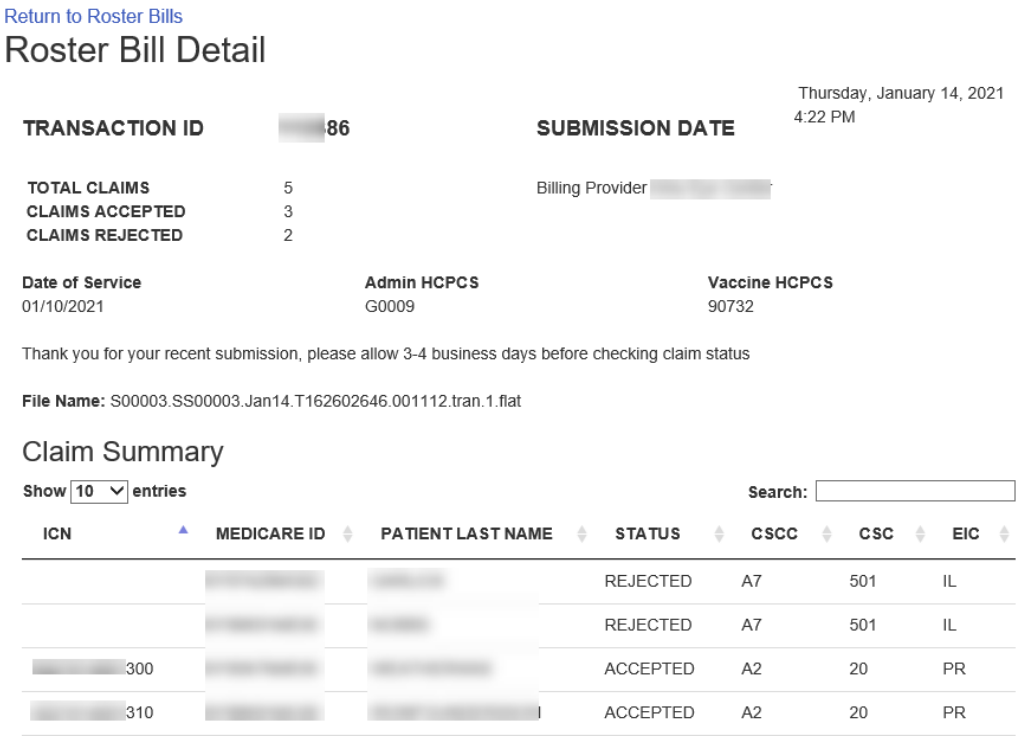


After the bill submission summary section, each line in the worksheet will display.

Bill submissions will show in a pending status for the first day or two until the individual claims reach the processing system.

The ICN will display where claims were accepted into the claim system. If a claim is rejected there will be no ICN.

Figure 47: Roster Bill Detail



Allow three to four days for the ICNs to be available for viewing from the claim inquiry feature.

5.0 Remittances

5.1 How do I 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.

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.

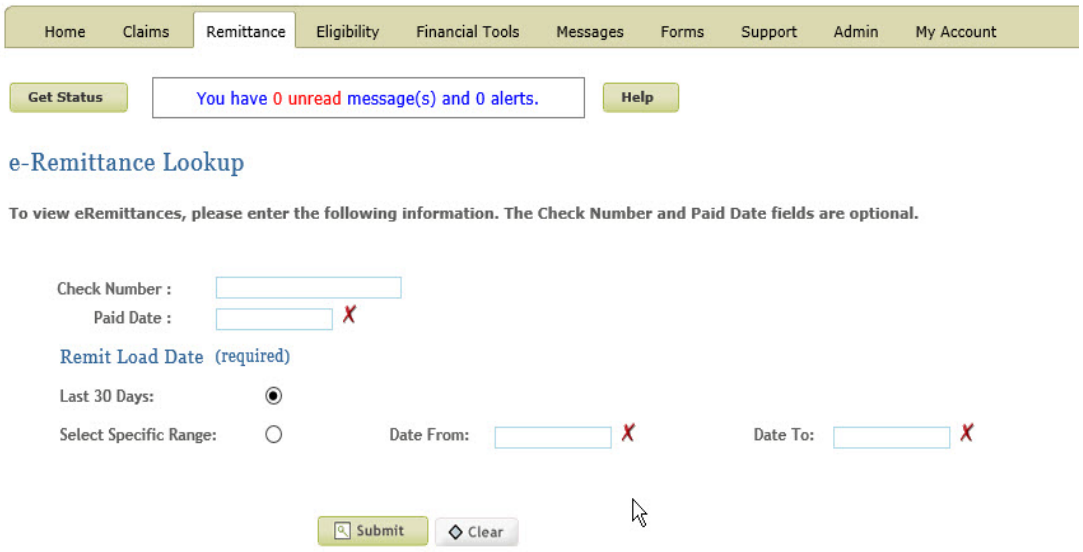
Additional search parameters, such as Check Number and Paid Date, can also be entered to narrow down your query results.

These values will also be displayed in your results screen to help you identify specific remittances.

Once a remittance has been viewed, the line will be grayed out. Users have the option to select remittances that have been viewed by you or by anyone.

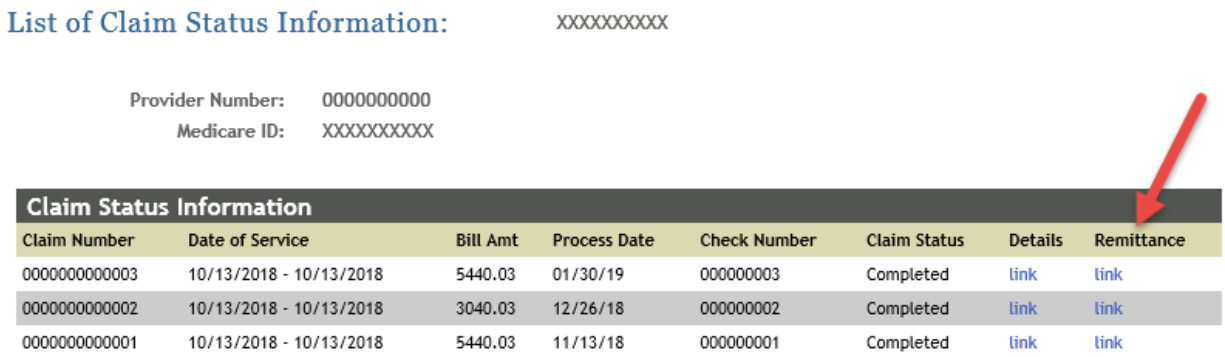
You may also download and print the Remittance Search Results to excel.

Figure 48: Remittance Tab



Remits are also accessible directly from the Claim Summary Screen. Perform your claim status inquiry on the Claims tab to return the list of claims that match your search criteria. Then click the Remittance link on the claim line you wish to view.

Figure 49: Claim Summary Screen



List of Claim Status Information: XXXXXXXXXX

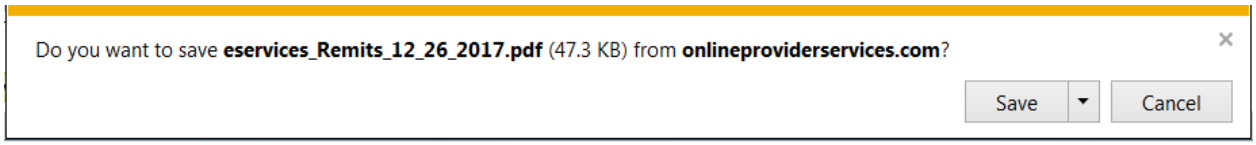
Provider Number: 0000000000
Medicare ID: XXXXXXXXXX

Claim Status Information

Claim Number	Date of Service	Bill Amt	Process Date	Check Number	Claim Status	Details	Remittance
0000000000003	10/13/2018 - 10/13/2018	5440.03	01/30/19	000000003	Completed	link	link
0000000000002	10/13/2018 - 10/13/2018	3040.03	12/26/18	000000002	Completed	link	link
0000000000001	10/13/2018 - 10/13/2018	5440.03	11/13/18	000000001	Completed	link	link

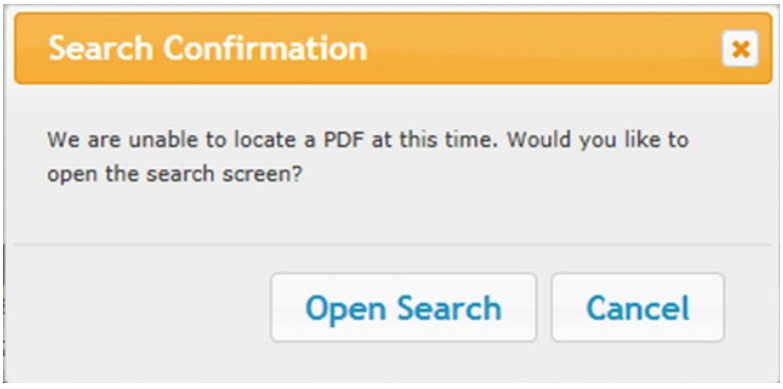
If a single match is found, the option to save as a PDF file will display at the bottom of the screen.

Figure 50: Save Message Pop-up



If a match is not immediately found or multiple remittances are found, a pop-up window will display providing the option to search.

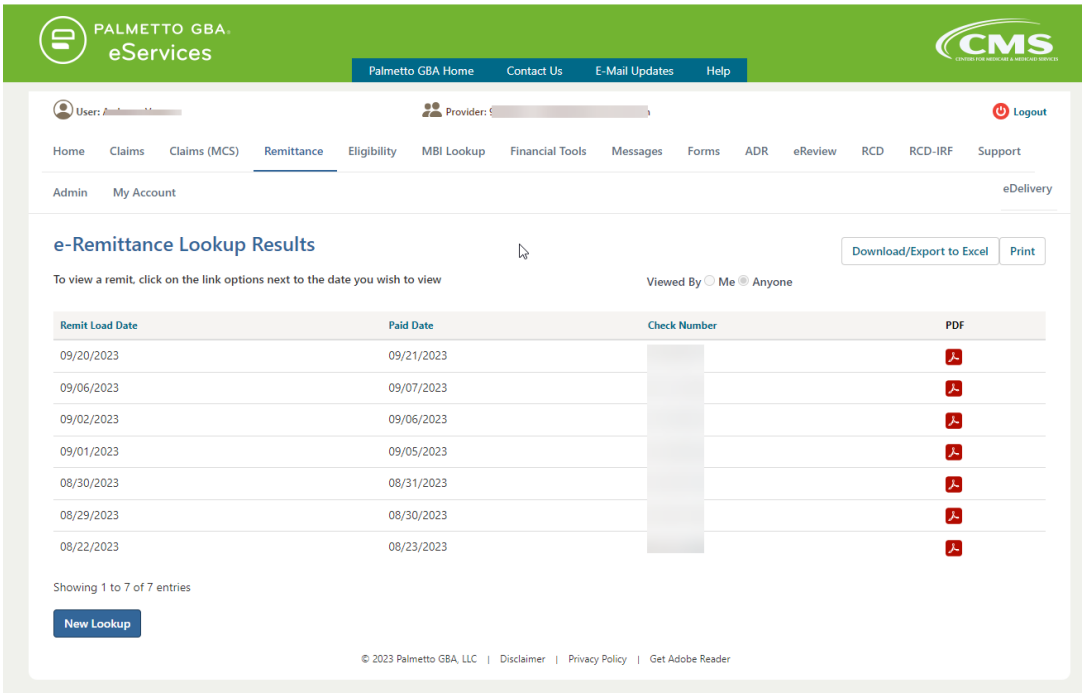
Figure 51: Search Confirmation Pop-up



Click Open Search to display the e-Remittance Lookup Screen. Click Cancel to remain on the Claim Inquiry Summary Screen.

For claims that do not have a check number, a list of possible remittances based on NPI will be displayed.

Figure 52: Remittance Results



You can use the buttons above the results table on the right side of the page to download the results to Excel. You can use the print button to print to a PDF.

5.2 How far back can I view remittances?

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

5.3 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 those remittances. If no remittances are displayed, you may want to select a specific date range.

Remittances are readily available online as described in section 5.2.

NOTE

You will only be able to view remits for the one PTAN/NPI combination associated with your user ID. If you have additional NPIs, they will need to be registered separately.

5.4 I do not see a remittance for the deposit date I am searching for. What should I do?

Remittances are listed in eServices by the remittance upload date and not the deposit date, so you may need to search a few days earlier or later in the remit list to find the specific remittance you are looking for.

NOTE

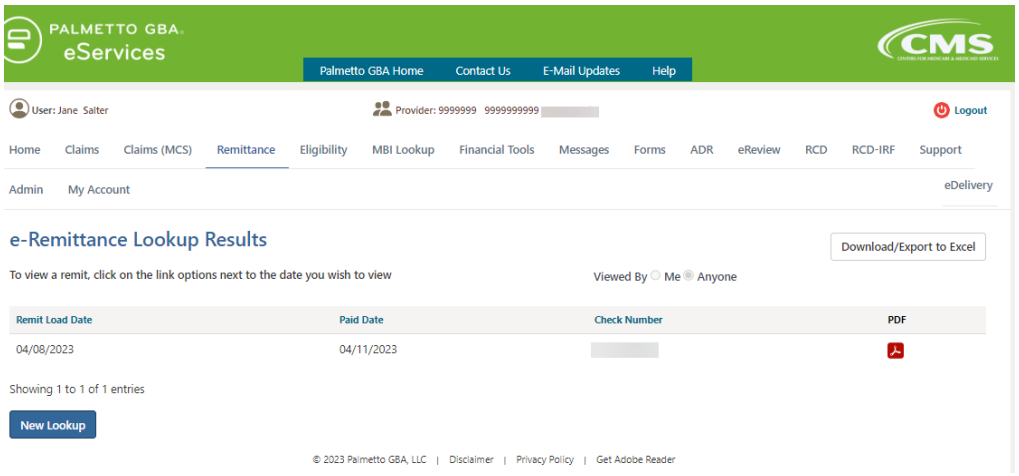
You will only be able to view remits for the one PTAN/NPI combination associated with your user ID. If you have additional NPIs, they will need to be registered separately.

5.5 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 list of remittances by clicking on the date column header. The option to save as a PDF file will display at the bottom of the screen. You may then select the option to open the saved file. 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. You must use Acrobat Reader X or Acrobat Pro X to successfully print remittances in eServices.

Please see Section 5.1 for information about how to access the remittance list.

Figure 53: Remittance Look-up Results



6.0 Eligibility

The eServices eligibility functions are based on CMS' HIPAA Eligibility Transaction System (HETS). 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:

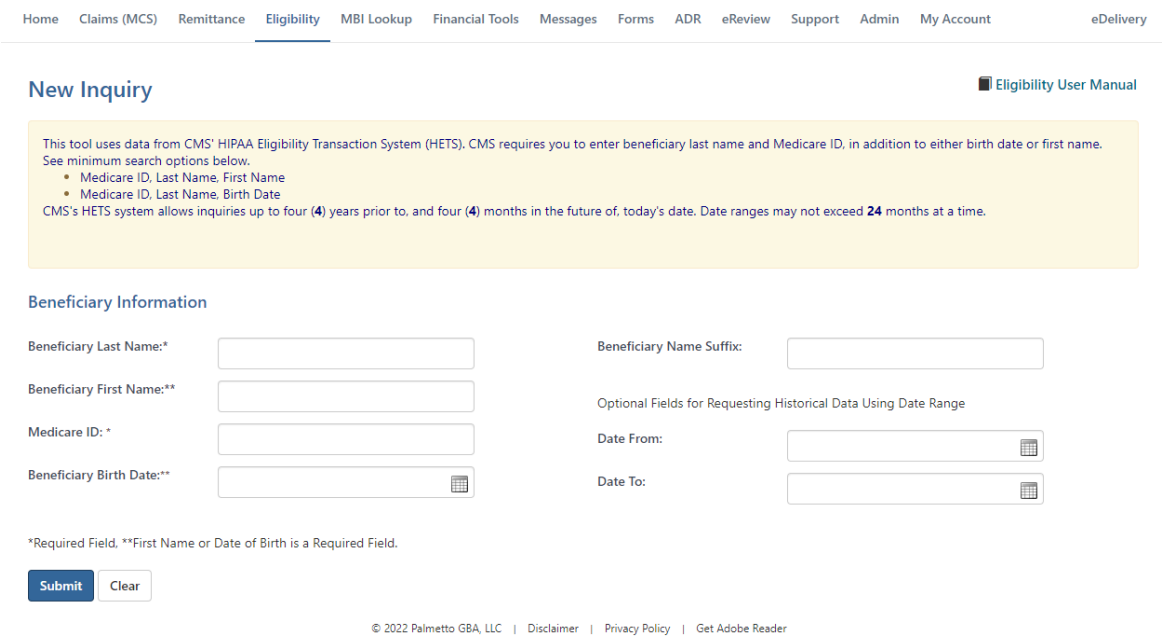
- Inquiry
- Eligibility
- Deductibles/Caps
- Preventive
- Plan Coverage
- MSP

- Hospice/Home Health
- Inpatient
- QMB

NOTE

eServices uses CMS's HETS 270/271 system, as required by CMS, for all eligibility inquiries. Although eServices pulls data from HETS in real time, the data available in the HETS 270/271 system is only updated once daily in the mornings (Eastern Time). The HETS response is not updated further during the day. Providers should not resubmit the same transaction multiple times thought out the day expecting to receive different results. As soon as updated data is available in the HETS 270/271 system, providers will be able to view it in eServices. For more information on HETS, visit HIPAA Eligibility Transaction System (HETS) | CMS.

Figure 54: Eligibility Tab



6.1 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 sub-tab to enter beneficiary information and submit a Medicare beneficiary eligibility request. The user should enter a beneficiary's information into the fields below. To protect the privacy of beneficiary data, all fields entered, including optional fields, must match the beneficiary's data as it is maintained in CMS' HIPAA Eligibility Transaction System (HETS); otherwise, eligibility data will not be returned.

The following fields are required:

- Subscriber's[1] Last Name - The suffix (i.e., Jr, Sr, etc.) 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's First Name[2]
- Subscriber Birth Date[2]
- Medicare ID

You may enter data into optional fields, but these fields are not required to receive a valid Medicare beneficiary eligibility benefit response. If data entered into an optional field does not match the beneficiary's data maintained in CMS' HETS system, eligibility data will not be returned on the eligibility response tabs.
The optional fields are as follows:

- Subscriber Name Suffix – The beneficiary's suffix may be entered in this field if the beneficiary has it printed on their Medicare health insurance card
- Subscriber Gender
- Date From
- Date To

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

[2]To successfully submit an eligibility inquiry, you are required to enter either the Subscriber's First Name or Subscriber's Birth Date in addition to the Subscriber's Last Name and Medicare ID.

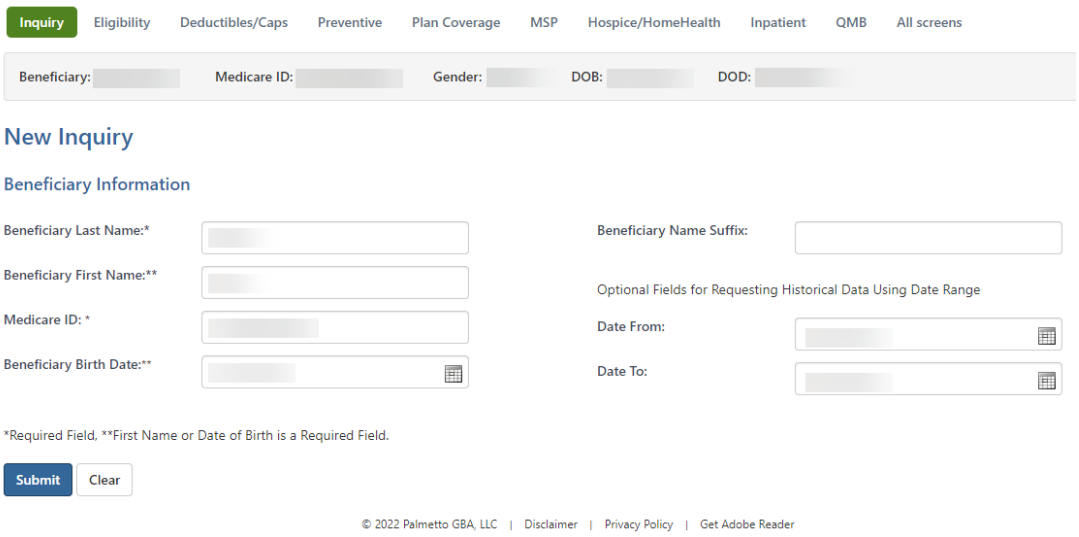
[3]The Medicare ID is the Medicare beneficiary identifier assigned by Medicare.

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

NOTE

To retrieve all information available, you must enter a valid date range. The HETS 270/271 system we are required to access for eligibility allows date requests up to four (4) years prior to, and four (4) months in the future of, the current date. Date ranges may not exceed 24 months at a time.

Figure 55: Eligibility, Inquiry Tab



6.2 How do I use the date range optional fields in the eligibility Inquiry tab?

The 'Date From' and 'Date To' fields are optional fields you can input to request beneficiary eligibility data for a specific time period. If no 'Date From' or 'Date To' is entered, the system will automatically use the current calendar date for the inquiry.

You will receive an invalid 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.

NOTE

To retrieve all information available, you must enter a valid date range. The HETS 270/271 system we are required to access for eligibility allows date requests up to four (4) years prior to, and four (4) months in the future of, the current date. Date ranges may not exceed 24 months at a time.

Based on the 'Date From' and 'Date To' 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 'Date From' that is before the date of eligibility and no 'Date To' is entered
- A 'Date From' 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, 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 tab 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 up to four (4) years prior to, and four (4) months in the future of, the current date. Data ranges may not exceed 12 months at a time. The eServices Eligibility functions are based on the data available in CMS' HETS system.

6.3 How do I use the Eligibility sub-tab?

The Eligibility sub-tab provides information regarding the beneficiary's Part A and Part B eligibility, inactive periods (e.g., unlawful, deported, and incarcerated), beneficiary address and end-stage renal disease (ESRD). If this tab is available, it indicates that the beneficiary has some type of Medicare eligibility. If the beneficiary is eligible for Medicare benefits, the screen will display the beneficiary's Part A and/or Part B Eligibility period(s) as appropriate. 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.

Figure 56: Eligibility, Eligibility Tab

NOTE

If the 'Part A Eligibility' benefit information. 'Part B Eligibility' or "Part B Immunosuppressive Drug Eligibility" 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	Descrip
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

Part B Immunosuppressive Drug Eligibility Benefit Information

Field Name	Description
Effective Date	A date that indicates the start of eligibility for Medicare Part B – ID benefits
Termination Date	A date that indicates the termination of eligibility for Medicare Part B – ID benefits. No date in this field means Medicare Part B – ID benefits 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

6.4 How do I use the Deductibles Tab?

The Deductibles sub-tab provides information regarding the beneficiary's Part B deductibles; coinsurance; blood deductibles; occupational therapy; physical and speech therapy; pulmonary, cardiac and intensive cardiac rehabilitation sessions; Part B free services and mental health co-insurance amounts.

Figure 57: Eligibility, Deductibles Tab

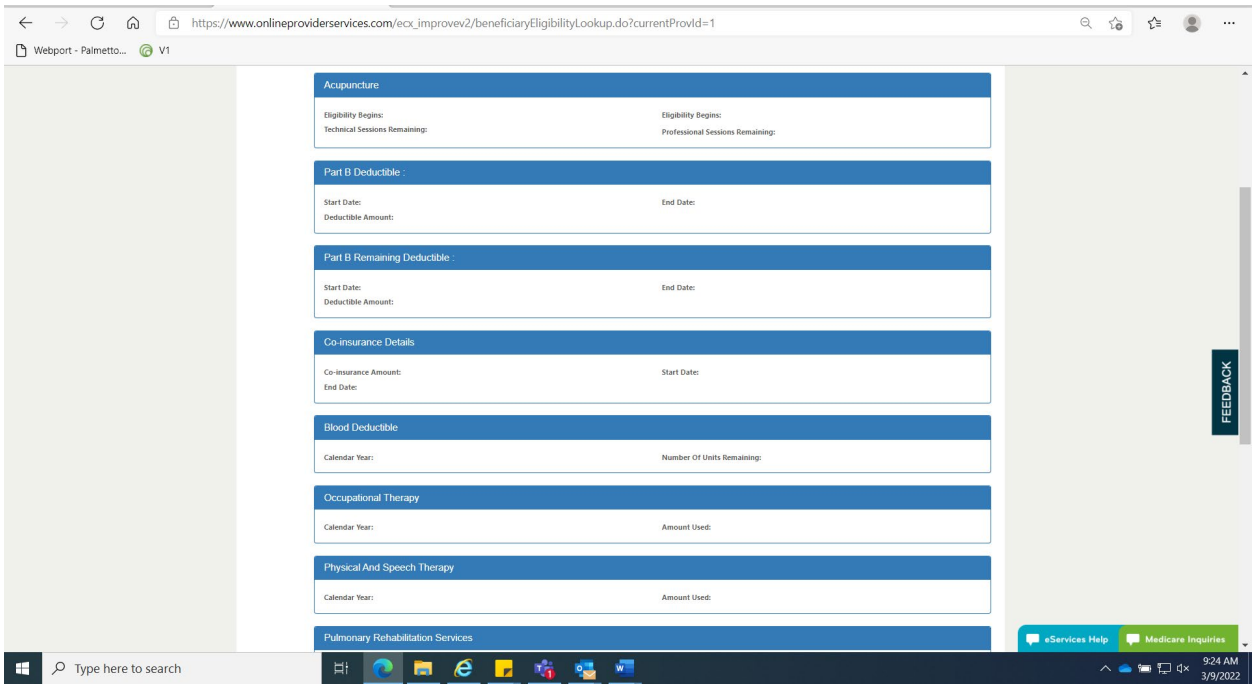
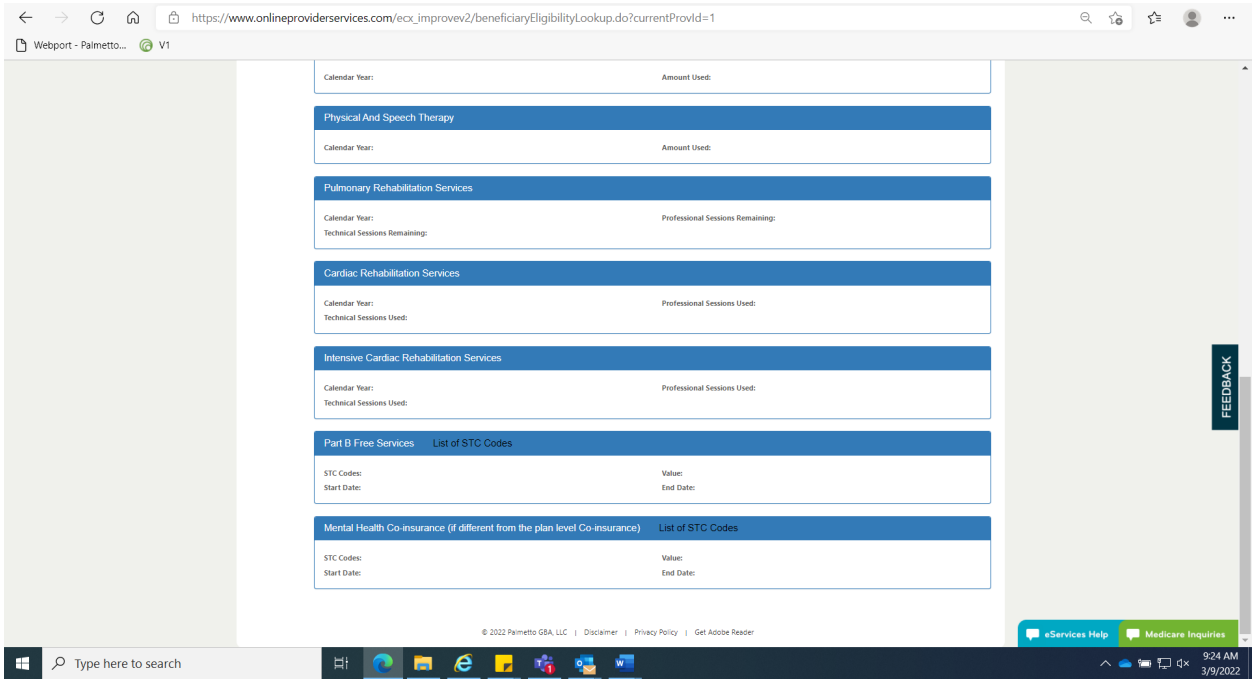


Figure 58: Eligibility, Deductibles Tab Continued



The following tables provide information for the Deductible Tab.

Part B Deductible Information

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

Co-insurance Amount

Field Name	Description
Co-insurance Amount	The patient's portion of responsibility for a benefit, represented as a percentage
Start Date	The start date of the benefit period, typically the first day of the calendar year indicated
End Date	The end date of the benefit period, typically the last day of the calendar year

Blood Deductible Information

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

Occupational Therapy Information

Field Name	Description
Calendar Year	The calendar year associated with the used dollar amount applied to the capitation limit
Amount Used	Occupational Therapy services used dollar amount applied to the capitation limit associated with the calendar year indicated

Physical and Speech Therapy Information

Field Name	Description
Calendar Year	The calendar year associated with the used dollar amount applied to the capitation limit
Amount Used	Physical and Speech Therapy services used dollar amount applied to the capitation limit associated with the calendar year indicated

Pulmonary Rehabilitation Services Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining sessions for pulmonary rehabilitation services
Professional Sessions Remaining	The number of pulmonary rehabilitation sessions remaining for the professional component
Technical Sessions Remaining	The number of pulmonary rehabilitation sessions remaining for the technical component

Cardiac Rehabilitation Services Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining sessions for cardiac rehabilitation services
Professional Sessions Remaining	The number of cardiac rehabilitation sessions used for the professional component
Technical Sessions Remaining	The number of cardiac rehabilitation sessions used for the technical component

Intensive Cardiac Rehabilitation Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining sessions for intensive cardiac rehabilitation
Professional Sessions Used	The number of intensive cardiac rehabilitation sessions used for the professional component
Technical Sessions Used	The number of intensive cardiac rehabilitation sessions used for the technical component

Part B Free Services

Field Name	Description
STC Codes	The STC codes associated with Part B services that have a 0% co-insurance amount
Value	The patient's portion of responsibility for a benefit, represented as a percentage
Start Date	The start date of the benefit period, typically the first day of the calendar year indicated
End Date	The end date of the benefit period, typically the last day of the calendar year

Mental Health Co-insurance

Field Name	Description
STC Codes	The mental health STC codes that are listed as having a co-insurance amount that is different than the plan level co-insurance
Value	The patient's portion of responsibility for a benefit, represented as a percentage
Start Date	The start date of the benefit period, typically the first day of the calendar year indicated
End Date	The end date of the benefit period, typically the last day of the calendar year

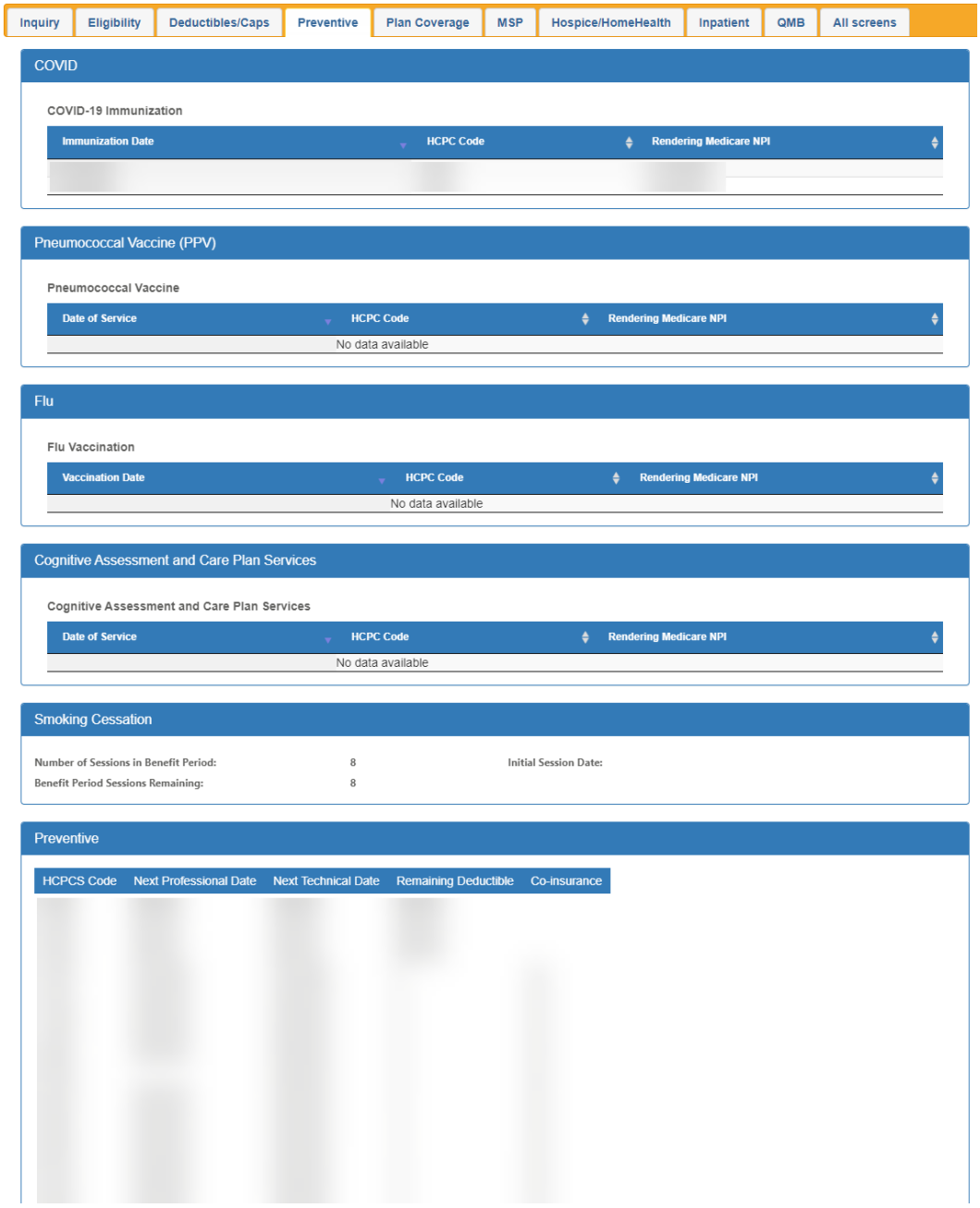
6.5 How do I use the Preventive tab?

The Preventive tab provides information regarding the beneficiary's 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).

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. Pneumococcal Vaccine (PPV) information is displayed for the last 10 dates of service.

Figure 59: Eligibility, Preventive Tab



The following tables provide information for the Preventive Tab.

COVID-19 Immunization

Field Name	Description
Immunization Date	Immunization date for the HCPC code
HCPC Code	A Healthcare Common Procedure Coding System (HCPCS) code
Rendering Medicare NPI	NPI of the provider that administered the services for the applicable code.

Pneumococcal Vaccine

Field Name	Description
Date of Service	Date the HCPC was administered.
HCPC Code	A Healthcare Common Procedure Coding System (HCPCS) code
Rendering Medicare NPI	NPI of the provider that administered the services for the applicable code.

Flu Vaccination

Field Name	Description
Date of Service	Date the HCPC was administered.
HCPC Code	A Healthcare Common Procedure Coding System (HCPCS) code
Rendering Medicare NPI	NPI of the provider that administered the services for the applicable code.

Cognitive Assessment and Care Plan Services

Field Name	Description
Date of Service	Date the HCPC was administered.
HCPC Code	A Healthcare Common Procedure Coding System (HCPCS) code
Rendering Medicare NPI	NPI of the provider that administered the services for the applicable code.

Pneumococcal Vaccine (PPV) Information

Field Name	Description
Date of Service	Last date of service for the applicable code. The last 10 dates of service will be provided.
HCPC Code	A Healthcare Common Procedure Coding System (HCPCS) code
Rendering NPI	NPI of the provider that administered the services for the applicable code.

Smoking Cessation Information

Field Name	Description
Number of Sessions in Benefit Period	Number of smoking cessation counseling sessions available for a beneficiary during the benefit period
Benefit Period Sessions Remaining	Number of smoking cessation counseling sessions remaining for a beneficiary

Field Name	Description
Next Session Date	The next available begin date for smoking cessation counseling 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
Remaining Deductible	The remaining deductible amount associated with the indicated HCPCS code
Co-insurance	The patient's portion of responsibility for the indicated HCPCS code, represented as a percentage

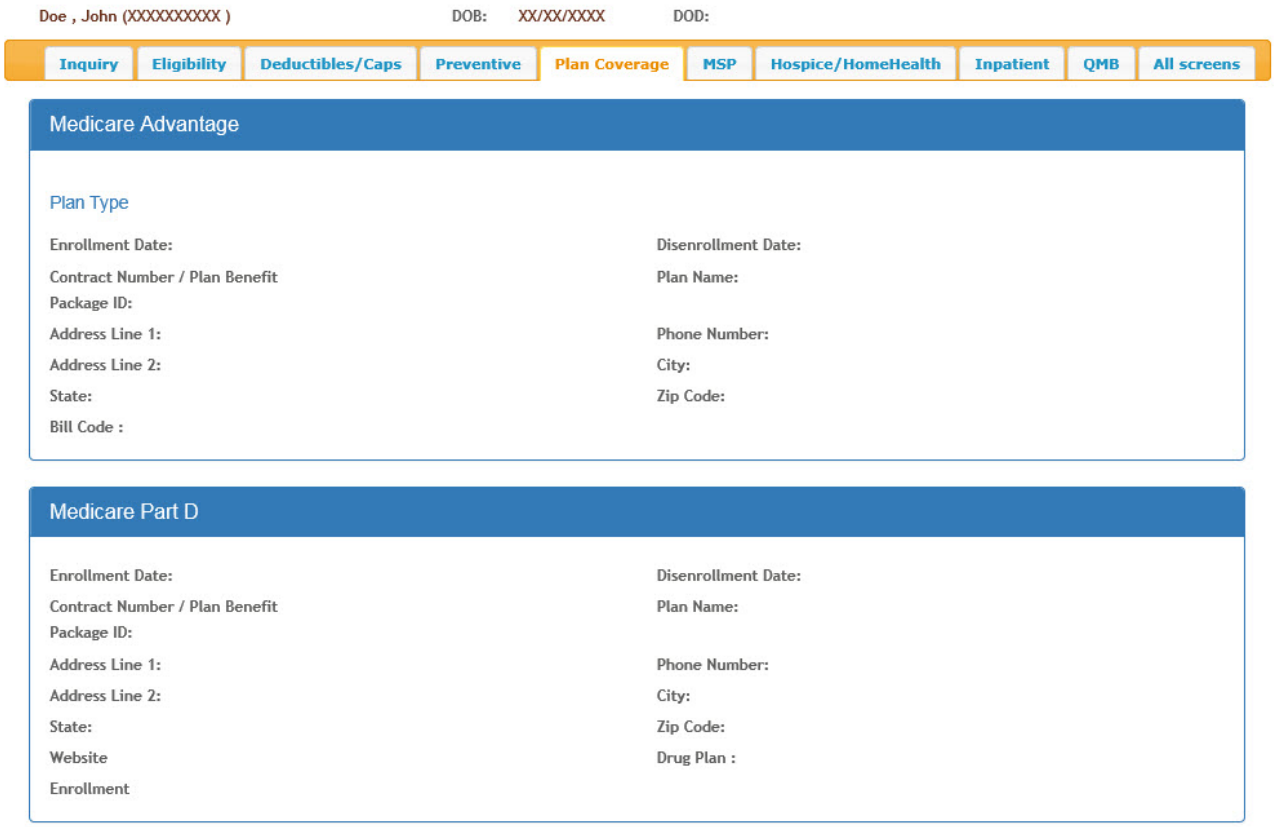
6.6 How do I use the Plan Coverage Tab?

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.

NOTE

Whenever eServices 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. Information is available up to four (4) years prior to, and four (4) months in the future of, the current date. Data ranges may not exceed 12 months at a time.

Figure 60: Eligibility, Plan Coverage Tab



Part D contracts provide prescription drug coverage

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, or 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 plan provider if there is any question about the plan's terms and conditions.

The table below describes the Plan Coverage fields.

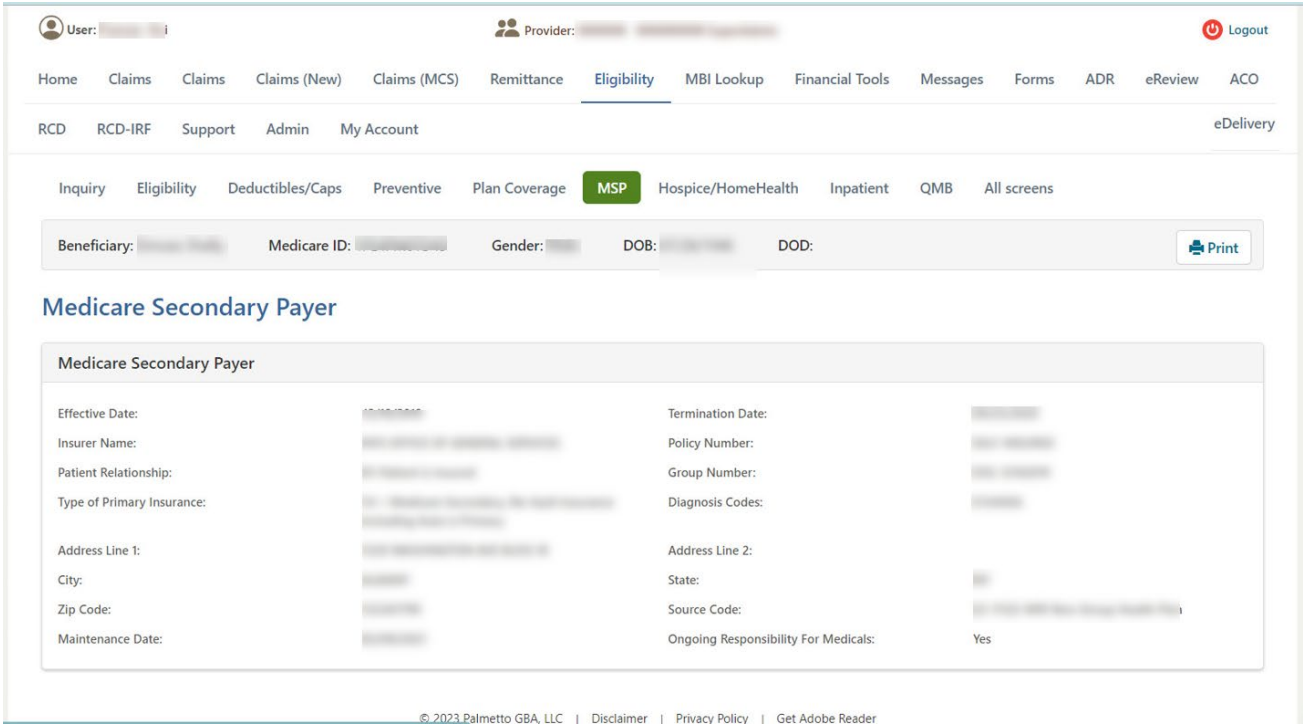
Plan Coverage Information

Field	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
Bill Code	The bill code of the plan type. This field only applies to plan types HM, HN, IN, PR and PS. <u>Medicare Beneficiary "locked in" to MCO</u> A - Fiscal Intermediary should process all claims B - MCO should process only in-plan Part A claims and in-area Part B claims C - MCO should process all claims <u>Medicare Beneficiary NOT "locked in" to MCO</u> 1 - Fiscal Intermediary should process all claims 2 - MCO should process only in-plan Part A claims and in-area Part B claims
Website	The coverage plan's website address that will provide information on the beneficiary's insurance

6.7 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.

Figure 61: Eligibility, MSP Tab



NOTE

The MSP tab only displays MSP data per the dates requested. When inquiring on MSP information, always enter a date range on the search page. You can search for up to 24 months at a time, going back for up to 4 years prior.

The following table describes the MSP fields.

MSP Information

F	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

F	Description
Patient Relationship	The relationship to the other policy 01 = Self 02 = Spouse 03 = Child 04 = Other 20 = Life or Domestic Partner
Group Number	The other insurance group policy number
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
Source Code	Describes the origin of the patient's admission to the hospital
Maintenance Date	The last date an update was made to the beneficiary's MSP information
Ongoing Responsibility for Medicals(ORM)	"Yes"will be displayed when bene is marked available and "blank"when bene is marked not available.

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

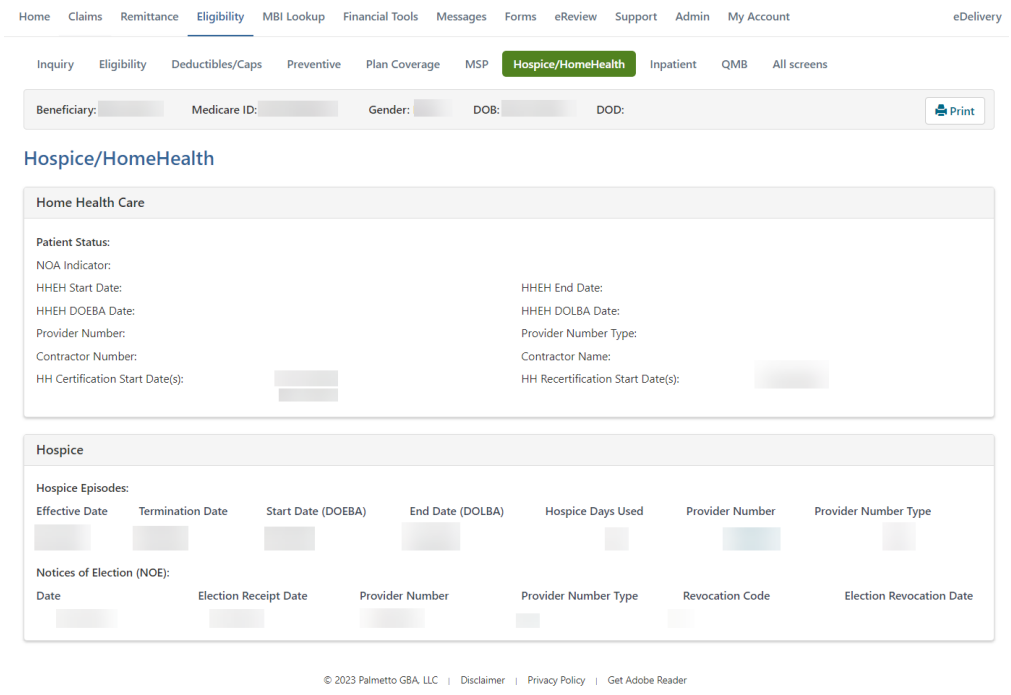
The Hospice/Home Health tab includes two sections:

- Home Health Care
- Hospice

> **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 HIPAA Eligibility System (HETS) 270/271 system we are required to access for eligibility allows date requests up to four (4) years prior to, and four (4) months in the future of, the current date. Data ranges may not exceed 12 months at a time.

The Home Health Care section provides information for each episode start and end date and the corresponding billing activity dates.

Figure 62: Eligibility, Hospice/Home Health Tab



The Hospice section provides eligibility information when the hospice benefit is effective and when it terminates in addition to the total hospice occurrence count for the listed beneficiary.

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 along with the revocation code. 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.

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

Home Health Information

Field	Description
Patient Status	A display of the beneficiary status code along with its description.
NOA Indicator	This field will indicate if the NOA was received with or without condition code 47.
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
Contractor Number	A display of the contractor number
Cert Date	The date the beneficiary was certified to receive home health care services
Recert Date	The date the beneficiary was recertified to receive home health care services

Hospice Information

Field	Description
Total Occurrence Count	Total number of hospice occurrences on file for the beneficiary, including those listed for the date range requested
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. If you click the hyperlink you will be taken to the National NPI Registry to look up the Provider name and address.
Provider Number Type	A display of 'Legacy' or 'NPI' depending on the source of the provider number

Field	Description
Revocation Code	The code indicating the revocation status for the spell listed Medicare Beneficiary in Hospice Care 0 - Not revoked, open spell Medicare Beneficiary with Hospice Care Revoked 1 - Revoked by notice of revocation 2 - Revoked by notice of revocation with a non-payment code of 'N' and an occurrence code of '42' 3 - Revoked by a hospice claim with an occurrence code of '23'

6.9 How do I use the Inpatient Tab?

The Inpatient sub-tab includes Inpatient, Skilled Nursing Facility (SNF), and Psychiatric Benefit Data sections. The inpatient section provides hospital inpatient benefit and billing information. The SNF section provides SNF benefit and billing information.

NOTE

While the Psychiatric Benefit Data section now displays in eServices, the data is not yet available in CMS' HIPAA Eligibility Transaction System (HETS) 270/271 system we are required to access for eligibility.

Figure 63: Eligibility, Inpatient Tab

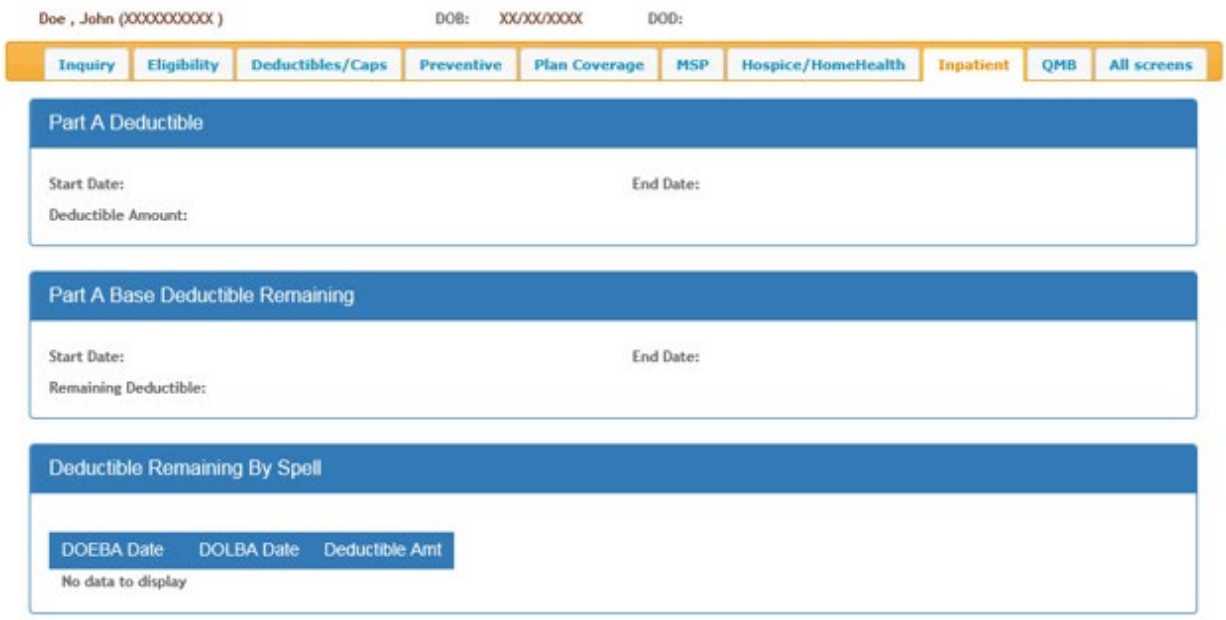


Figure 64: Eligibility, Inpatient Tab Continued

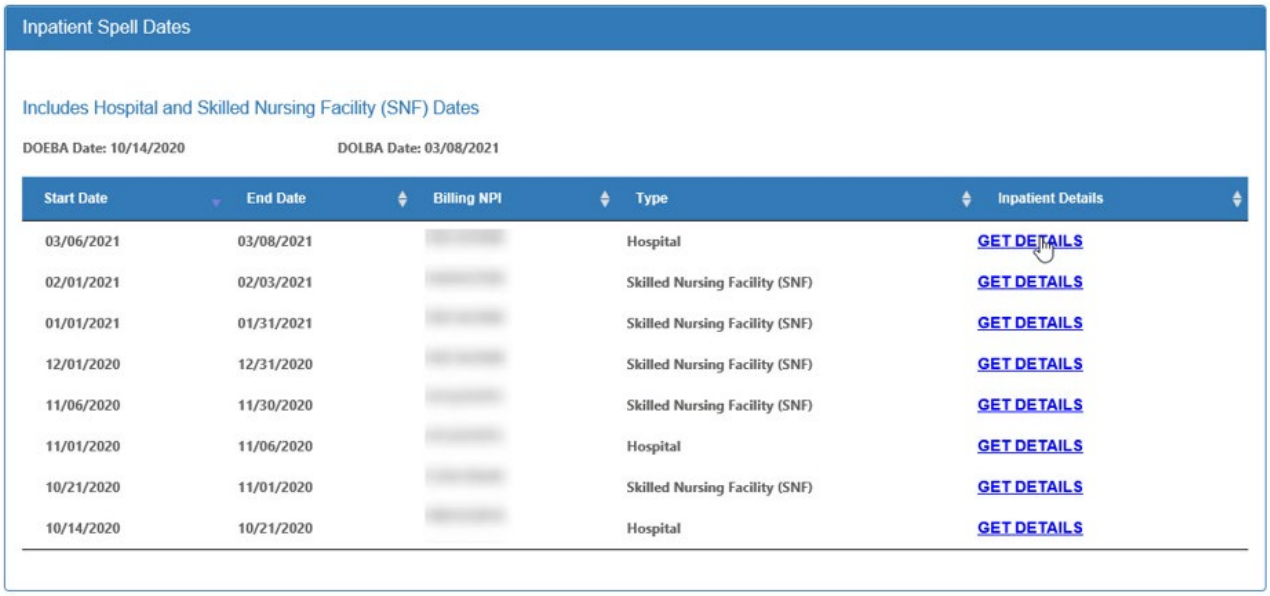


Figure 65: Eligibility, Inpatient Tab Continued

The system will return hospital inpatient default deductibles based on the requested 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, inpatient copayment days and SNF copayment 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 less than or equal to the requested start year

NOTE

Depending on the date(s) range requested, multiple inpatient 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 the Common Working File (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 date requests up to four (4) years prior to, and four (4) months in the future of, the current date. Data ranges may not exceed 12 months at a time.

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

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

The tables below describe the Inpatient Tab fields.

Deductible Remaining By Spell

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
Deductible Amount	The amount of the deductible remaining to be met for the spell of illness

Inpatient Days Remaining By Spell

Field	Description
DOEBA Date	The date of earliest billing activity for the spell of illness
DOLBA Date	The date of latest billing activity for the spell of illness
Full Inpatient Days	The full inpatient days remaining in the spell
Full Inpatient Co-Pay Days	The full inpatient co-payment days remaining in the spell

SNF Days Remaining By Spell

Field	Description
DOEBA Date	The date of earliest billing activity for the spell of illness
DOLBA Date	The date of latest billing activity for the spell of illness
Full SNF Days	The full SNF days remaining in the spell
Full SNF Co-Pay Days	The full SNF co-payment days remaining in the spell

Inpatient Base Summary

Field	Description
Calendar Year	The calendar year requested
Full Days Allowed	The number of inpatient full days allowed for the calendar year requested
Full Co-payment Days Allowed	The number of inpatient full co-payment days allowed for the calendar year requested
Co-pay Amount	The amount of the inpatient co-payment for the calendar year requested
Deductible	The amount of the inpatient deductible for the calendar year requested

Inpatient Spell Dates

Field	Description
Start Date	The start date of the benefit period, typically the first day of the calendar year indicated
End Date	The end date of the benefit period, typically the last day of the calendar year
Billing NPI	NPI of the provider that administered the services for the applicable code
Type	Type of facility
Inpatient Details	Get Details will take them to NPPES for address,contact no and more details.

SNF Base Summary

Field	Description
Calendar Year	The calendar year requested
SNF Full Days Allowed	The number of SNF full days allowed for the calendar year requested
SNF Full Co-payment Days Allowed	The number of SNF full co-payment days allowed for the calendar year requested
SNF Co-pay Amount	The amount of the SNF co-payment for the calendar year requested

Lifetime Reserve Days

Field	Description
Lifetime Days Allowed	The number of lifetime reserve days allowed
Lifetime Days Remaining	The number of lifetime reserve days remaining
Calendar Year	The calendar year requested
SNF Co-pay Amount	The co-payment amount per lifetime reserve day

Psychiatric Benefit Data

Field	Description
Lifetime Psychiatric Base Days	The number of lifetime psychiatric days allowed

Field	Description
Lifetime Psychiatric Remaining	The number of lifetime psychiatric days remaining

6.10 How do I use the QMB tab?

Beneficiaries who are enrolled in the Qualified Medicare Beneficiary (QMB) program are dually eligible for both Medicare and Medicaid. Beneficiaries who are enrolled in the QMB program are not liable for Medicare co-insurance or deductible payments. Note that QMB status may fluctuate for a minority of Beneficiaries. If eligibility results indicate the Beneficiary QMB enrollment has terminated, please verify the patient's QMB status through state online Medicaid eligibility systems or other documentation, including Medicaid Identification cards and documents issued by the state proving the patient qualifies for the QMB program.

The QMB sub-tab includes Medicaid Enrollment, Part A Deductible, Inpatient, Skilled Nursing Facility (SNF), Part B Deductible, and Part B Co-Insurance sections.

Figure 66: Eligibility, QMB Tab

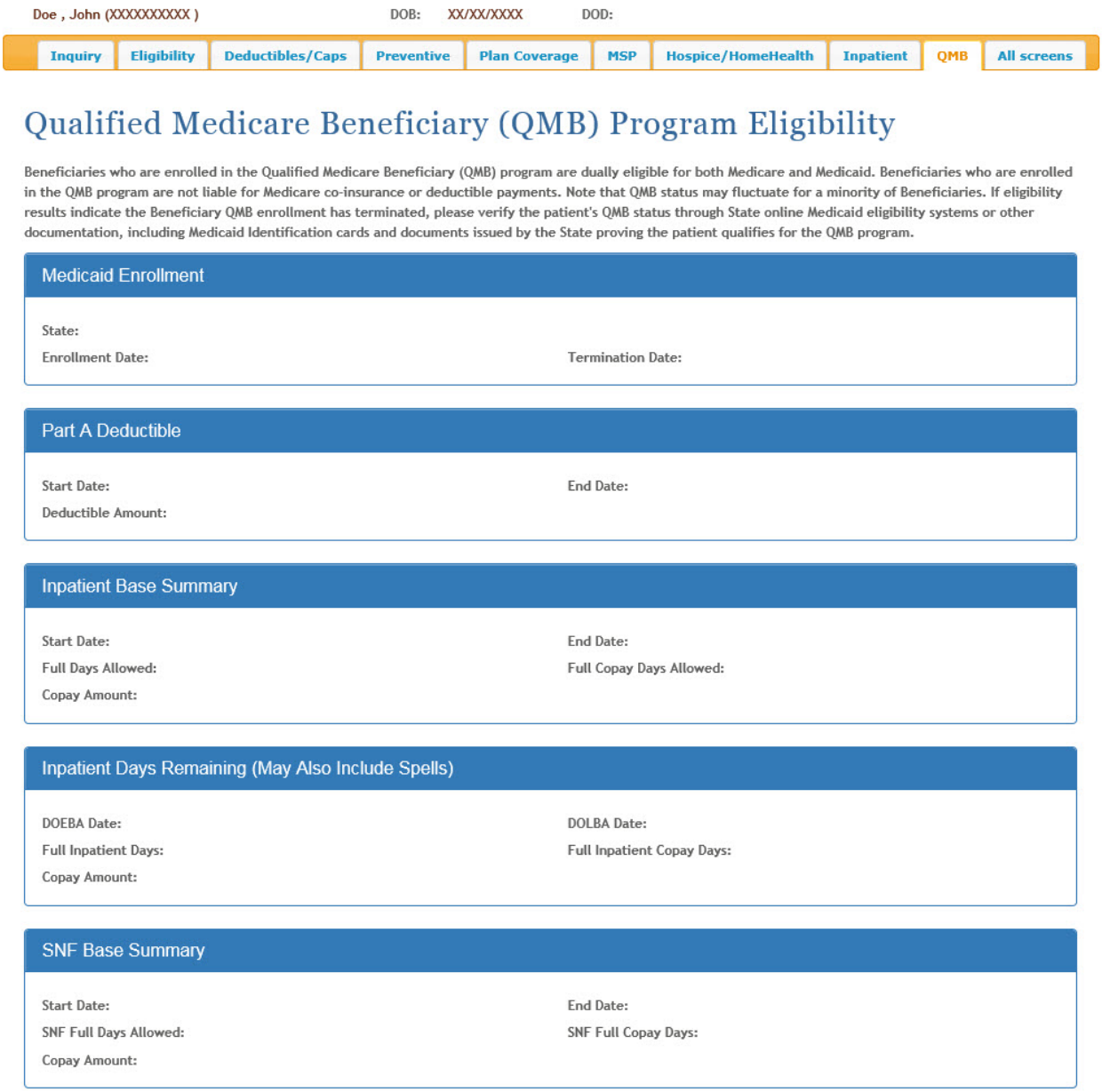


Figure 67: Eligibility, QMB Tab Continued

6.11 When do I need to call the IVR for eligibility information?

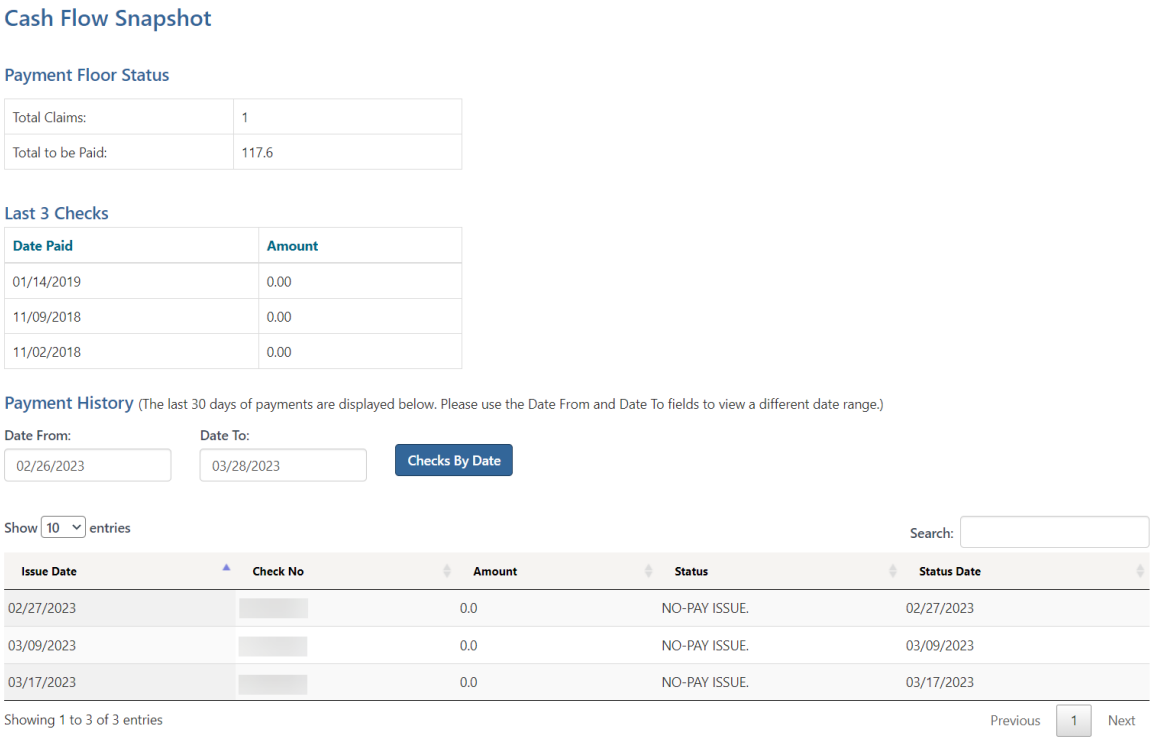
Crossover information is not available through the eligibility function of eServices. Call the IVR for this information.

7.0 Financial Tools

7.1 How do I use the Financial Tools tab?

Open the Financial Tools tab to inquire about your payment floor status and last three checks paid. When you first access the screen there will be no information. Click the Submit button and information will be retrieved.

Figure 68: Financial Tools Tab



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.

The payment history for the last 30 days will be listed. Users also have the option to search for other payments using the Date From and the Date To fields. The date range cannot exceed 30 days.

The Payment History section will provide the payment history for the last 30 days. Users can change the date range using the Date From and Date to fields. The date range can be no more than 30 days.

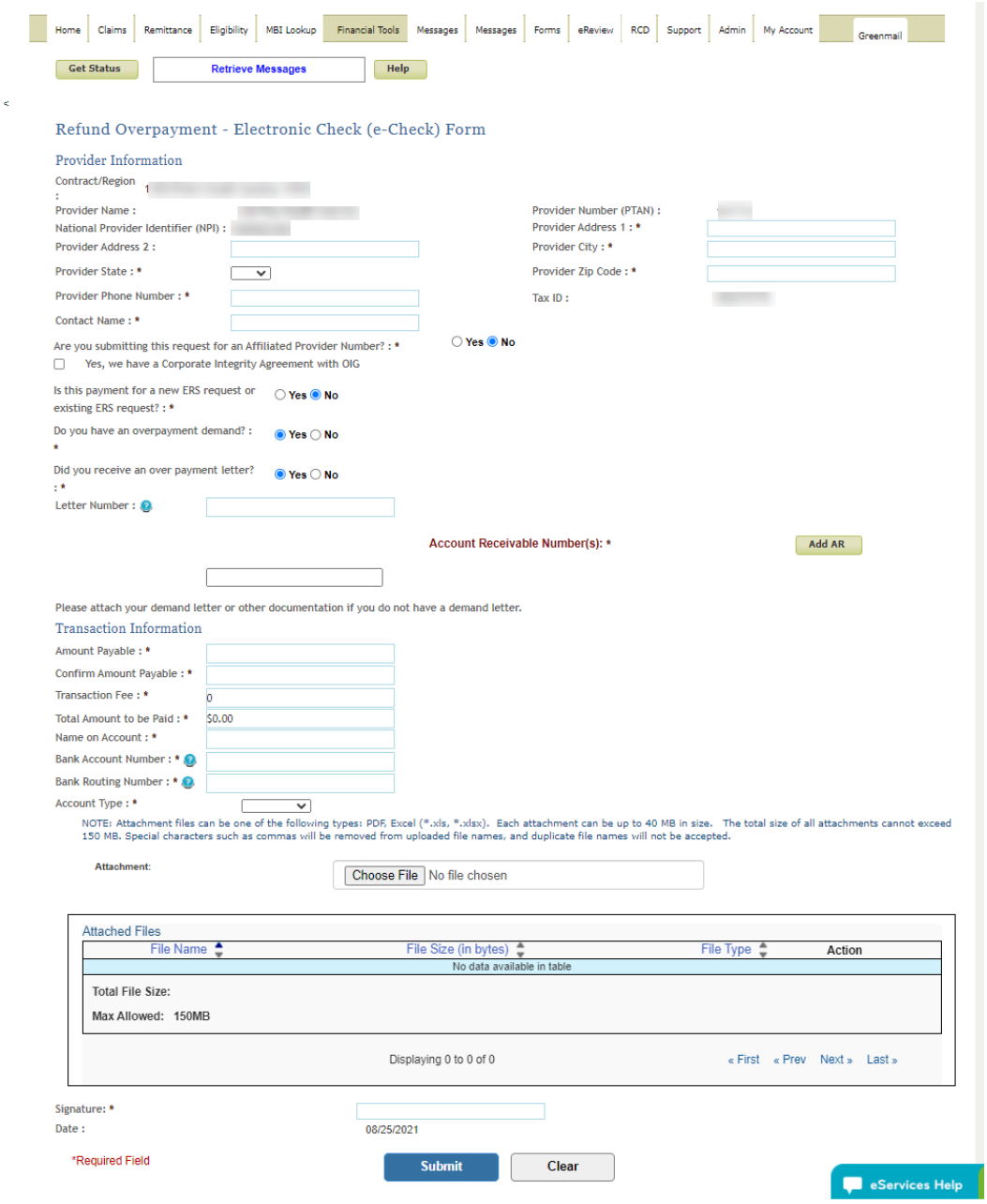
7.3 What is eCheck?

The eCheck function allows payments to be sent electronically via ACH to Palmetto GBA. Only direct debits from your designated bank account are accepted through this form. Submitting the form through eServices automatically enters your information into Palmetto GBA's workflow management system, iFlow, for processing according to current Medicare guidelines. There is no transaction fee for submitting a check payment.

The eCheck function can be accessed from the Financial Forms sub-tab located under the Financial Tools tab. Once on the financial forms landing page, select the option for 'eCheck' from the 'Payment Type' drop-down menu. Then select the eCheck form link.

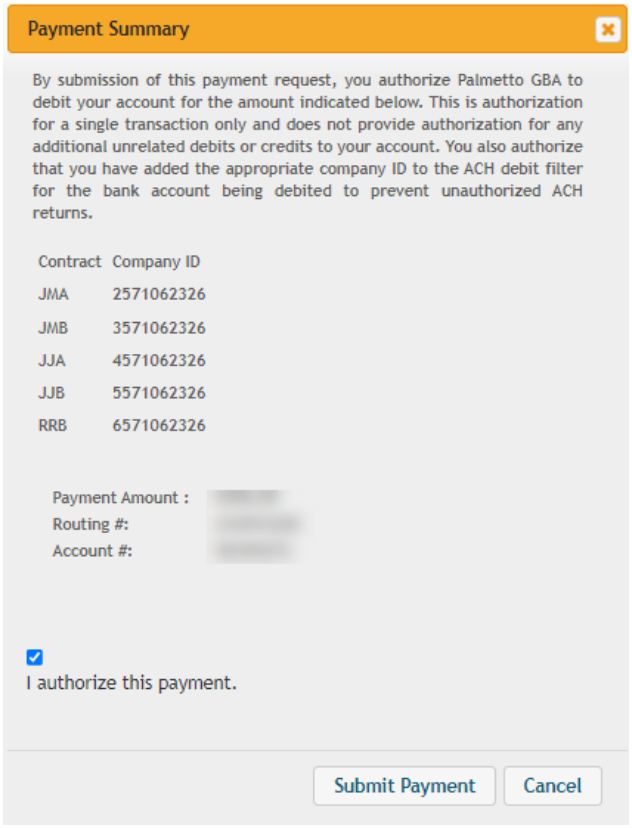
The form will prepopulate the Contract/Region, Provider Number (PTAN) and National Provider Identifier (NPI) fields with the data associated with the user ID that is logged in.

Figure 69: eCheck Form



The form is dynamic and contains edits to ensure that the information needed to process the overpayment is entered. Users may submit PDF attachments up to 40 megabytes (MB) in size. While there is no longer a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB in size. Once the form is submitted, users will be prompted with a payment confirmation summary pop-up where they confirm the payment information for processing. The check box labeled " I authorize this payment" has been added to allow a user to signify their approval of submission. This is a required field and the user will need to check the box to proceed.

Figure 70: eCheck Payment Confirmation



You will receive a message when the form is submitted and another message with the Document Control Number (DCN) when the form has started processing.

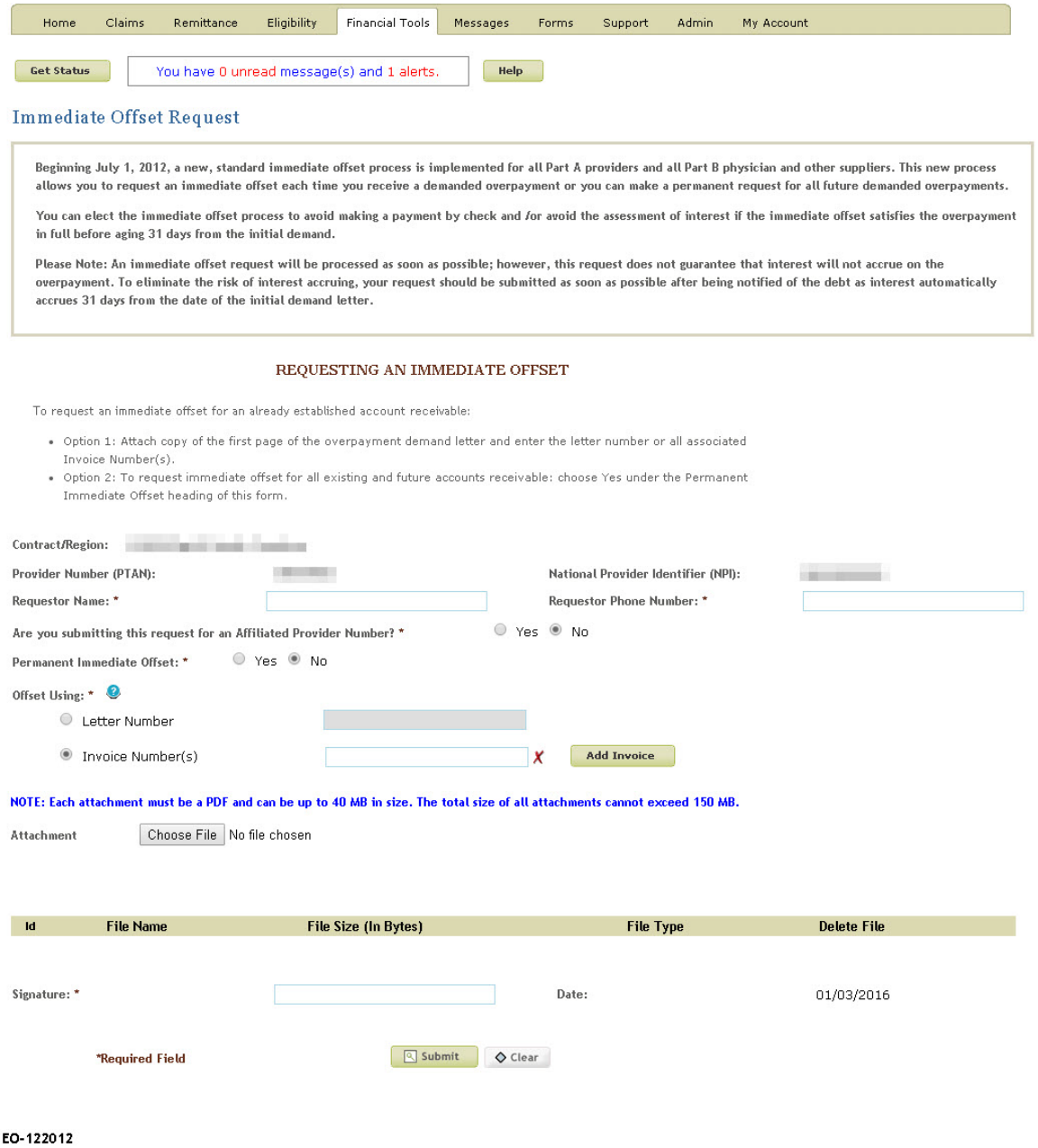
7.4 What is eOffset?

The eOffset function allows offset information to be sent electronically to Palmetto GBA. Users have the option to request an immediate offset when they receive a demanded overpayment or make a permanent request for all future demanded overpayments. More information regarding this is located on the form page.

The eOffset function can be accessed from the Financial Forms sub-tab located under the Financial Tools tab. Once on the financial forms landing page, select the option for ‘eOffset’ from the ‘Payment Type’ drop-down menu. Then select the eOffset form link.

The form will prepopulate the Contract/Region, Provider Number (PTAN) and National Provider Identifier (NPI) fields with the data associated with the user ID that is logged in.

Figure 71: eOffset Form

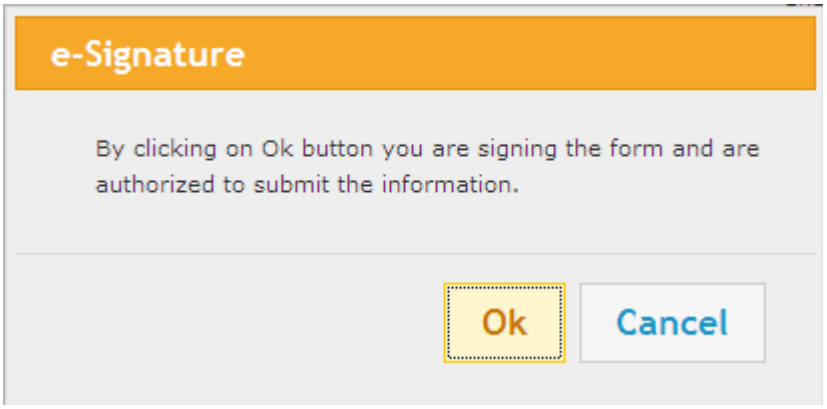


The form is dynamic and contains edits to ensure that the information needed to process the overpayment is entered. Users may submit PDF attachments up to 40 megabytes (MB) in size. While there is no longer a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB in size. Once the form is submitted, users will be prompted with a signature confirmation pop-up where they confirm their authorization to submit the request for processing.

NOTE

Users are only able to submit an eOffset form for the PTAN/NPI combination that matches the user ID they are logged in with.

Figure 72: eOffset Signature Confirmation



You will receive a message when the form is submitted and another message with the Document Control Number (DCN) when the form has started processing.

7.5 How to submit a CMS-838 Credit Balance Report

The form is prepopulated with the information we know from your registration record. This will save you several steps. Complete all of the required information. Then, add any attachments. Users may submit attachments up to 40 megabytes (MB) in size. While there is no longer a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB in size. Files must be either PDF or Excel format.

The CMS-838 Credit Balance Report Form must be an attachment to this submission and be completed in full. This will include the provider name, six digit provider number, calendar quarter end, signature of officer or administrator, date signed, and name and phone number of contact person. Also, indicate if the provider is low utilization, if a detail page is attached, or if there are no credit balances to report for the given quarter. If a fully completed, correct CMS-838 form is not attached, Medicare payments may be withheld until a correct report is received.

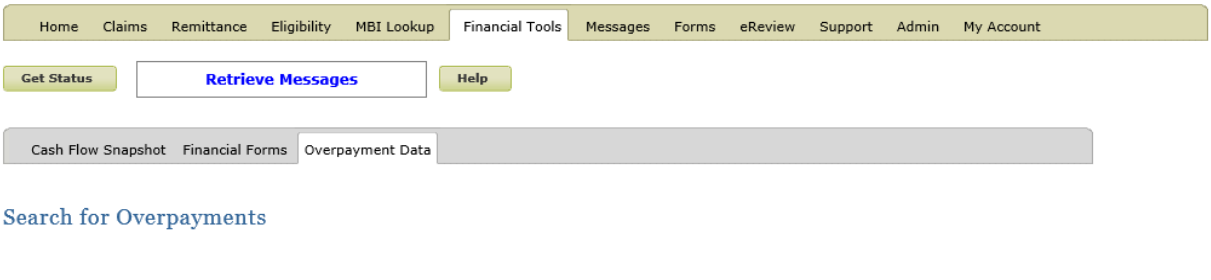
7.6 What is Overpayment Data?

Overpayment data is available for all lines of business including JJ Part A/B, JM Part A/B, and RRB. To access this data, you will enter either an Accounts Receivable (AR) Transaction number or a Demand Letter number.

Accessing your overpayment balance is achieved in four easy steps. After logging into the eServices portal:

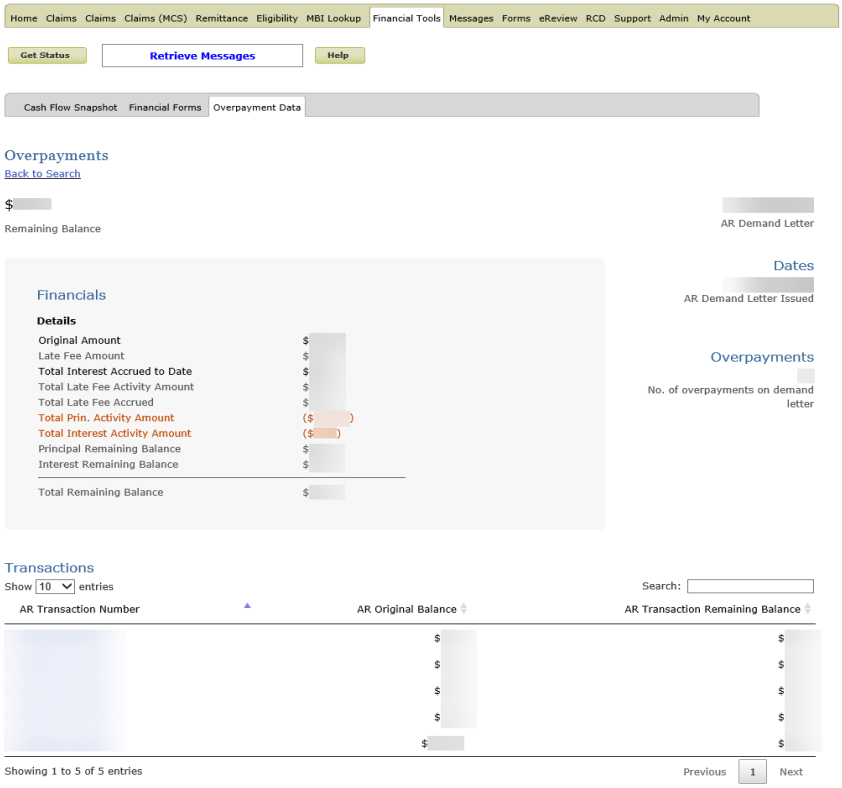
1. Click on Financial Tools Tab
2. Select Overpayment Data sub tab
3. Input AR Transaction Number or Demand Letter Number
4. Click Submit

Figure 73: Overpayment Data



When the Demand Letter number is searched, all information related to the searched number will be displayed. Any AR Transaction number associated the Demand Letter will also be listed. You can access the information for each AR Transaction by selecting the AR Transaction Number link.

Figure 74: Demand Letter Details



8.0 Secure Messaging and Forms

8.1 What is secure messaging and secure forms?

If you are a provider administrator, you will notice the Messages and Forms tabs as well as a message box on your home page. If you are a provider user, you must be granted permission to these tabs by your provider administrator.

In addition to the financial forms, eServices users have the ability to submit appeals forms, a Prior Authorization form (JM Part B only), General Inquiry, Documentation Submission form (Part A only), Benefit Integrity form (Railroad Medicare only), Billing Dispute Request form and Medical Review ADR Response form along with attachments, through eServices. Once you have submitted the form you will receive a message either advising you on how to correct the form for resubmission or that the form was received by Palmetto GBA. Once the form has been accepted into our processing system, the received date will be assigned and an additional message will be generated with the Document Control Number (DCN). If a form is submitted over the weekend, the DCN may not be assigned until the next business day.

Please access the Financial Tools section for information on eCheck, eOffset, and CMS-838 Credit Balance submission. JJ Part B and JM Part B users can view the Claims section for information on the Additional Documentation form.

8.2 How do I access secure forms?

If the secure forms function is available for you, you will see a Forms tab as part of the menu once you successfully log in. If you do not have permission to this tab, it will appear 'grayed out'.

Select the Forms tab to access the secure forms page. Use the 'Select a Topic and Select a type' drop down boxes to access forms available to you. The forms available will appear as links at the bottom of the page. Select the link to access the secure form.

Please access the Financial Tools tab for eCheck, eOffset, and CMS-838 Credit Balance submission. JJ Part B and JM Part B users can access the Additional Documentation form via the Claims tab.

Figure 75: Secure Forms Screen

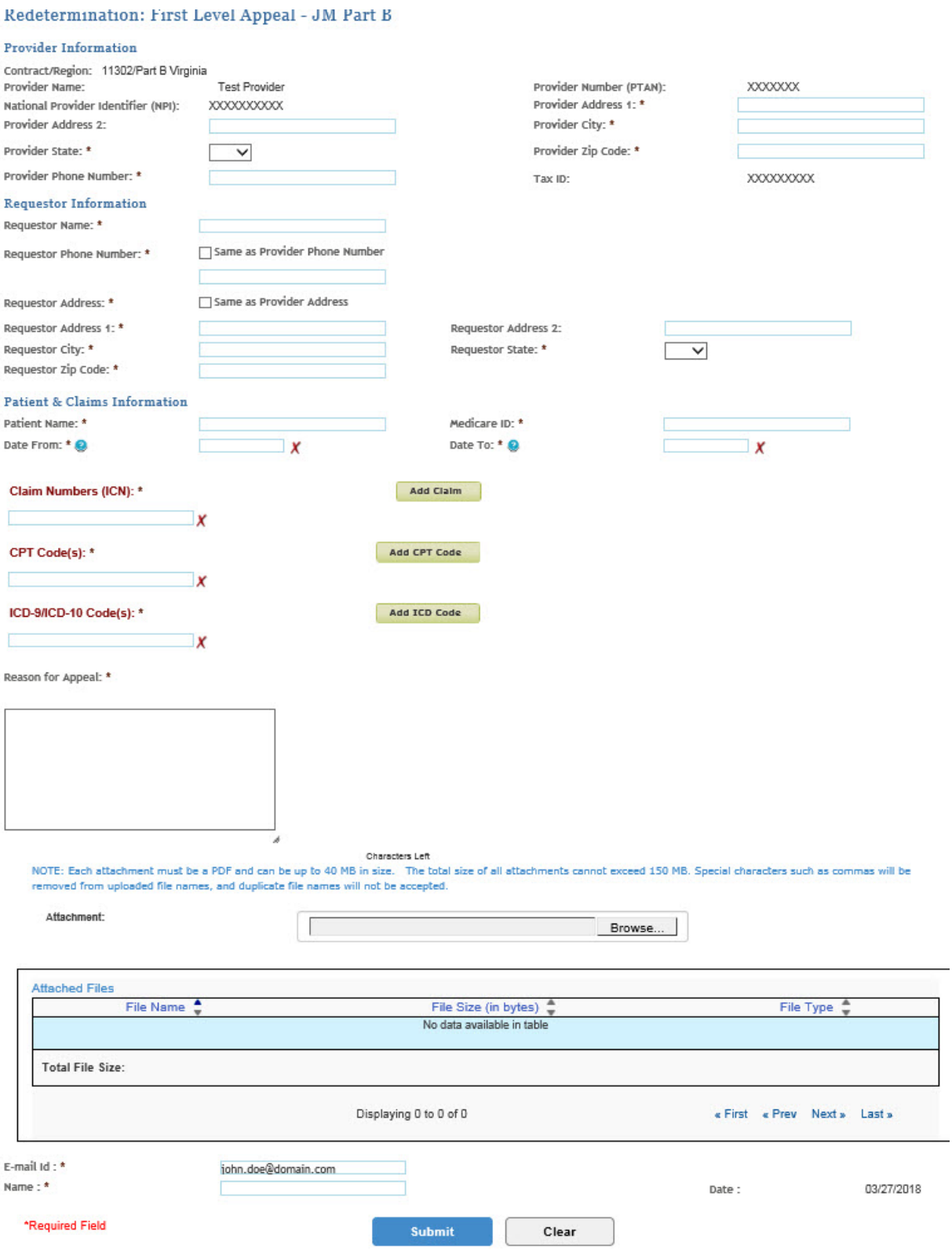
Provider administrators will have permission to access the tab by default. All provider users must contact their provider administrator to gain access to the Forms tab.

8.3 How do I submit a form?

The form is prepopulated with the information we know from your registration record. This will save you several steps. Complete all of the required information. Then, add any attachments. Users may submit attachments up to 40 megabytes (MB) in size. While there is no longer a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB in size. All attachments must be in PDF format unless otherwise noted.

Once the form is submitted, you will receive a message in your message inbox that the form was submitted successfully. The message will be updated with the DCN when the form is received by Palmetto GBA and has begun to be processed. If a form is submitted over the weekend or on a holiday, the DCN may not be assigned until the next business day.

Figure 76: Appeals Form Example



8.4 How do I upload attachments in secure forms?

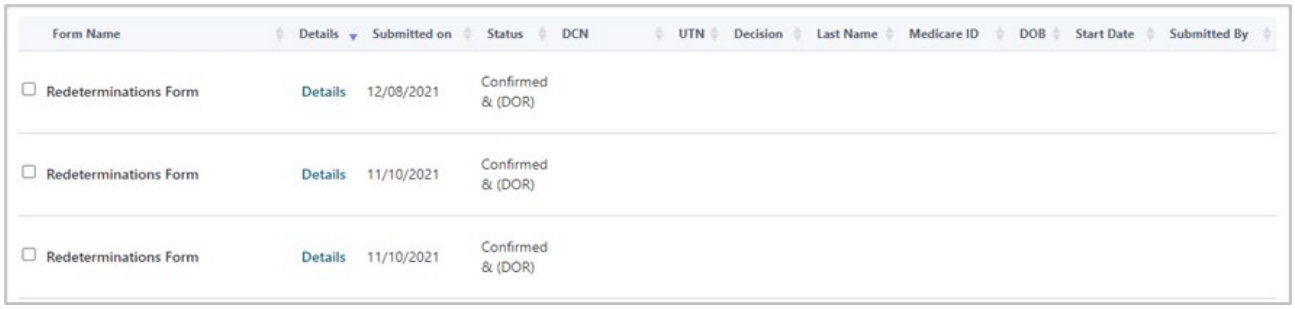
You may add attachments up to 40 megabytes (MB) each to a form. While there is no longer a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB. All attachments must be PDF documents unless otherwise noted. Most scanners have the ability to save documents in the PDF format. If you receive an error when uploading the file, your form will refresh with the error listed at the top of the page, and the PDF will no longer be attached. Errors can occur if the PDF is corrupt or if it was not created using PDF software. For example, you cannot change a file extension to PDF. It will not be in the correct PDF format and you will be unable to upload it.

If your file is over 40 MB, you will want to break it down into smaller files in order to attach it to your form. You can do this through your PDF software or by changing your original files and creating the PDFs again.

8.5 How will I know my form has been received in eServices?

Secure forms successfully submitted via eServices will automatically generate inbox messages containing important information about the secure form submissions. The transaction ID and status can be viewed either in the Notification Center or in Message Details. Once the form has been accepted into our processing system, the status and details will be updated with the official date of receipt by Palmetto GBA and the DCN for this form submission. If a form is submitted over the weekend or on a holiday, the DCN may not be assigned until the next business day.

Figure 77: Secure Messaging Inbox



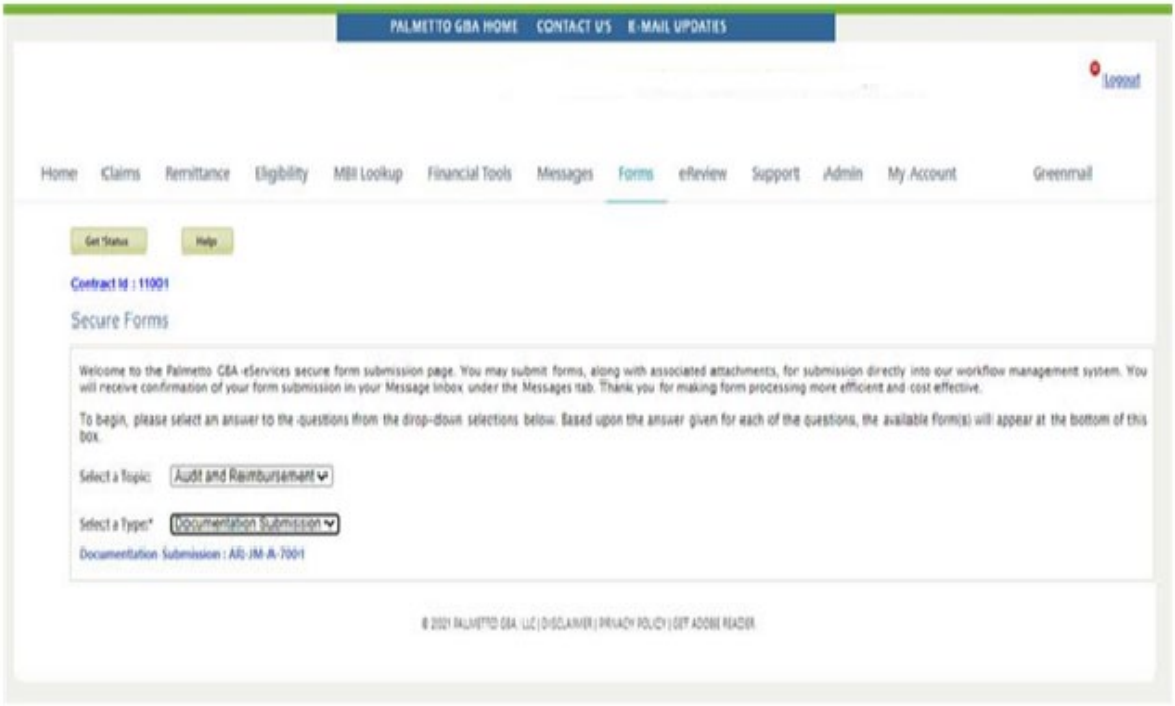
8.6 How do I check the status of a submitted form?

You can use the Document Control Number (DCN) that is assigned to your form to look up form processing status and view your submitted forms. When you select the Details option in the Notification Center, you can view the status of your form. In addition, you may view the form and list of attachments you submitted. When you are logged into eServices, you can also access the status look-up tool by clicking the 'Get Status' button on the Messaging/Forms tab. You will need to input the DCN to view the status through this screen.

8.7 Submitting a Documentation Submission Form

You can use the Document Control Number (DCN) that is assigned to your form to look up form processing status and view your submitted forms. When you select the Details option in the Notification Center, you can view the status of your form. In addition, you may view the form and list of attachments you submitted.

Figure 78: Documentation Submission Form



The Provider Information section will be pre-filled with the information related to the PTAN/NPI combination associated with the eServices user ID that you are logged in under, or the PTAN/NPI combination selected if you have multiple accounts linked to your user ID. You may then complete the Documentation Submission Data section and upload attachments.

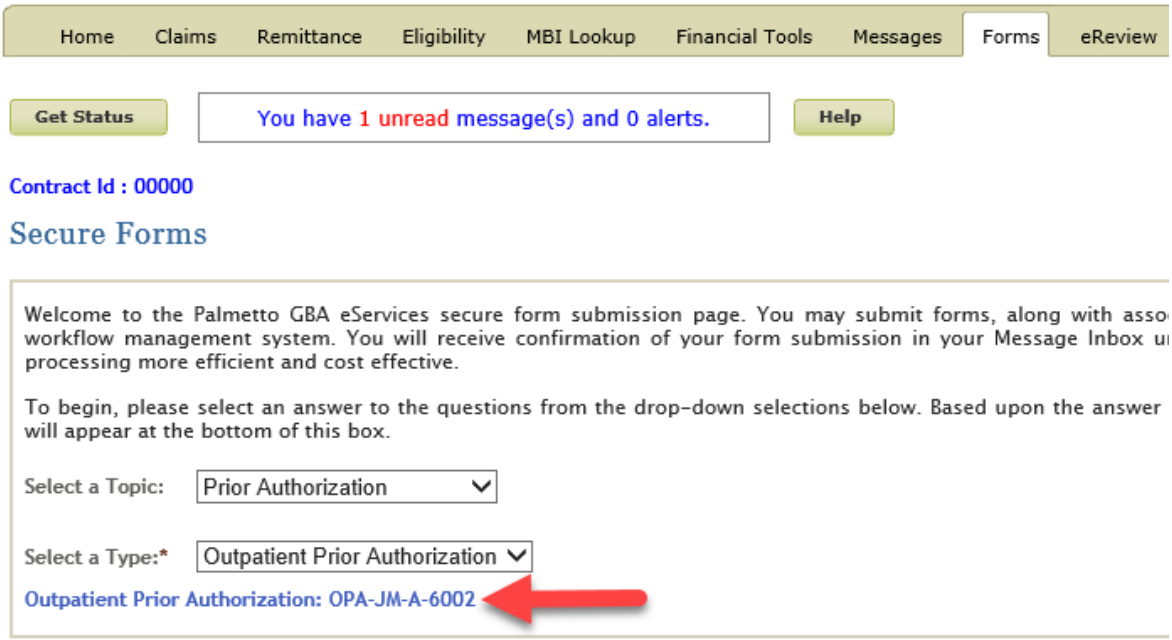
Note: For Documentation Submission forms, eServices users may submit attachments in one of the following formats: PDF, Excel (*.xls, *xlsx), or Word (*.doc, *.docx). Each attachment may be up to 40 MB in size. While there is no limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB.

8.8 Submitting an Outpatient Prior Authorization (OPA) form?

Outpatient Prior Authorization (OPA) is prior authorization that will determine if a requested procedure is medically necessary instead of cosmetic. This form is applicable to JJ Part A, JM Part A and HHH users.

Users can access the OPA Form via the Forms tab in eServices. Once on the Forms tab, choose Prior Authorization from the ‘Select a Topic’ drop-down menu and Outpatient Prior Authorization from the ‘Select a Type’ drop-down menu. The link to the form should appear in blue, just below the second drop-down menu. Once you click the link, you will be directed to the Outpatient Prior Authorization Form.

Figure 79: Outpatient Prior Authorization Form



The Provider Information section will be pre-filled with the information related to the PTAN/NPI combination associated with the eServices user ID that you are logged in under, or the PTAN/NPI combination selected if you have multiple accounts linked to your user ID. You may then complete the Outpatient Prior Authorization Data section and upload attachments.

Note: For Outpatient Prior Authorization forms, eServices users may submit attachments only in PDF format. Each attachment may be up to 40 MB in size. While there is no limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB.

9.0 Profile Verification and Recertification

9.1 Why am I being asked to complete eServices profile verification?

Palmetto GBA and CMS are dedicated to ensuring that access to Medicare data is secure. To do this, CMS requires that all users regularly verify and/or update the information on their eServices profile. This includes validating the user's email address listed on their profile. This must occur for Palmetto GBA to continue to offer eServices. Users must verify their profile for each user ID at least once every 250 days to avoid an interruption in access and/or deactivation. We appreciate your effort to help us keep Medicare data secure.

9.2 Why am I being asked to complete eServices recertification?

Palmetto GBA and CMS are dedicated to ensuring that access to Medicare data is secure. To do this, CMS requires that all provider administrators verify access for all of the users on the account at least once every 360 days for security purposes. This must occur for Palmetto GBA to continue to offer eServices. Provider administrators must complete recertification at least once every 360 days to avoid an interruption in access and/or deactivation. We appreciate your effort to help us keep Medicare data secure.

9.3 Do I have to complete profile verification for each of my eServices user IDs?

Yes. eServices profile verification is completed on the user ID level. Users will only be able to verify and/or update the profile for the eServices user ID they are currently logged in under.

9.4 Do I have to complete recertification for all of my eServices accounts?

Yes. Each PTAN/NPI combination must be registered separately in eServices. Therefore, recertification of user access is completed on the eServices account level. Provider administrators will only be able to recertify access for the active users listed for the PTAN/NPI combination associated with their eServices user ID.

9.5 How often will profile verification occur?

CMS requires that all users regularly verify and/or update the information on their eServices profile. This includes validating the user's email address listed on their profile. This must occur for Palmetto GBA to continue to offer eServices. Users must verify their profile for each user ID at least once every 250 days to avoid an interruption in access and/or deactivation. We appreciate your effort to help us keep Medicare data secure.

9.6 How often will recertification occur?

CMS requires that all provider administrators verify access for all of the users on the account at least once every 360 days for security purposes. This must occur for Palmetto GBA to continue to offer eServices. Provider administrators must complete recertification at least once every 360 days to avoid an interruption in access and/or deactivation. We appreciate your effort to help us keep Medicare data secure.

9.7 What happens if I do not verify my eServices profile?

If your profile has not been verified and/or updated within 10 days of entering the profile verification period, your access will be restricted to your My Account tab until this process is completed. If your profile has still not been verified within 10 days after your access has been restricted, your user ID will become permanently deactivated and you must contact your active provider administrator for access. If the only provider administrator on the account fails to complete their profile verification, the entire eServices account will be terminated. Once terminated, the provider administrator would need to re-register and create new user IDs for any additional users to regain access. Users must verify their profile for each user ID at least once every 250 days to avoid an interruption in access and/or deactivation.

9.8 What happens if a provider administrator does not recertify user access?

If user access has not been recertified for the account within 10 days of entering the recertification period, your access will be suspended until this process is completed. If your access has still not been recertified within 10 days after your access has been suspended, the entire eServices account will be terminated. Once terminated, the provider administrator would need to re-register and create new user IDs for any additional users to regain access. Provider administrators must complete recertification at least once every 360 days to avoid an interruption in access and/or deactivation.

9.9 What do I do if I did not receive my validation email?

Once you register or update your profile, you will receive an email with a link to validate your access. Make sure that you are logged out of your account before clicking on the link in your email. Once this is completed, you will be able to log in to eServices. If you do not click on the validation link and you try to log in, you will see your profile screen where you can update or correct your email address and submit. If your email address is correct, you may use the request new email button to have another

email sent. Please make sure your email address is correct on your profile before calling Palmetto GBA for assistance.

If you are sure your email address is correct, but you do not receive your email, your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email address you will be receiving the validation email from is:

ops.no.reply@palmettogba.com

If you experience password errors during the above process, please use the 'Forgot or Change Your Password?' link on the login page to reset your password.

9.10 I have requested a new validation email several times, but I never receive it. What do I need to do to complete eServices profile verification?

You must click the link in the validation email to complete your profile verification. Please verify that the email address listed on your eServices profile is entered correctly. If the email address is correct, please add our email address to your safe senders list. Then log into your eServices account and use the request new email button to receive a new email to complete your profile verification. You may need to get the email address added so you will be allowed to receive the email. Your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email address you will be receiving the validation email from is:

ops.no.reply@palmettogba.com

The process of receiving the email may take a while and is based on your email client configuration and the security configuration of your network. You may have to refresh your inbox to make sure all emails have been received.

If you still do not receive your validation email, please contact your Medicare Contractor for further assistance.

9.11 I have completed eServices profile verification, but when I log in I get the message that my account has not been verified. What do I need to do?

Once you have updated the information on your profile, you must log out and click the link in your email to validate your email address and finalize the profile verification process. The profile verification process is not complete until you have successfully used the profile verification link and logged in.

9.12 I have clicked on the link in my validation email and I got the error message 'This user is already logged in or failed to logout properly.' How can I log back into my account?

If you do not properly log out of eServices, you must wait 15 minutes to log in again. Please keep in mind that if you are logged in to eServices and you want to exit eServices, you will need to click on the logout link in the upper right of every page. If you do not do this, you will be locked out for 15 minutes. We do not unlock accounts that are in the lock-out period.

9.13 I am a provider administrator, how do I recertify the provider users on my account?

Provider administrators can recertify access for all users, including additional provider administrators, from their Admin tab. If it has been less than 360 days since the last recertification, you may use the Recertify Users button to begin the process. Active accounts that have not recertified in the past 360

days will automatically be directed to the recertify users screen upon login. Please check the boxes next to all users who need their access recertified. Any IDs left unchecked will be permanently deactivated. Failure to recertify access for at least one provider administrator will result in termination of the entire account.

9.14 Who should I recertify?

Provider administrators should only recertify access for users who should still have access to eServices. Users must have also participated in basic security awareness training within the past year as outlined in the eServices Terms of Use.

Any user IDs left unchecked will be permanently deactivated. Failure to recertify access for at least one provider administrator will result in termination of the entire account.

9.15 How do I recertify access for users who are not displaying on my recertification screen?

Provider administrators can only recertify access for users who have an active user ID for the PTAN/NPI combination that corresponds to the user ID they are logged in with. They must recertify access for each PTAN/NPI combination separately. Provider administrators can grant access for any additional users who are not currently listed by using the 'Add New User' button on their Admin tab.

9.16 I am a provider administrator and I mistakenly left off one of my users when I was trying to recertify their access. How can I restore their access?

You must create a new user ID for this user. Once you log in to your eServices account, go to the Admin tab and use the ‘Add New User’ button to create a new account for this user.

9.17 Once I recertify users, I am taken to a Terms and Conditions screen. How do I get back to my account??

After reading the document, please check the ‘I agree’ box at the bottom and click ‘Submit’. If you close the browser window without logging out first, you will be locked out of your eServices account for 15 minutes. We do not unlock accounts that are in the lock-out period.

9.18 I am receiving a message that my provider administrator must recertify my access. How do I find out who is listed as the provider administrator for my account?

If you do not know who the eServices provider administrator is for your account, contact the provider’s staff to find out if they have registered to the system and who is designated as the provider administrator.

If you are an eServices provider administrator, you can see who else is designated as a provider administrator for this account on the Admin tab.

9.19 I am an eServices user and I completed profile verification. Why am I now receiving a notification that my provider administrator must complete recertification?

eServices recertification and profile verification are two separate processes, but users may be due for both during the same time frame. Please follow the directions in the notification to have your provider administrator complete eServices recertification and prevent termination of access.

9.20 I am a provider administrator and completed profile verification. Why am I now receiving a notification that I must complete recertification?

eServices recertification and profile verification are two separate processes, but users may be due for both during the same time frame. Please follow the directions in the notification to complete eServices recertification and prevent termination of access.

9.21 My provider administrator completed recertification. Why am I now receiving a notification that I must complete profile verification?

eServices recertification and profile verification are two separate processes, but users may be due for both during the same time frame. Please follow the directions in the notification to complete eServices profile verification and prevent termination of access.

9.22 I am a provider administrator and completed recertification. Why am I now receiving a notification that I must complete profile verification?

eServices recertification and profile verification are two separate processes, but users may be due for both during the same time frame. Please follow the directions in the notification to complete eServices profile verification and prevent termination of access.

9.23 I have completed my profile verification, but when I log in I get an error stating that my access to eServices has been suspended until my provider administrator completes the recertification process. How can I get my access restored?

You must contact your provider administrator on this account and have them recertify your access.

10.0 Administration

10.1 How do I administer users?

The person who registers is the provider administrator. Only **one** provider administrator can register per PTAN/NPI combination. Provider administrators have access to the Admin tab. Through this function, they can administer users. The provider administrator grants access for additional users to access, view and print from eServices the information related to registered provider.

Provider administrator responsibilities include 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 provider users or additional provider administrators
- Select letters to receive as Greenmail

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.

Figure 80: Administration Tab, List of Provider Users

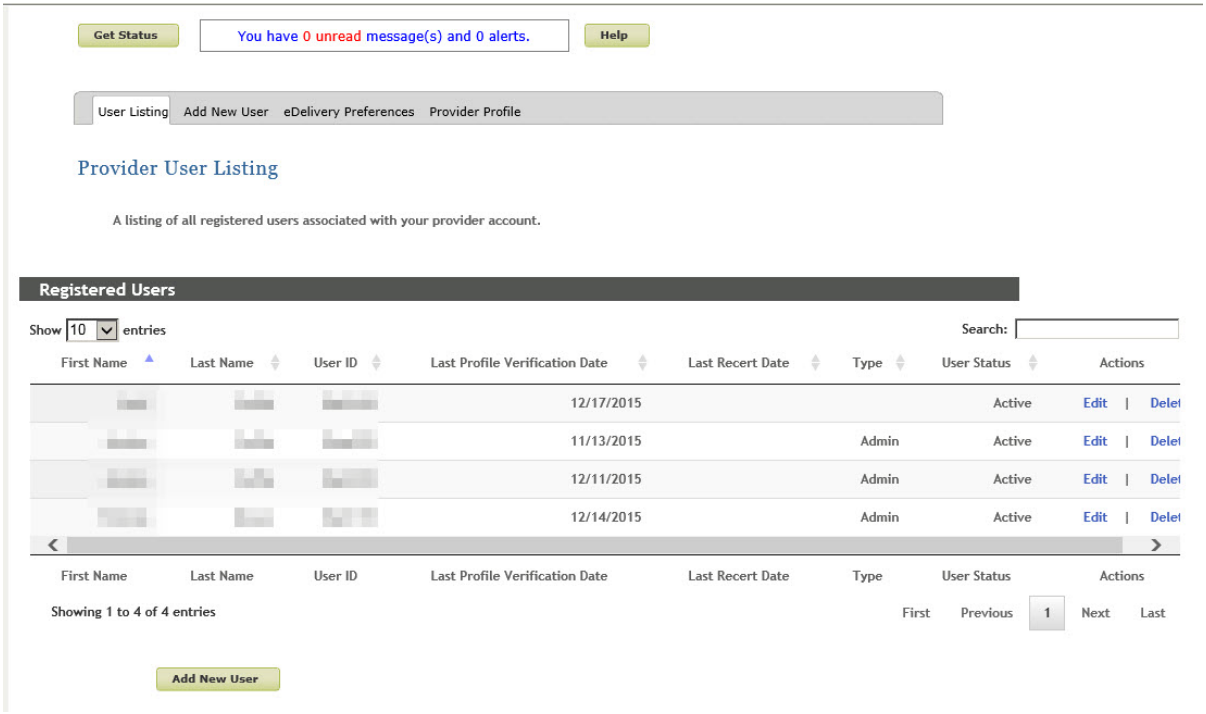


Figure 81: Administration Tab, Creating a New User

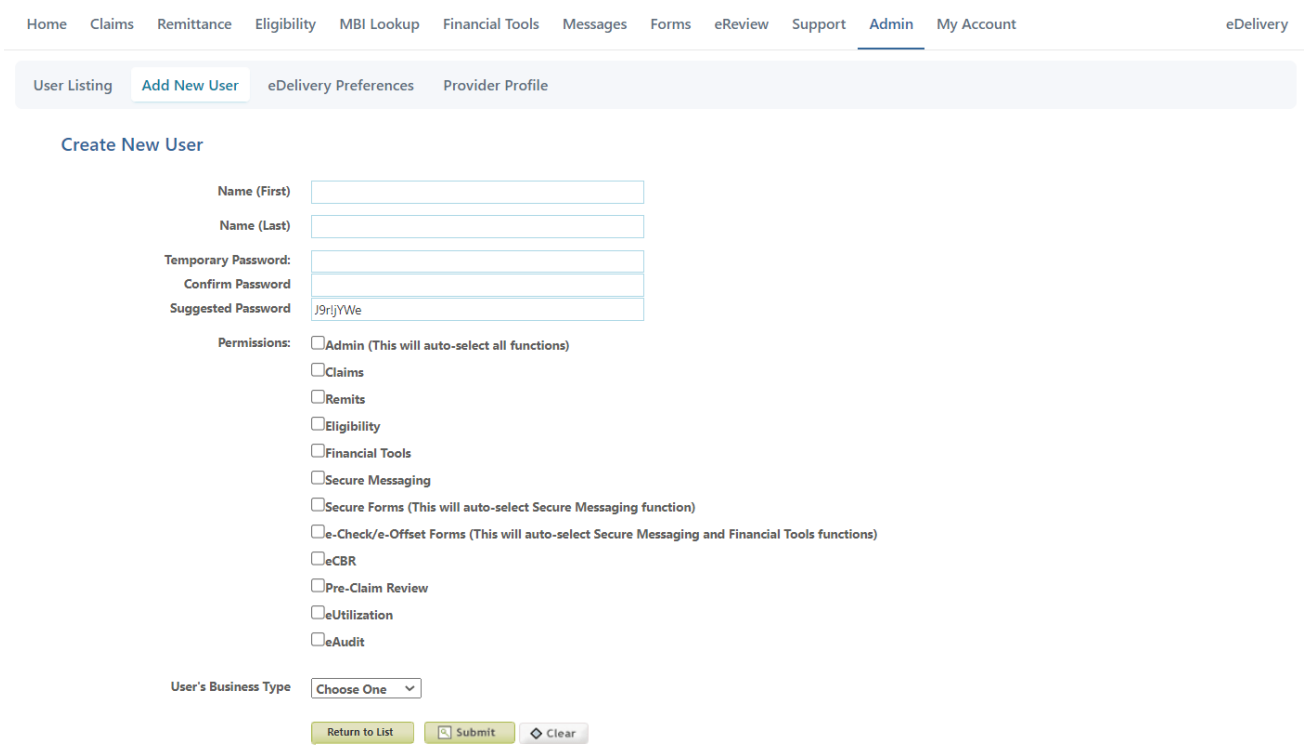
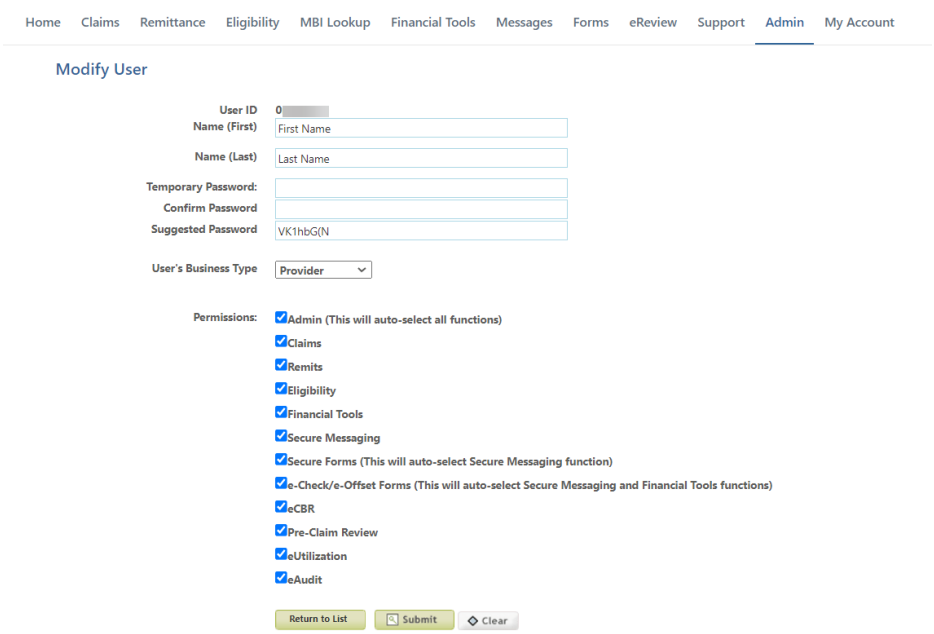


Figure 82: Administration Tab, Modifying a User



A provider user may be granted administrative access by the provider administrator. Keep in mind that provider administrators have access to all functions of eServices. Granting administrative access to a provider user also gives them access to all functions, including the ability to modify or delete the original provider administrator. Provider administrators can create and delete additional provider administrators. 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 and password.

If a user does not know who their provider administrator is, they need to contact the provider's staff to find out if they have registered to the system and who is designated as the 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 log in 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. To request that your record be removed, please contact your Medicare Contractor.

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

10.2 Who is my provider administrator?

If you do not know who the provider administrator is, contact the 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.

10.3 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 log in 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

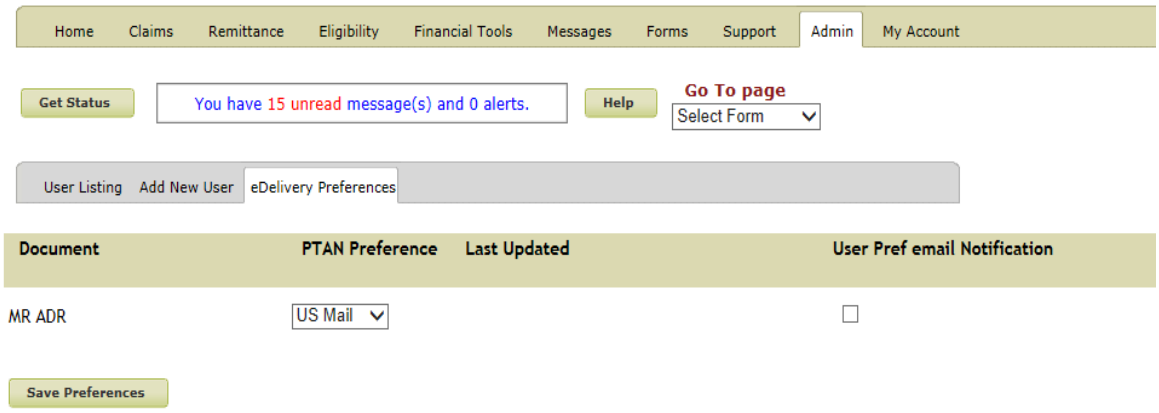
10.4 Can I use generic contact (user) names for provider administrators or provider users?

Generic contact (user) names are not permitted. Each user of eServices must have a unique user ID and password. This means that we expect each user to have a legitimate first and last name associated with each user ID. Examples of generic user names are: Front Desk, Account Coordinator, Billing Department, User A, or the name of the provider office. No sharing of user IDs and passwords is permitted. Palmetto GBA will delete, without notice, any user IDs that are associated with a generic user name.

10.5 eDelivery

Provider Administrators may select to receive letters electronically through eServices. After navigating to the admin tab, the user will have the option to select the eDelivery Preferences sub-tab.

Figure 83: Administration Tab, Selecting eDelivery Preferences



From this sub-tab, providers can opt to receive their letters by US mail or through eServices via eDelivery. For providers enrolled in eDelivery, an eDelivery message will be sent with a link to the letter. There is also a User Pref email Notification option that allows the user to receive an email when new eLetters are available in eServices.

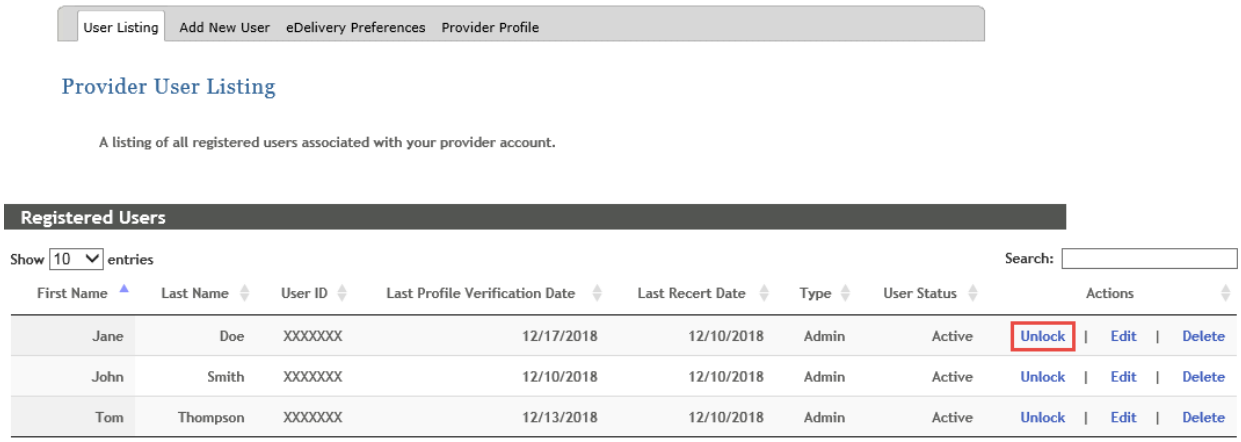
Note: If you have a registered account with esMD, you must select "B" as your delivery option. This will allow letters to be delivered in both the eServices portal and esMD.

10.6 User Unlocks

In the event that a user is locked out of their eServices account due to entering their password incorrectly three times, a provider administrator may unlock the user from their Admin tab. On the User Listing sub-tab, select the Unlock option listed in the Actions section for the user you wish to unlock.

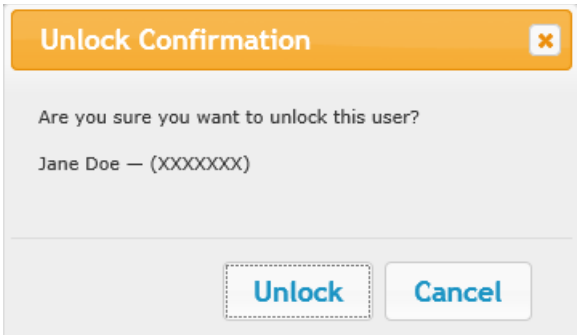
Note: If there are multiple active provider administrators on the account, any provider administrator may unlock another provider administrator.

Figure 84: User Unlock



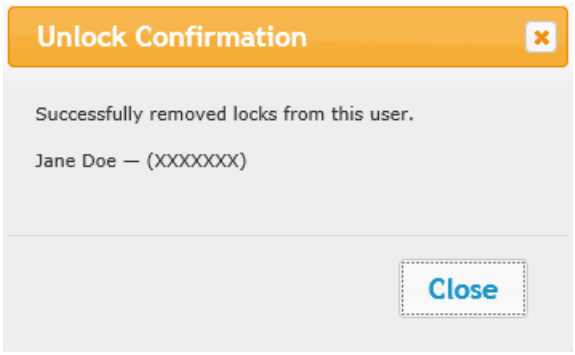
You will be prompted to confirm that you want to unlock this user. Click the Unlock button to proceed.

Figure 85: User Unlock Confirmation Request



A confirmation message will display advising that the selected user was successfully unlocked.

Figure 86: User Unlock Success Confirmation



11.0 eReview

11.1 How do I use the eCBR function?

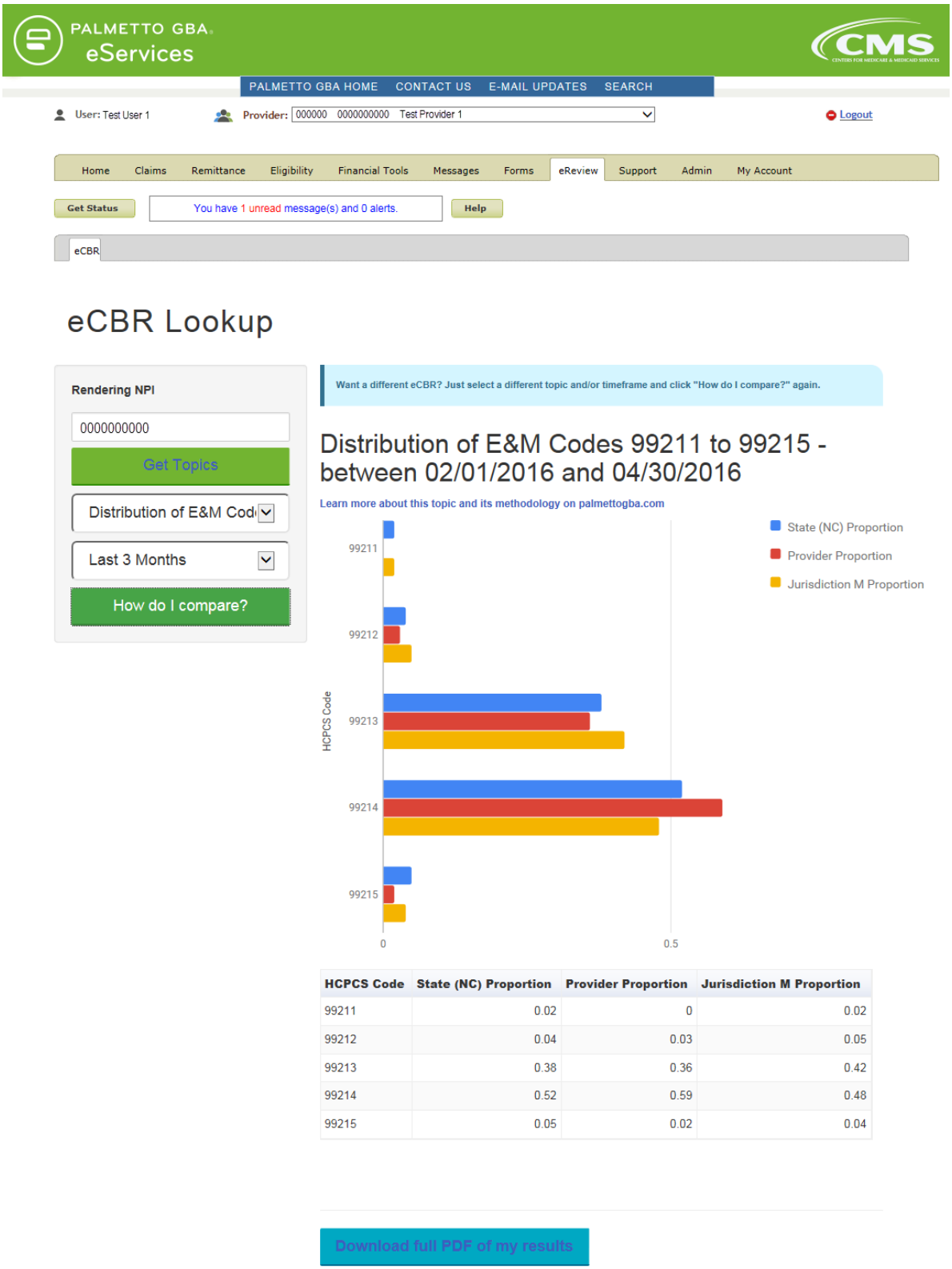
Palmetto GBA uses Comparative Billing Reports (CBRs) as an educational tool for providers to use in order to provide insight into your billing patterns and utilization of services in comparison to your peers. Providers can use this information to conduct a self-audit to ensure they are in compliance with the Medicare regulations and prevent improper claims submission in order to avoid possible pre or post-pay medical review.

The portal's eCBR function allows you to view and download your individual CBR online. You may also select the link for more topic-specific education.

To use the function,
- Enter Rendering NPI
- Select 'Get Topics' (This will dynamically populate the Topics and Time Frames based on your available data)
- Choose the Topic
- Choose the Timeframe
- Select "How do I compare?"
- View your data & download PDF if desired

A sample screenshot is shown below for your reference.

Figure 87: eCBR Report



11.2 How do I use the eUtilization function?

Electronic Utilization (eUtilization) reports offer rendering providers and ordering and referring providers access to their personal data. This data can be reviewed to ensure you are aware of when and by whom your NPI is being used for billing Medicare services and when you are notated on a Medicare claim as the ordering referring physician. This will provide you with the ability to identify possible misuse of your NPI.

Ordering and Referring
This function enables an individual physician to see all claims billed where their NPI was indicated as the ordering and referring provider for the beneficiary. The report will also allow you to click and see a summary by the type of code for the services billed.

Rendering
This will allow an individual provider who is part of a group practice or multiple groups to pull a data report for their NPI, which will enable them to view their utilization for each associated provider ID for a specified time period. Refer to the appropriate section on Palmettogba.com for more education.

To use the function,
- Select the Type (Ordering/Referring or Rendering)
- Enter Rendering NPI
- Select 'Get Time Frame' (This will dynamically populate the Time Frames based on your available data)
- Pick a Time Frame to view
- Select "Submit"

To view more information, select the 'Details' link for the desired provider and you will be shown the HCPCS codes, descriptions, and number of occurrences.

Sample screenshots are shown below for your reference.

Figure 88: eUtilization Summary Screen

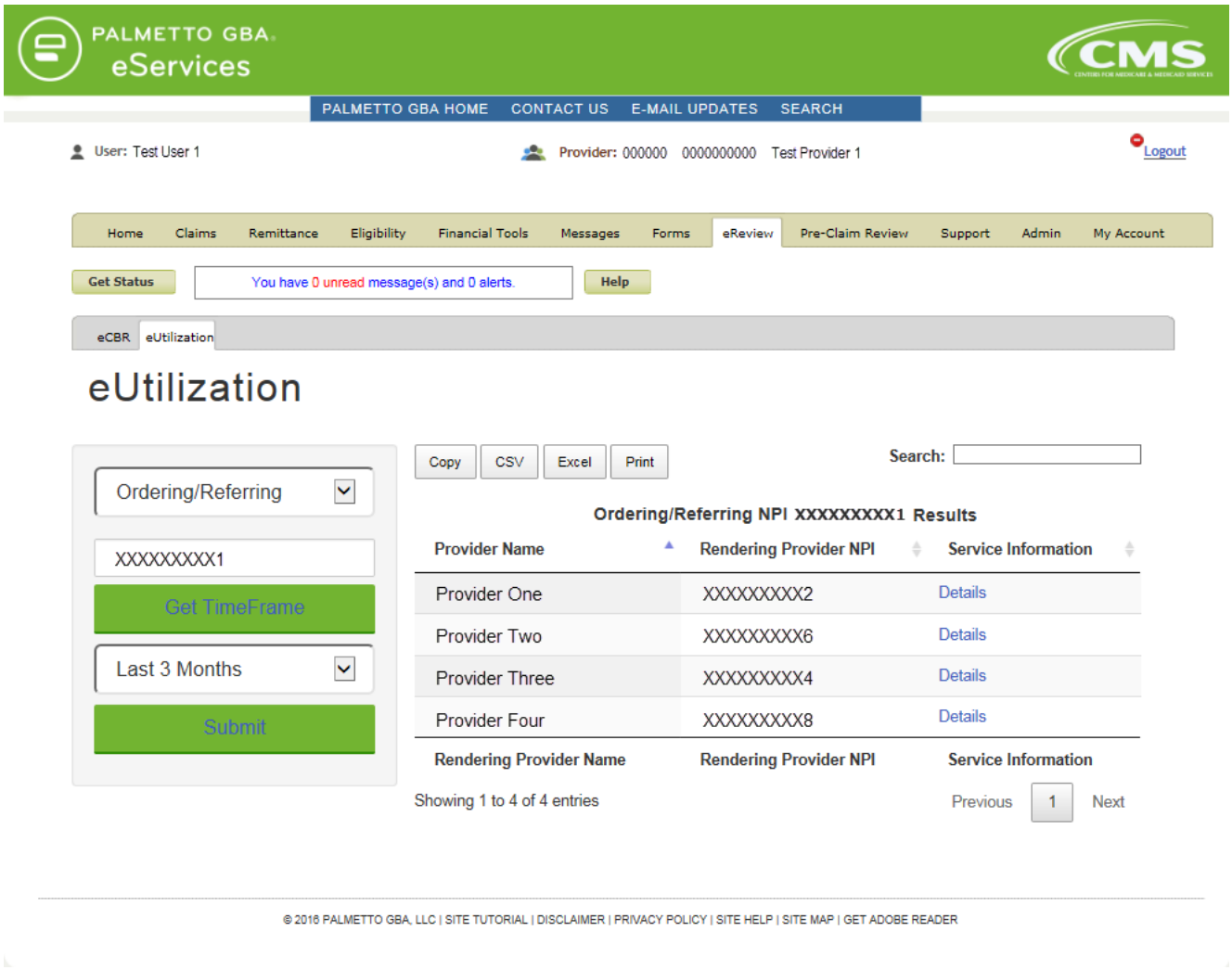
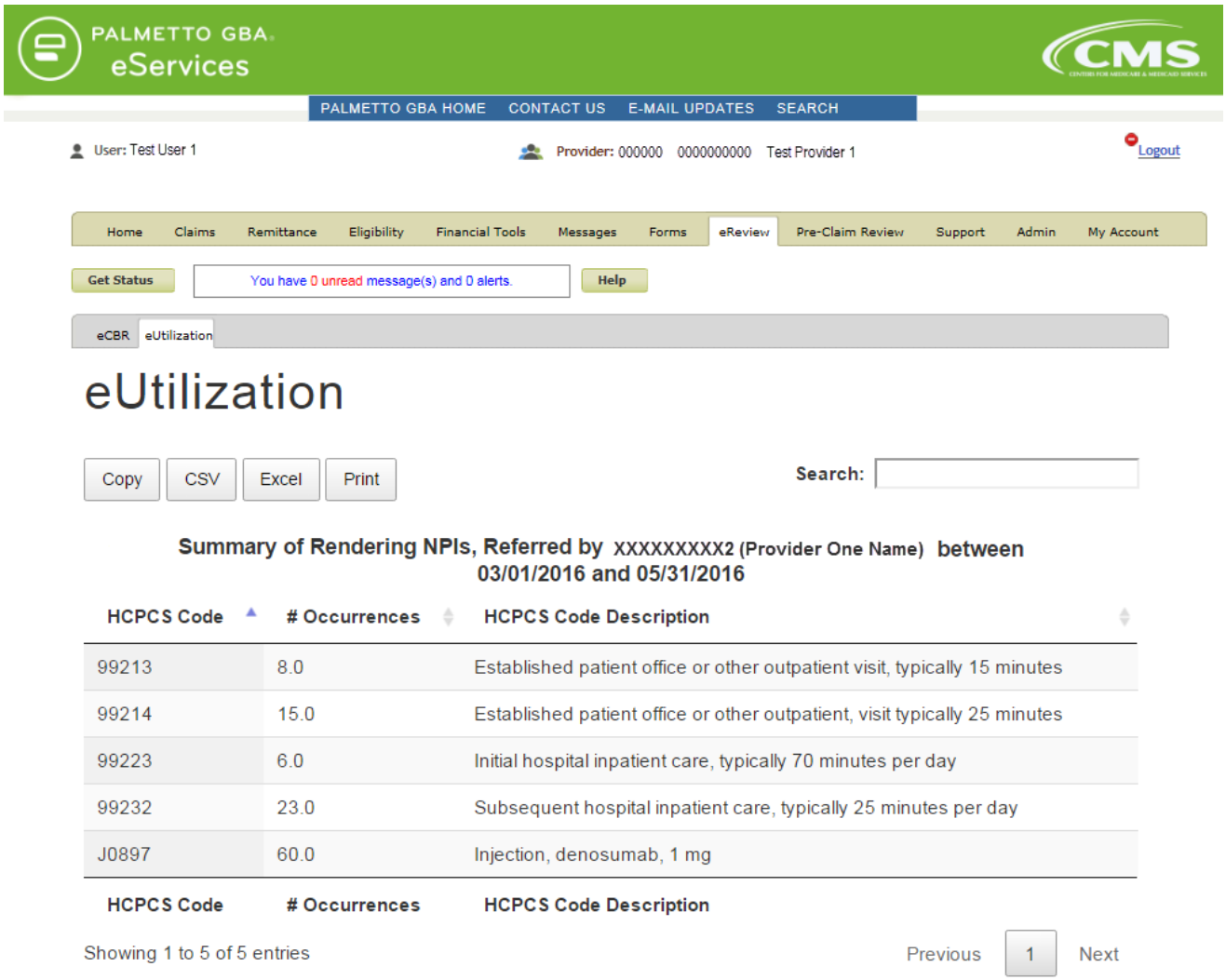


Figure 89: eUtilization Detail Screen



11.3 How do I use the eAudit function?

Electronic Audit (eAudit) reports offer a dashboard of audit results for claims which have been sampled by review contractors for Complex Medical Review. eAudit gives providers the opportunity to see what claims may be pending a complex medical review currently and the results of any recent medical review activities. This information can be used for self-assessment of provider performance on Medicare audits utilizing the dashboard containing common denial reasons.

To get started, select the eAudit tab, under the eReview tab. Once there, select the Audit Type and the screen will populate with a summary table of audit data.

Figure 90: Audit Type Landing Page

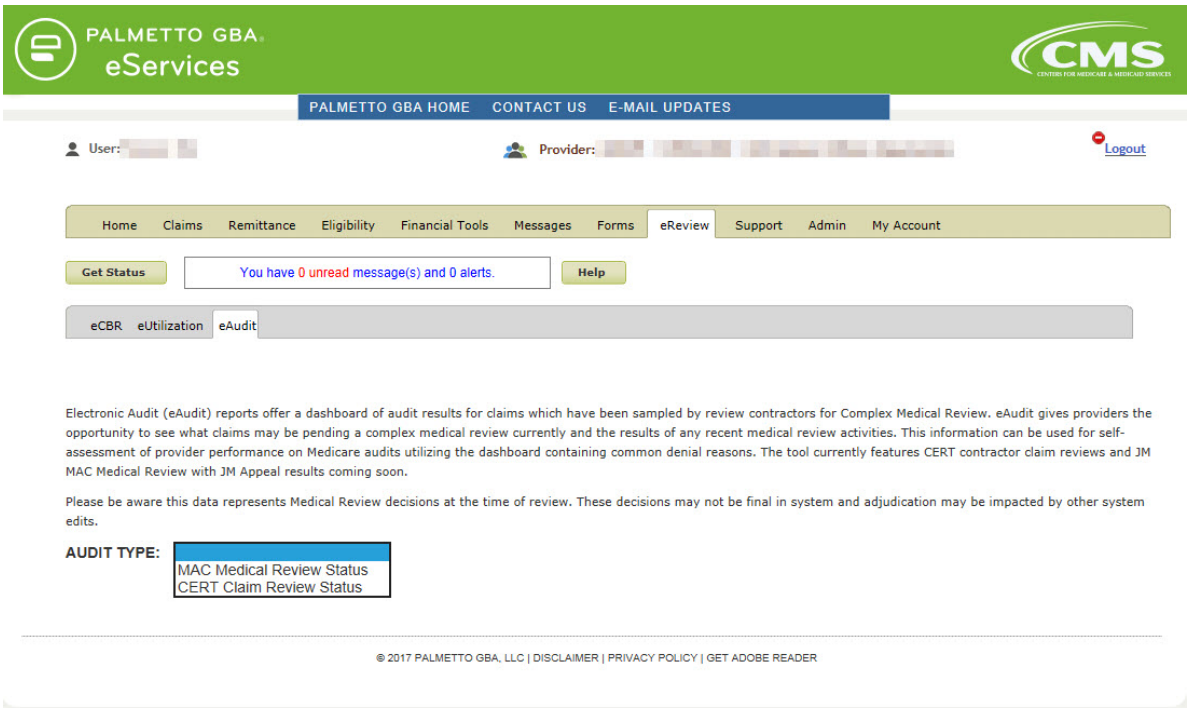
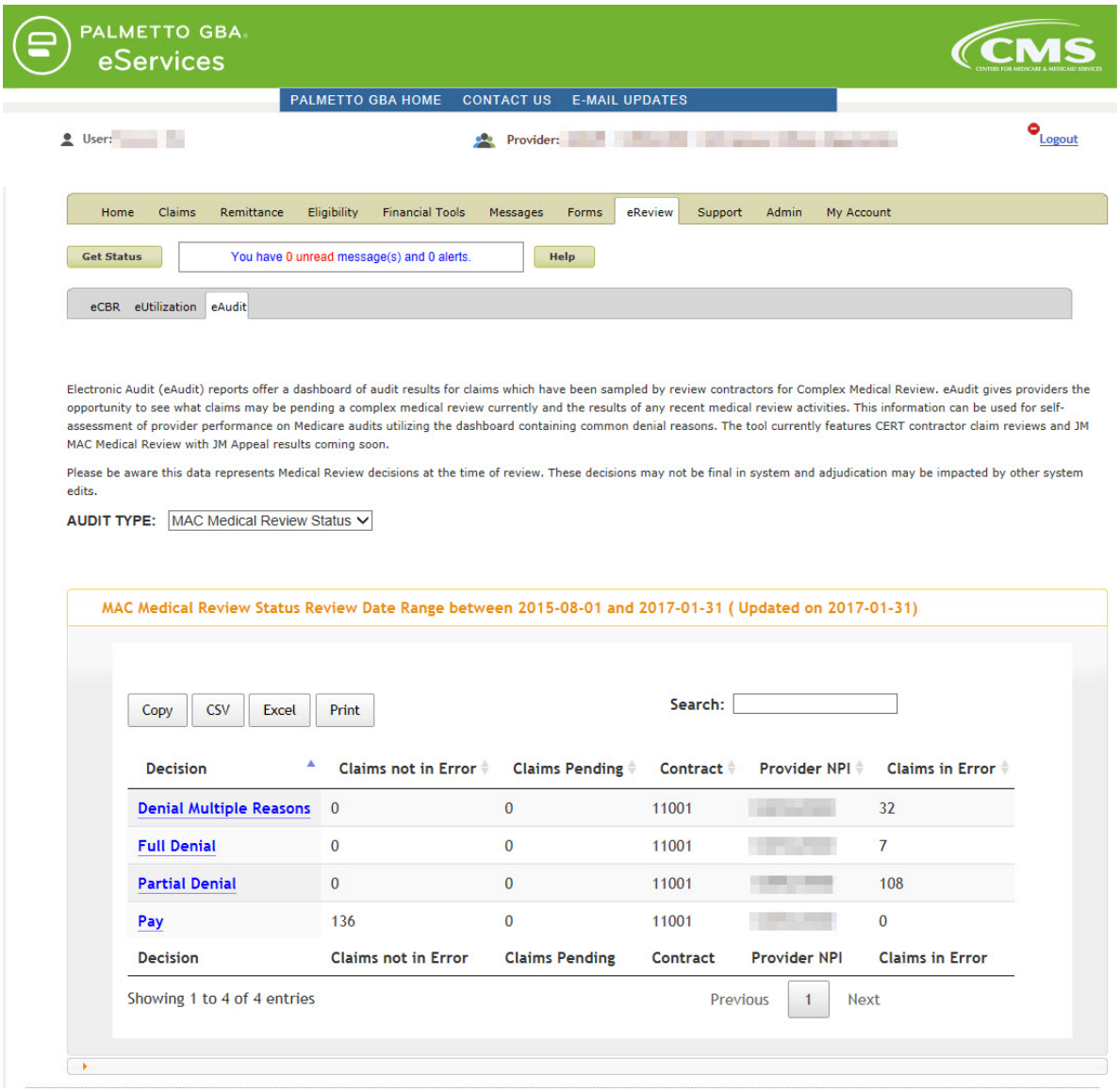


Figure 91: eAudit Claim Data Table – MAC Med Review Status



Users can select the category to be taken to a Claim Data Details Table to see the claim line details for that audit error code category. Each of the items in the Claim Data Details Table can be expanded for extra details as shown below.

Figure 92: eAudit Claim Data Details Table – MAC Med Review Status

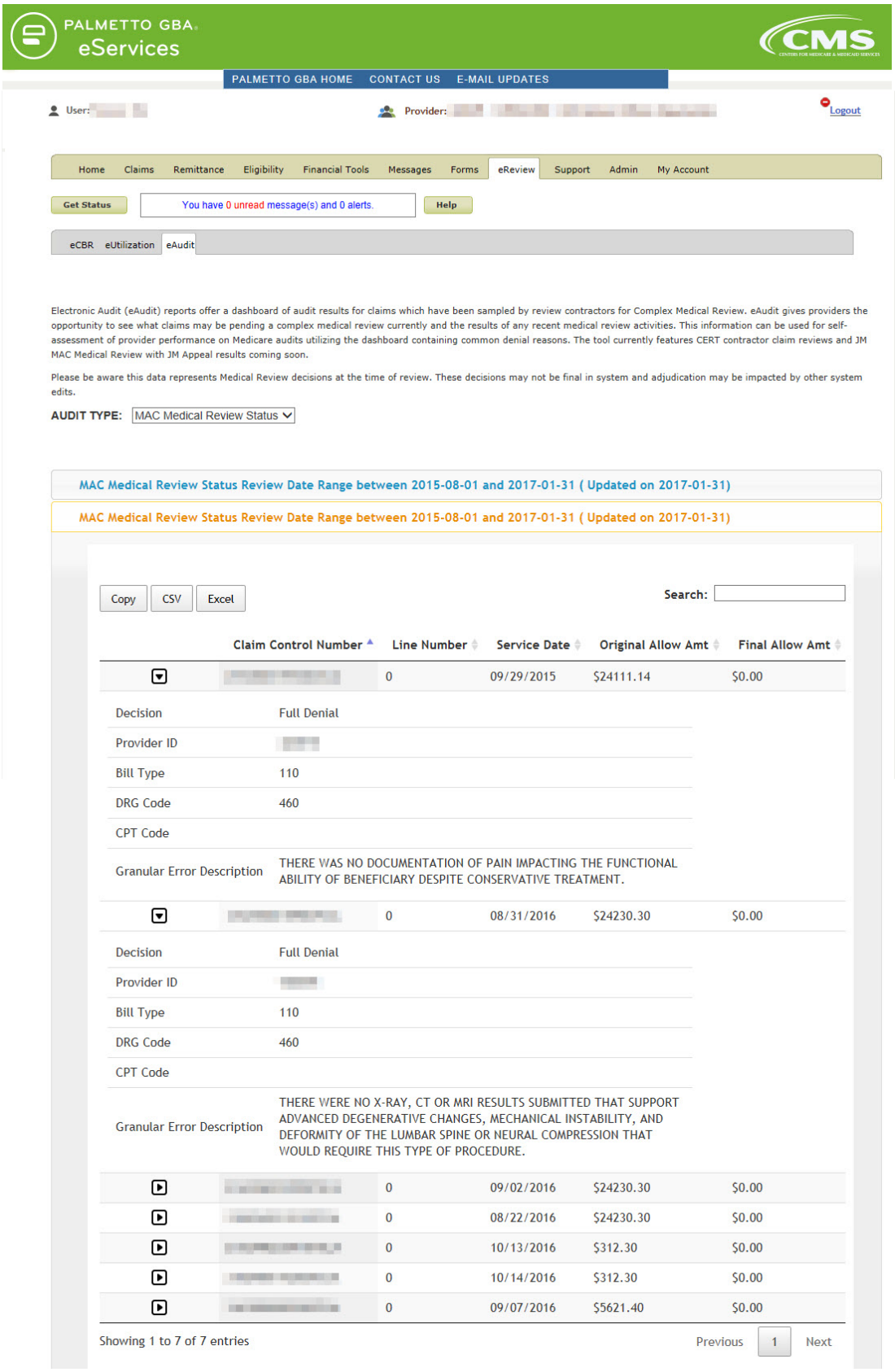


Figure 93: eAudit Claim Data Details Table – CERT Claim Review Status

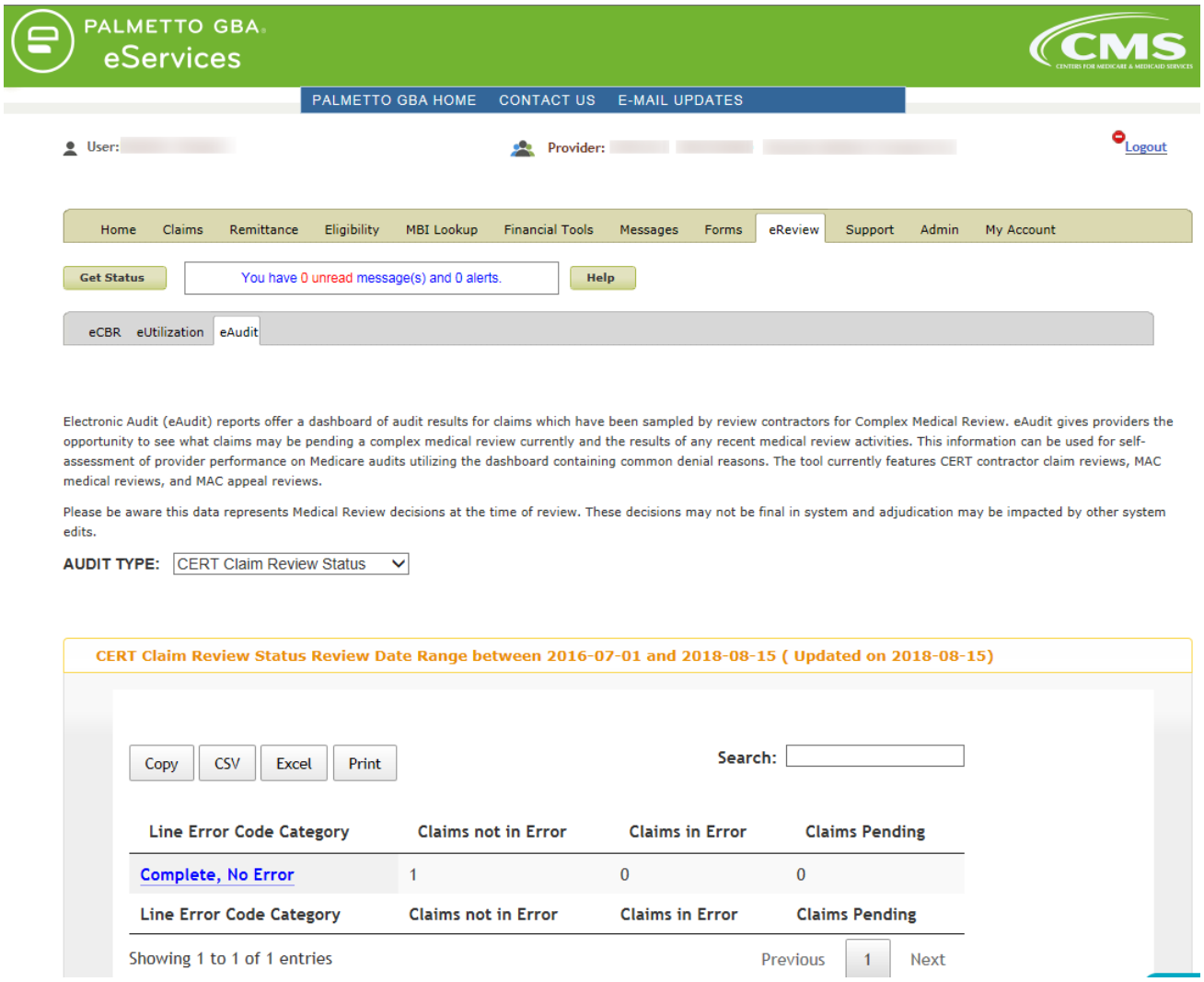
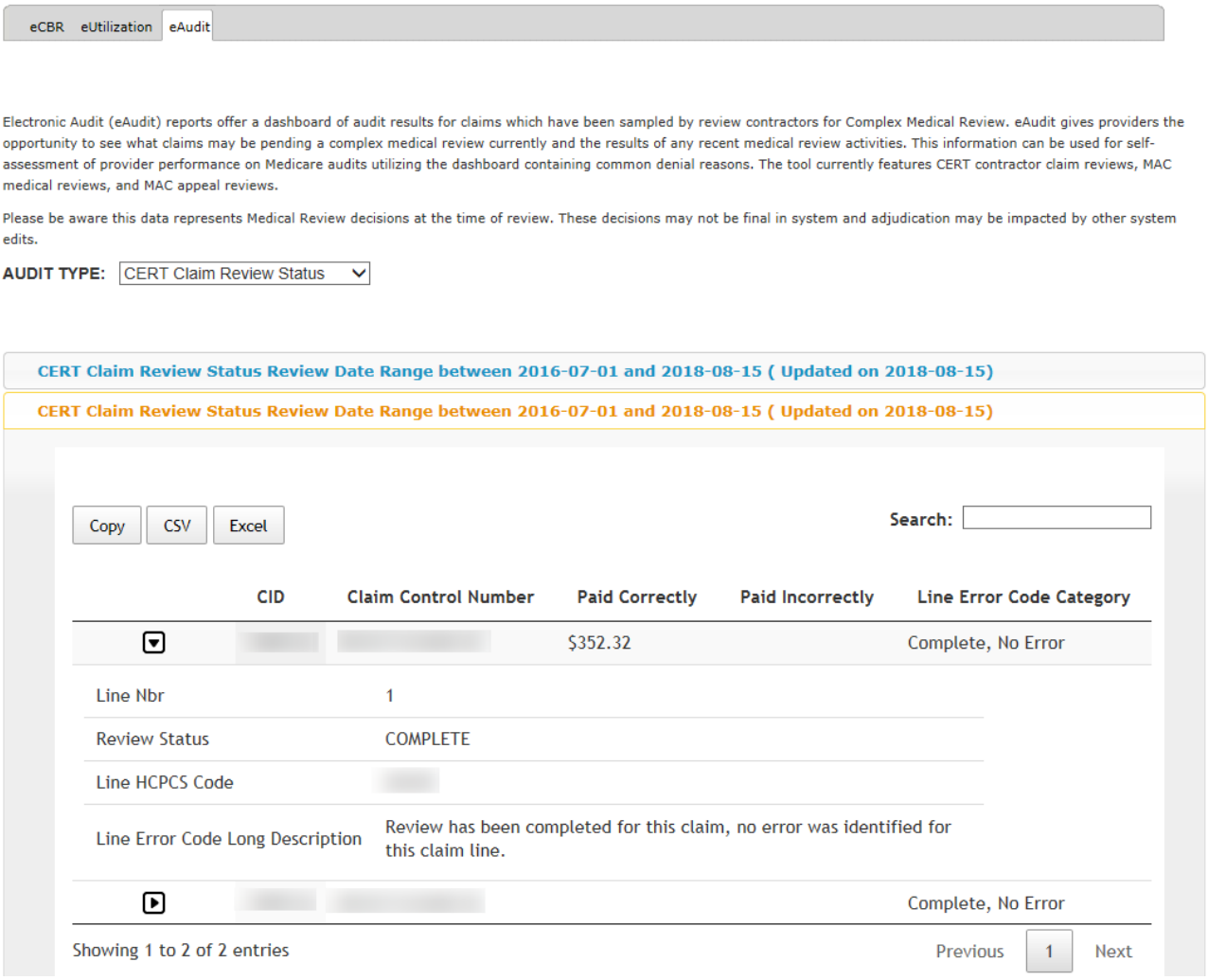


Figure 94: eAudit Claim Data Details Table – CERT Claim Review Status

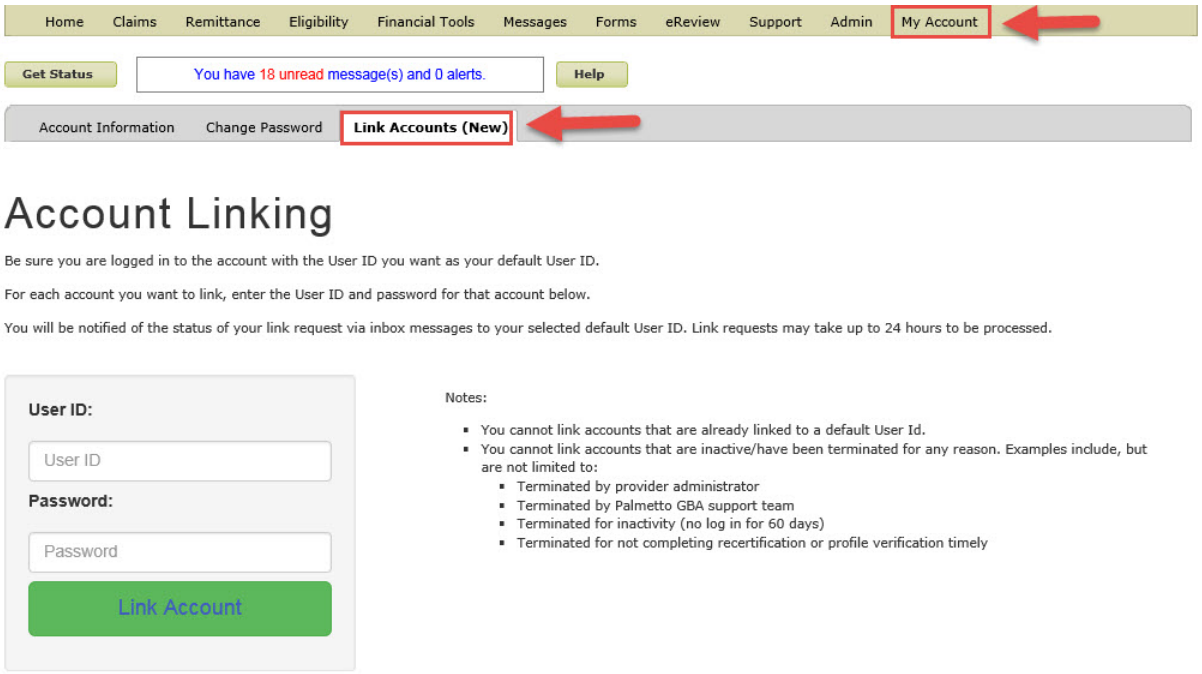


12.0 Account Linking

12.1 How to link existing eServices user IDs

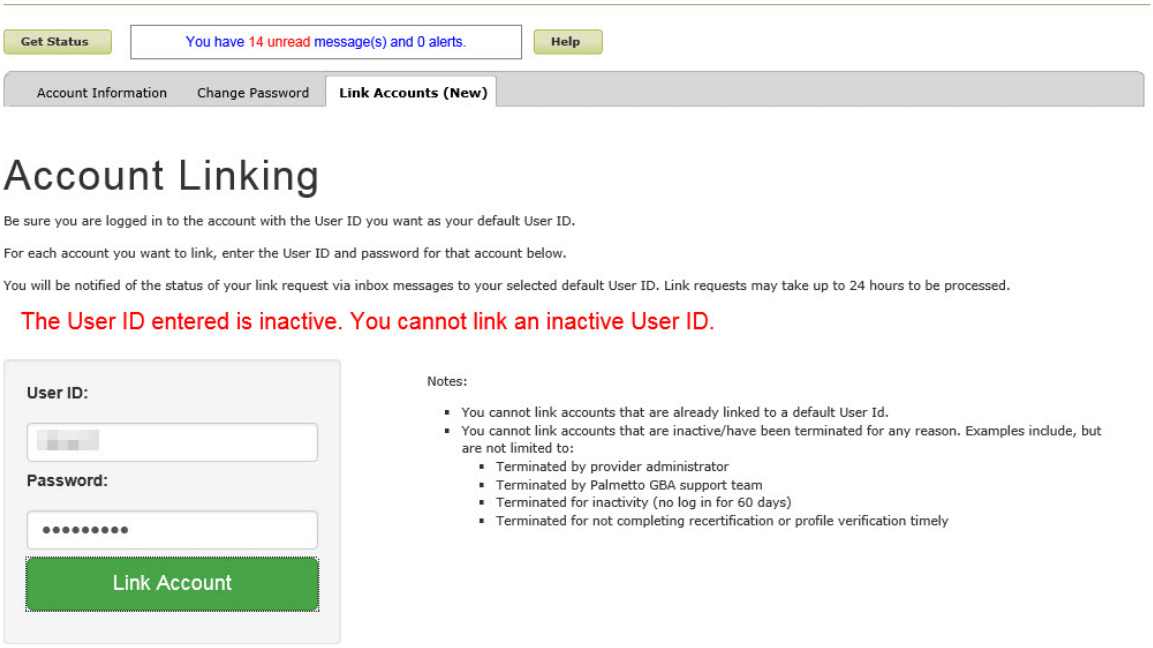
Palmetto GBA gives users the ability to link their previously assigned eServices user IDs under one default ID through the Account Linking sub-tab. Users should log into eServices with the user ID that they wish to use as their default. This is the user ID that will be used to access any linked accounts. Once the user has successfully logged into eServices, they may access the Account Linking sub-tab by first selecting the My Account Tab.

Figure 95: Account Linking Sub-Tab



Simply enter the user ID and password of the eServices account that you wish to link in the corresponding fields and click the Link Account button. Please note that only active IDs that are not already linked to a default user ID are eligible for account linking. In the event that there is an issue preventing successful linkage of the requested account, an error message will display. Please read the message and proceed accordingly.

Figure 96: Account Linking Error Message Example



If the account link request is submitted successfully, a submission confirmation message will display. Additionally, users will receive an eServices inbox message related to their account link request. Users may continue the account linking process for all desired user IDs.

12.2 Accessing linked accounts in eServices

Once your eServices user IDs have been linked, you will need to log in with your default ID. All other user IDs will be deactivated. You will still use the password that you previously created for this user ID to access eServices. Attempts to access eServices with a user ID that was linked to a default ID will result in an error message.

12.3 Switching between accounts in eServices

eServices users can easily switch between their linked accounts by using the Provider dropdown box located near the top of each tab. Simply click on the dropdown box to display the list of all linked accounts available and select the desired provider account. The dropdown box will be updated to show the selected provider. Upon login you will only be able to view tabs that match the access for your default account. As you choose a different account from the Provider dropdown menu at the top of the screen, you will see the tab availability change based upon your permissions. In the event that you do not have permission to view the current tab for the selected provider, you will receive an error message in red at the top of the page. The screen will display the tab for the previously selected provider account.

Figure 97: Account Linking Provider Dropdown

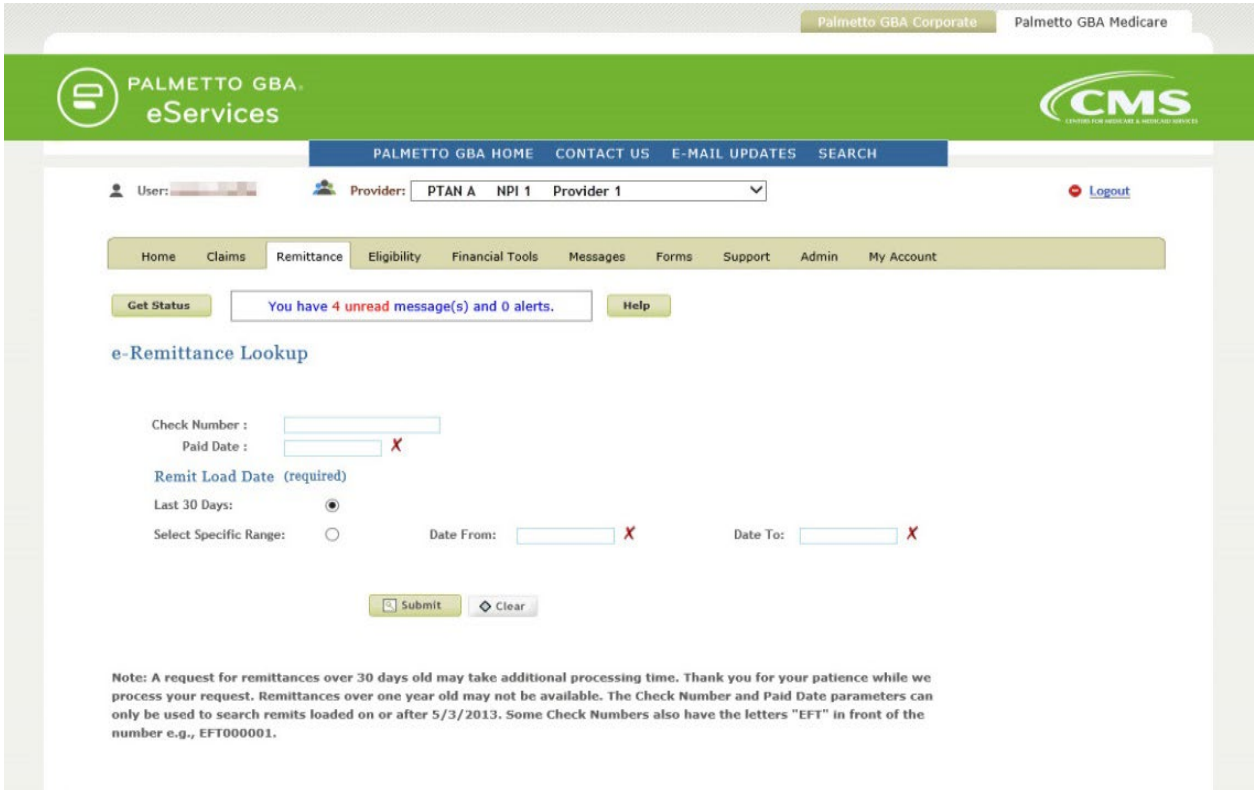


Figure 98: Account Linking Expanded Provider Dropdown

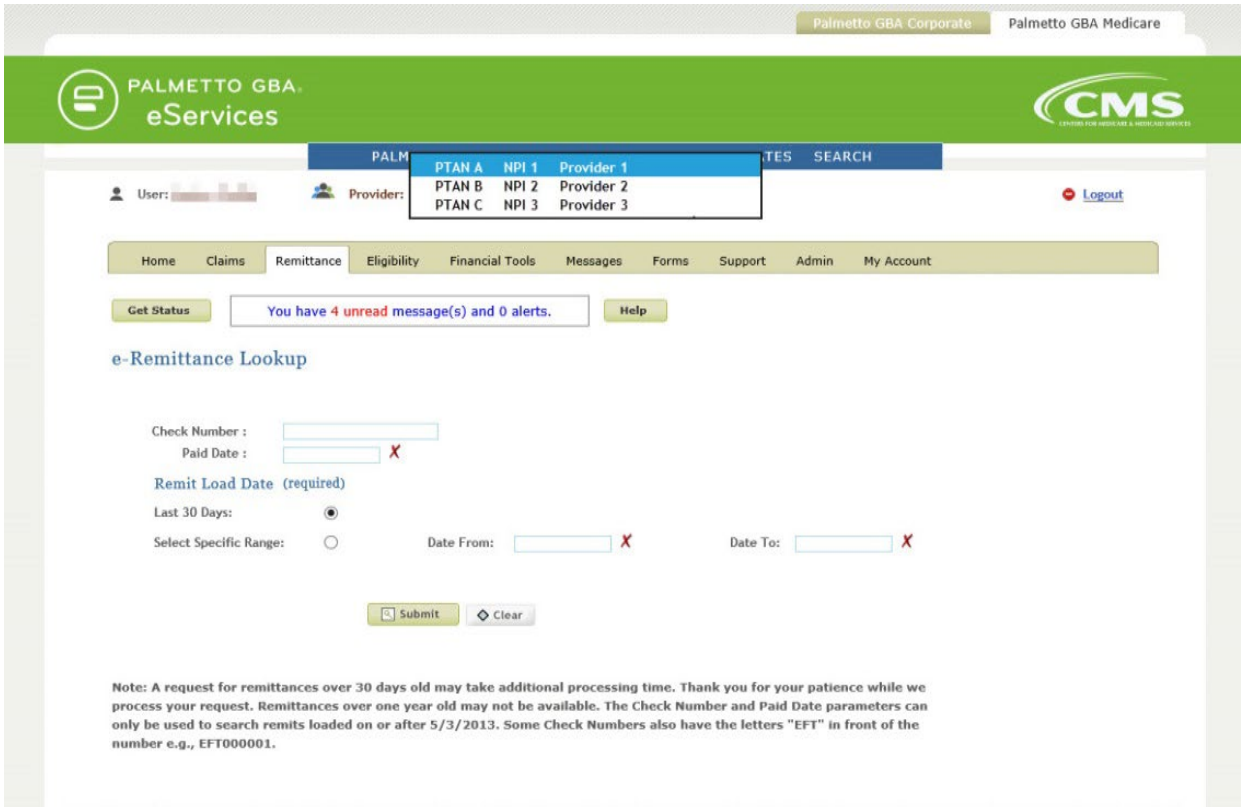


Figure 99: Account Linking Successful Provider Change

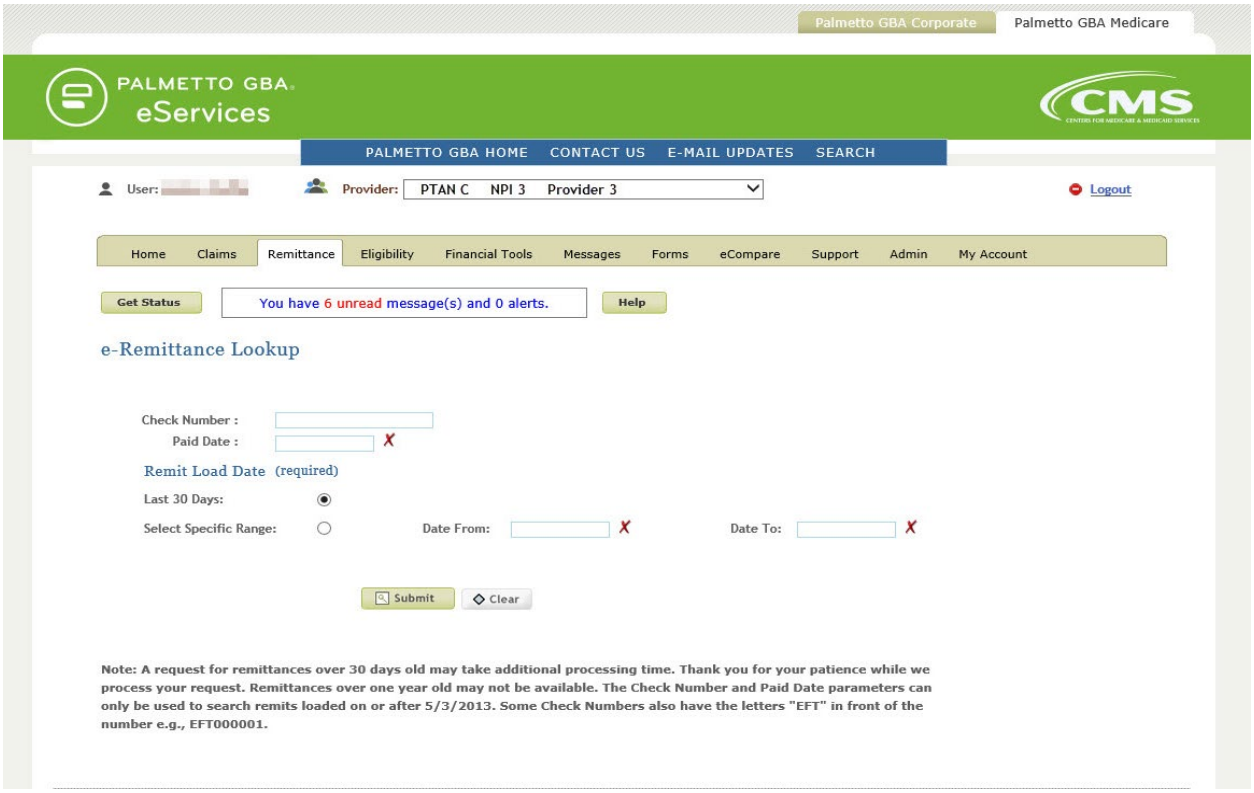
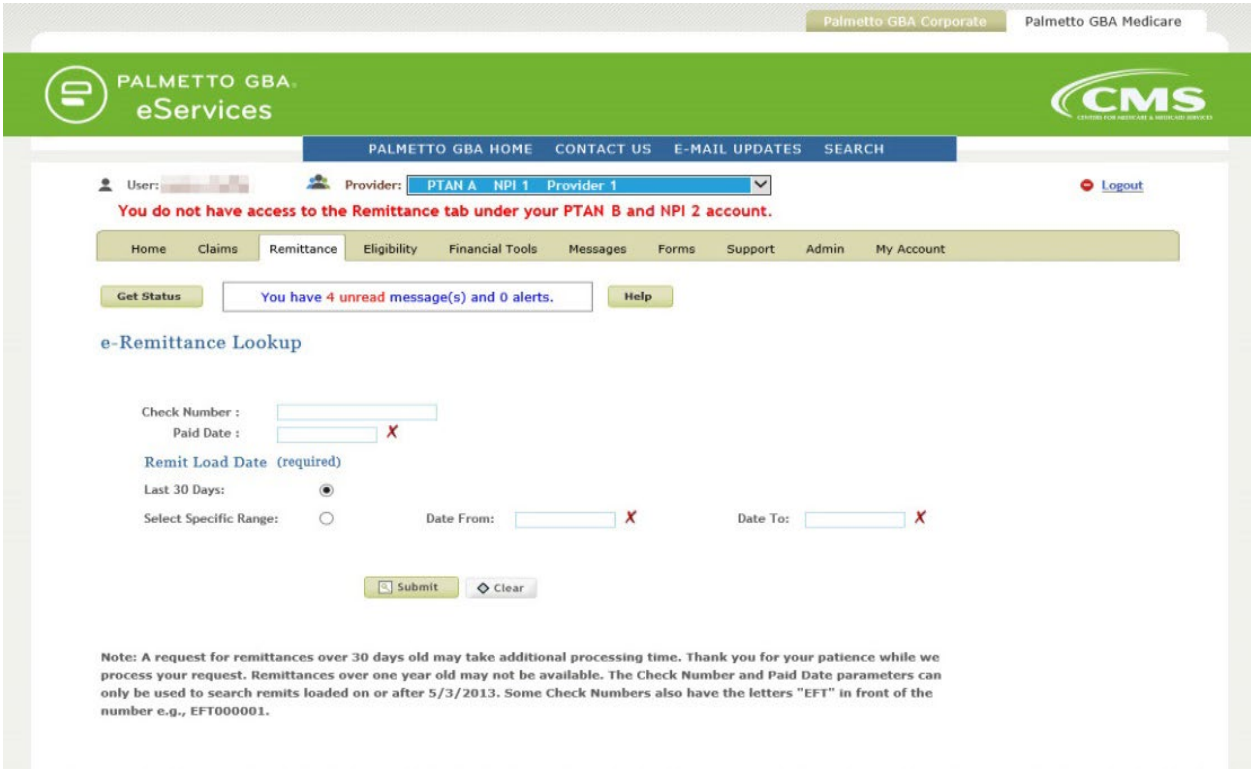


Figure 100: Account Linking Provider Change Error

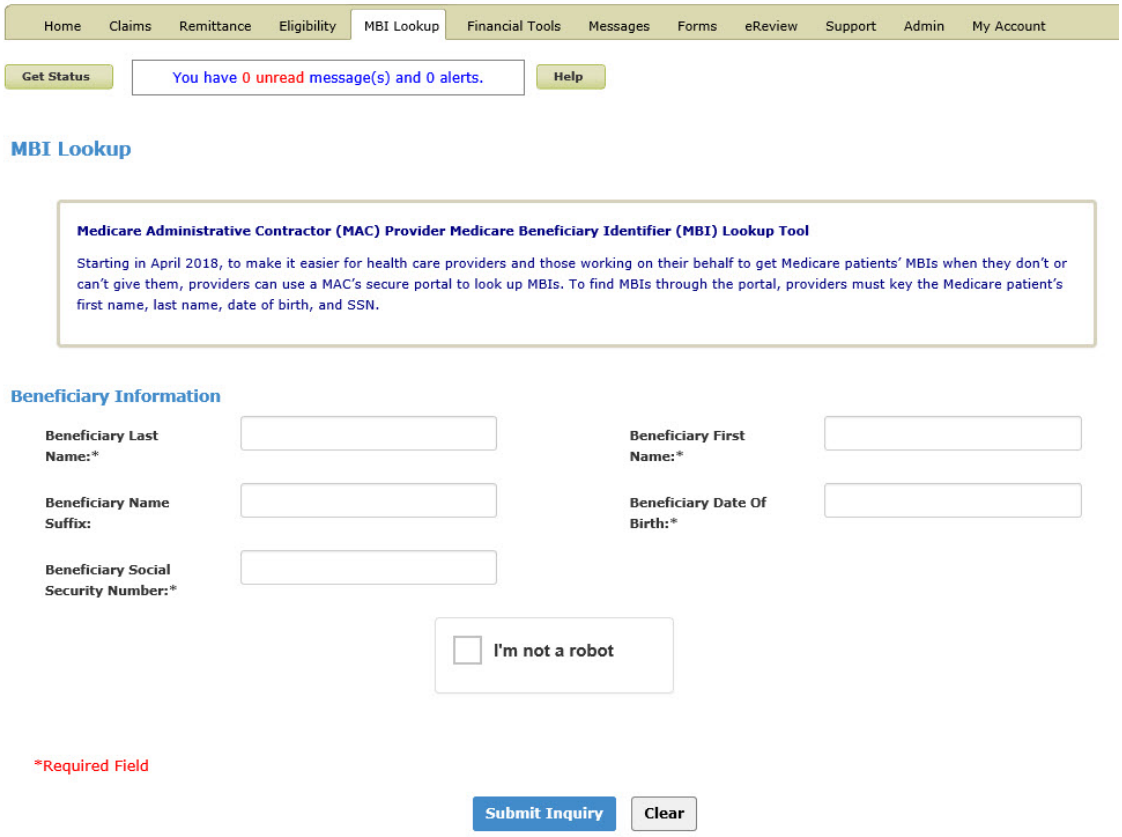


13.0 MBI Lookup

13.1 How to successfully perform an MBI lookup

When you click on the MBI Lookup tab, you will be presented with the MBI Lookup screen. You can use this MBI Lookup tool to find MBIs on behalf of Medicare patients when they don't have them or are unable to provide them. The user should enter a beneficiary's information into the fields below and use the Submit Inquiry button. To protect the privacy of beneficiary data, all fields entered, including optional fields, must match the beneficiary's data; otherwise, MBI data will not be returned.

Figure 101: MBI Lookup Tab



The following fields are required:

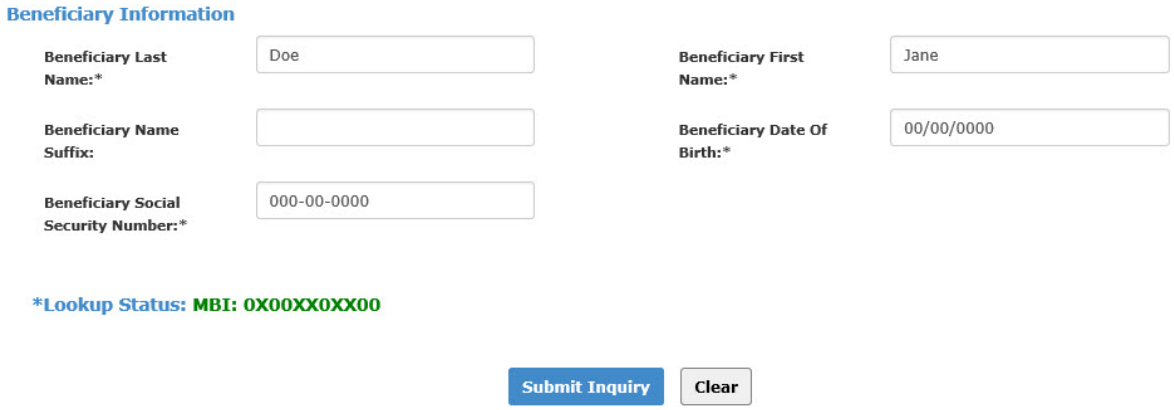
- Beneficiary Last Name
- Beneficiary First Name
- Beneficiary Date of Birth
- Beneficiary Social Security Number

The optional fields are as follows:

- Beneficiary Name Suffix – The beneficiary's suffix may be entered in this field if the beneficiary has it printed on their Medicare health insurance card.

If the inquiry successfully returns an MBI, the screen will refresh with the data at the bottom.

Figure 102: MBI Lookup Successful Response



13.2 MBI Lookup error messages

In the event that your MBI lookup request does not result in a successful response, eServices will display error messages to assist you. If any required fields are left blank or are not in a proper format, a message will appear advising you which fields to correct.

Figure 103: MBI Lookup Unsuccessful Response

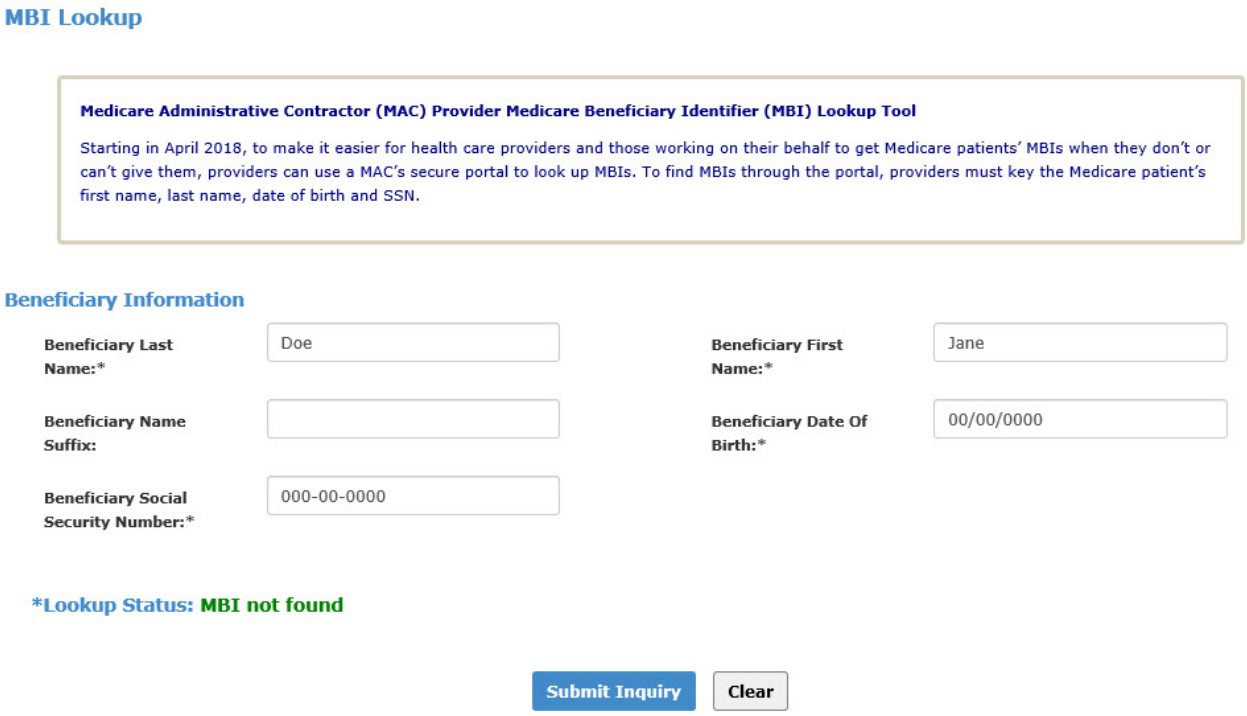
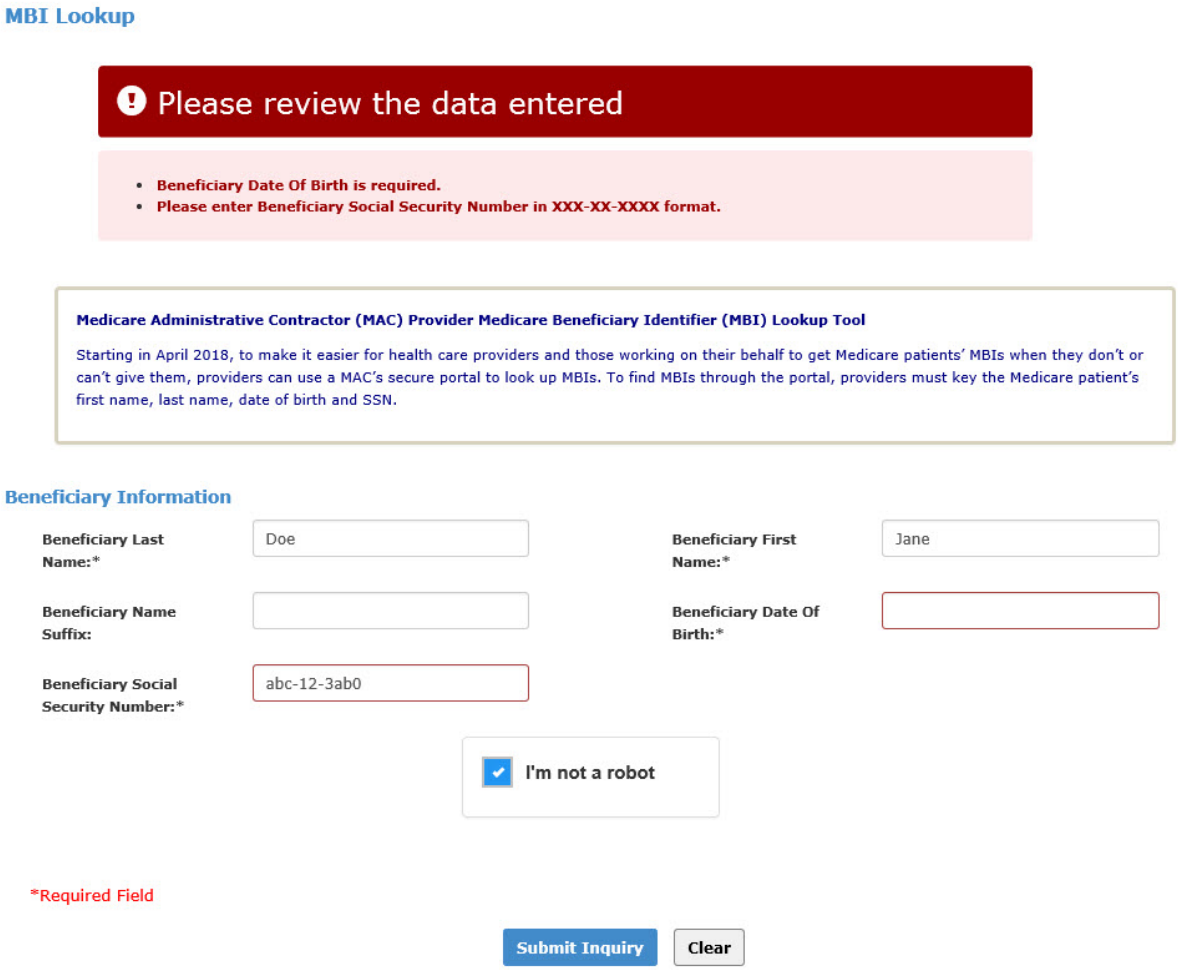


Figure 104: MBI Lookup Data Entry Errors



14.0 ADR Status Dashboard

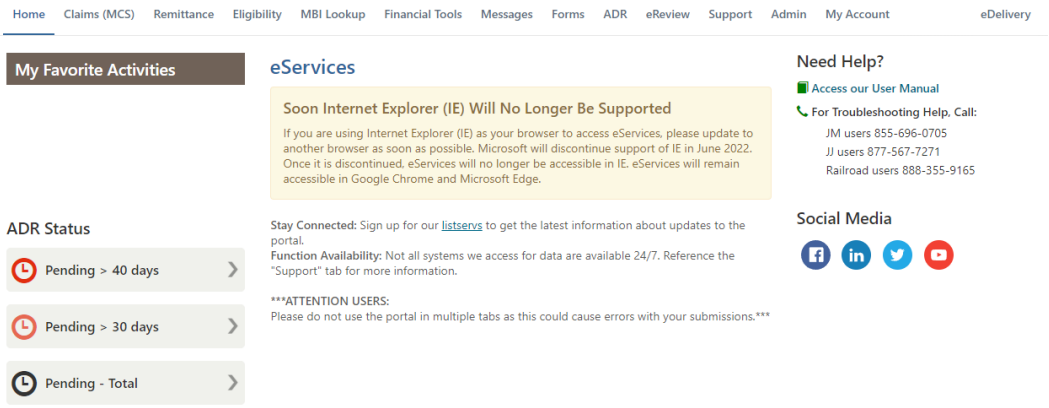
14.1 Using the ADR Status Home Page Widgets

Part B users will see a Pending ADR widget on the Home page. This new widget will provide an alert to users when there are ADRs that are older than 30 and 40 days. To see more details about the pending ADRs, a user can select the widget option to navigate to the new Pending ADR Dashboard.

When the provider does not have pending ADRs, the home page will be gray with zeros. The user will also not be able to click on the widget to get to the ADR tab.

Note: Users must have access to Secure Forms in order to view the details on the Pending ADR Dashboard.

Figure 105: ADR Status Widget on Home Page

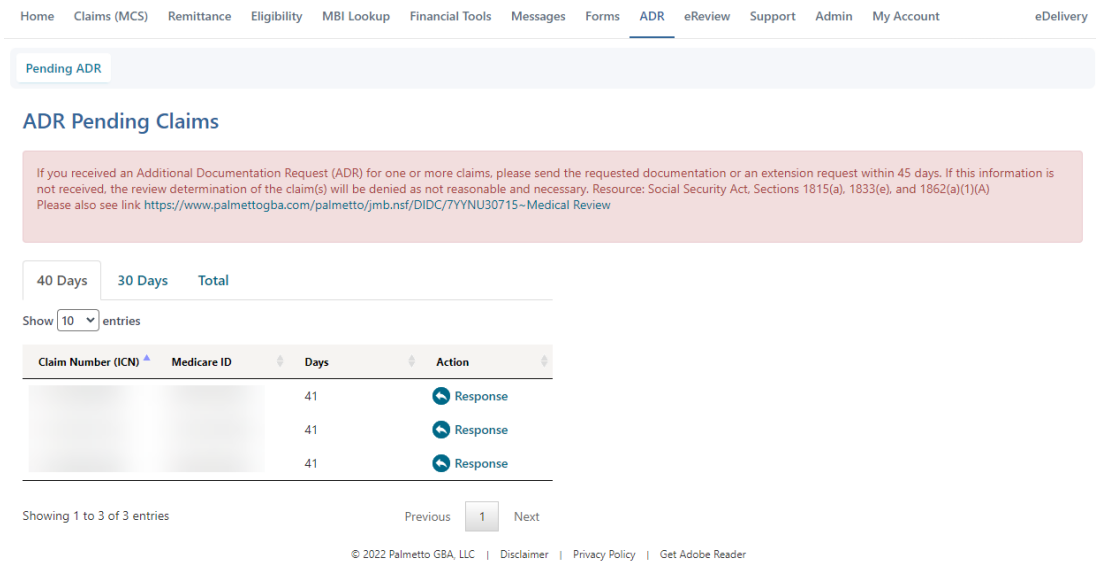


14.2 Pending ADR Dashboard

Users can access the Pending ADR Dashboard by selecting either the ADR Status Widget or the ADR tab. The dashboard will have the ADRs organized in tabs by the number of days the ADRs have been pending. Users can click the claim number listed to navigate to the claim detail page.

Once an ADR Response is submitted, the Response action will be removed as an option.

Figure 106: Pending ADR Widget on Home Page



14.3 Submitting MR ADR Form from the Dashboard

Users can use the Response option to complete the submission for the MR ADR form. When Response is selected, the user will be navigated to the MR ADR from. The MBI and ICN fields on the form will be prepopulated with the information from the Pending ADR dashboard.

15.0 Messages Inbox

15.1 Using the Secure Message Inbox

When you click on the Messages tab, you will be presented with your Notification Center inbox. It contains important notifications regarding eServices submissions and eServices alert messages.

Note: Only messages for to the account associated with the user ID you are logged in with, or the account selected if you have multiple accounts linked to your user ID, will display.

15.2 Inbox Filtering

The list of messages displayed will appear in chronological order. You may use the inbox filtering options to only view a certain message type and/or view messages related to a specific DCN. If you receive a message that there is no data available in the table, please adjust your filter criteria and try again. Items must match all entered criteria to display.

When using the filter feature, you must select the Search button to display the results found.

Users will be able to Export (Excel) or Download (PDF) the table information for the provider's inbox.

Note: Only messages for to the account associated with the user ID you are logged in with, or the account selected if you have multiple accounts linked to your user ID, will display.

Figure 107: Inbox Filtering

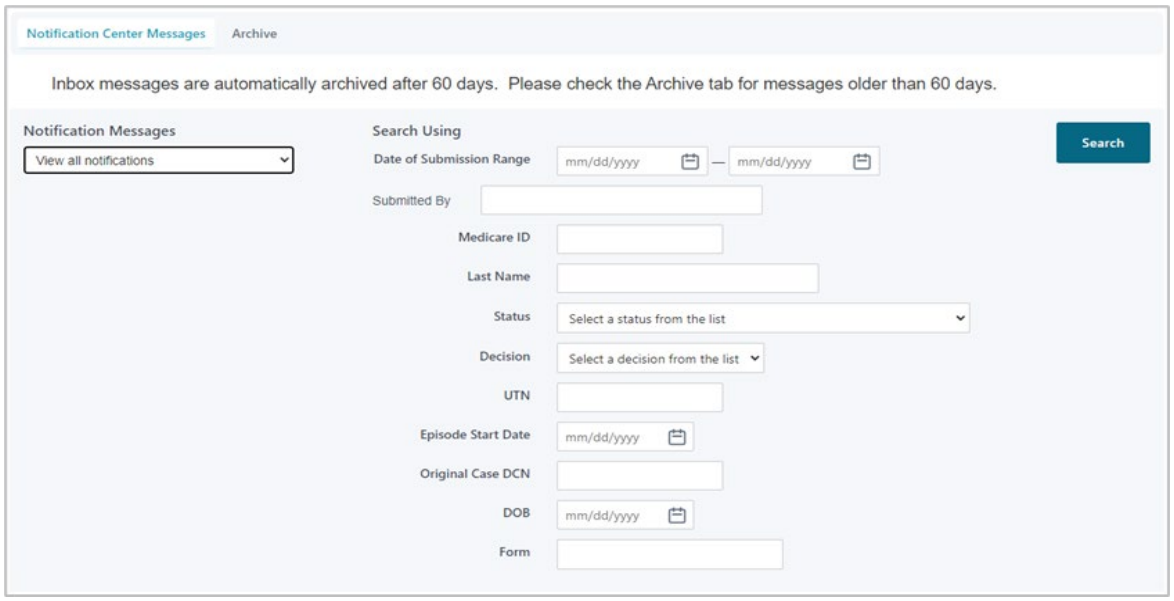
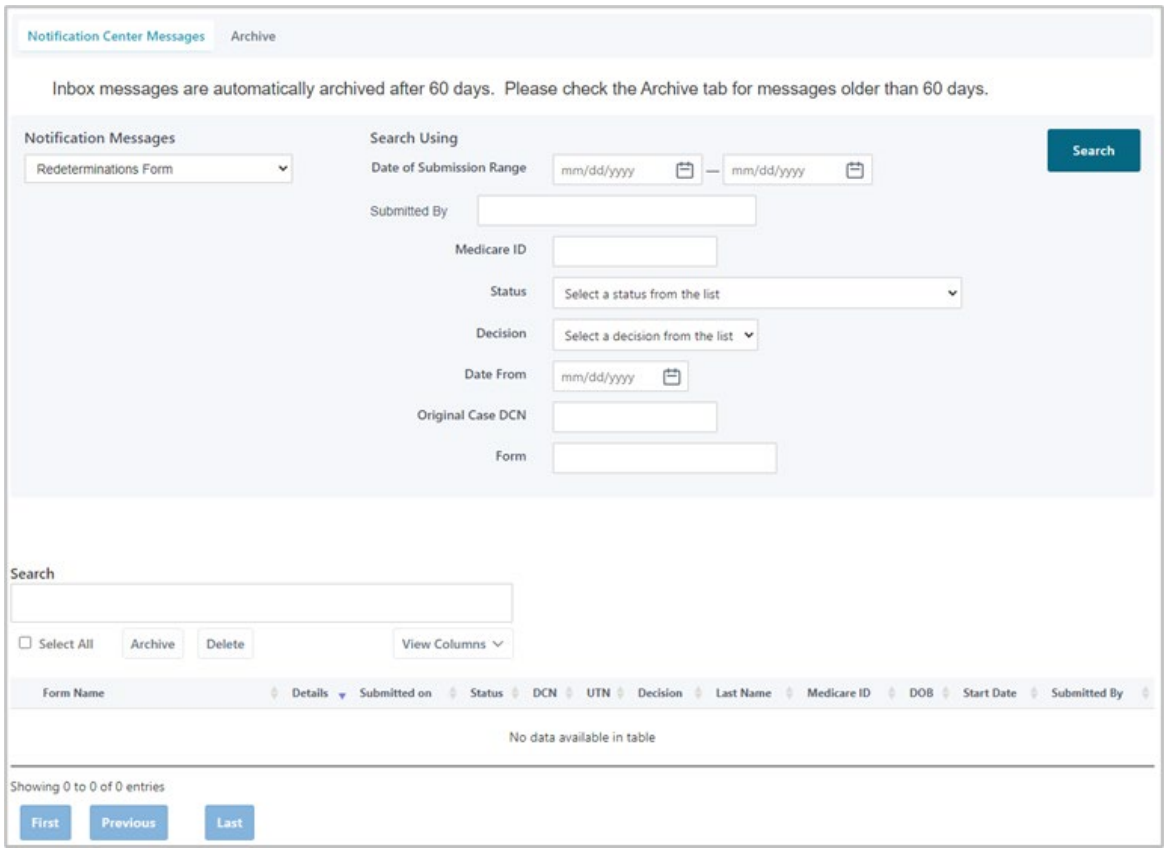


Figure 108: Inbox Filtering - No Data Available



15.3 Using the eDelivery Inbox

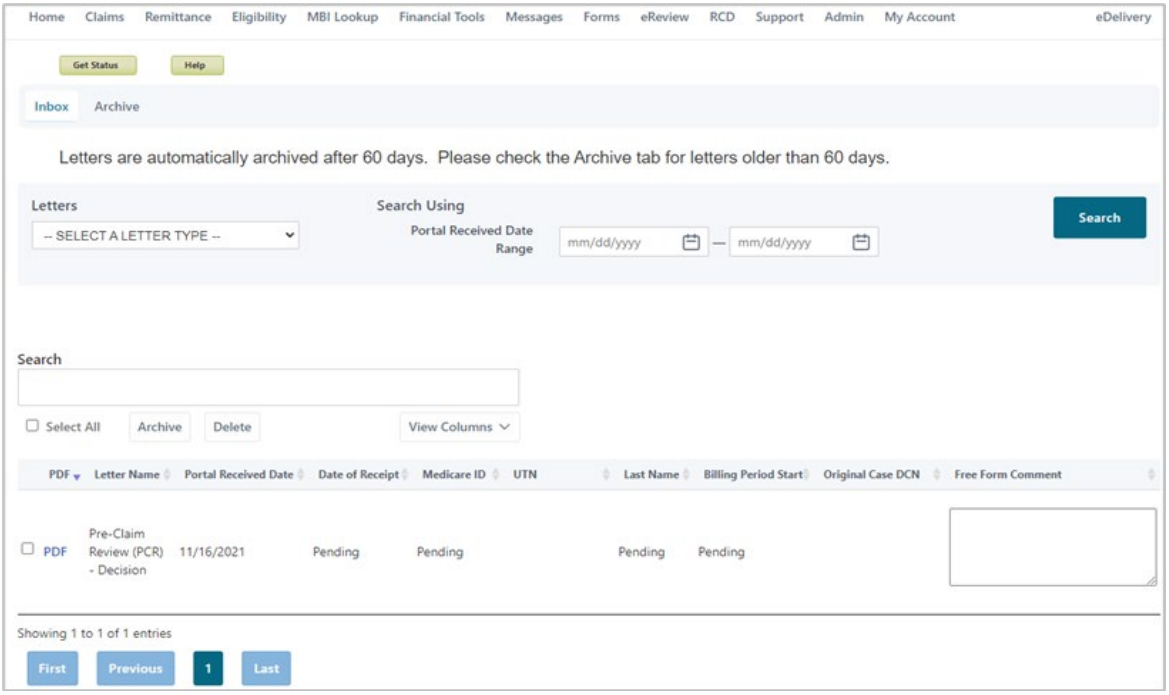
When you click on the eDelivery tab, you will be presented with your eDelivery inbox. It contains eServices Letters. Users can also leave comments for each eDelivery message. Comments left on eDelivery messages are for provider use only. These messages are not transmitted back to Palmetto GBA to respond.

When there is an unread eDelivery message the eDelivery tab will be green.

Note: Only messages for to the account associated with the user ID you are logged in with, or the account selected if you have multiple accounts linked to your user ID, will display.

For certain eLetters, a "Take Action" column will display in the results grid. The column will contain links to other functions in eServices that are related to the letter topic. For example, if you received a MR ADR letter you will see the link to the ADR Response form. It will navigate you directly to the form. Users will need the permission to access the linked function.

Figure 109: eDelivery Inbox



15.4 Archived Messages

At any time, you may opt to archive an inbox message. Simply click the icon in the Archive column for the item you wish to archive. Once an item is archived, it cannot be moved back to your inbox. You may view archived messages at any time by selecting the Archive sub-tab under the Messages tab.

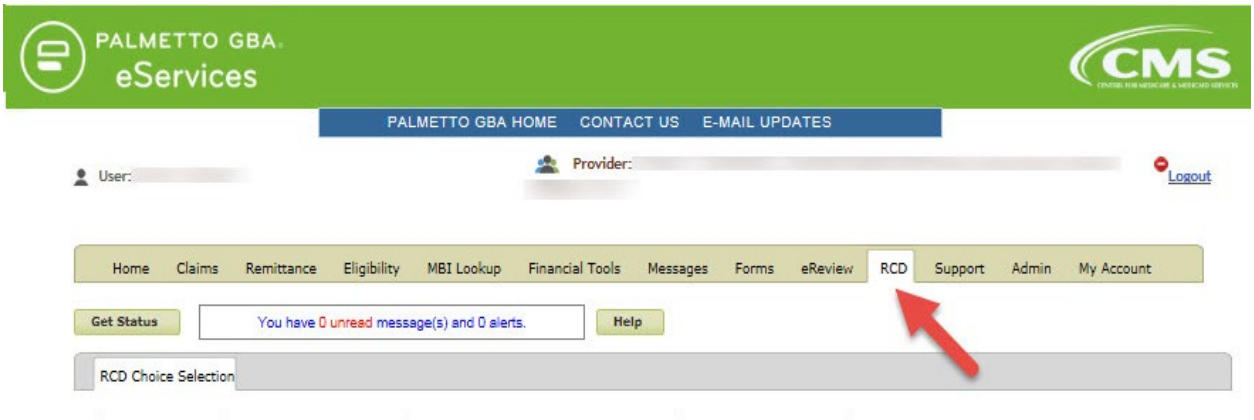
Any messages or eLetters older than sixty days will automatically be archived.

16.0 Review Choice Demonstration (RCD) Home Health (HH)

The Review Choice Demonstration -- Home Health program initiated by CMS for review claims/services for home health services.The demonstration will help ensure that payments for home health services are appropriate through either pre-claim, prepayment or post payment review.

Multiple sub-tabs will display under the RCD tab depending on the provider's review choice selection and the user's permissions.

Figure 110: RCD Tab



16.1 RCD Choice Selection Sub-tab

The RCD Choice Selection sub-tab is located under the RCD tab at the top of the page. Providers will use this tab to make their review choice selection.

Important information about RCD selection:

- Providers should read each option thoroughly prior to making a selection as some review choice selections require the provider to remain in that choice for the duration of the demonstration.
- Only eServices provider administrators are able to make the review choice selection.
- Multiple selections can be made in one day. Only the last one of the day will be processed.
- The page will indicate the selection is In Processing until the selection updates overnight.
- Under History, the last five selections can be viewed.
- The selection period will last for multiple weeks and the page will inform providers when the selection period ends.
- Providers can change their selection multiple times during the selection period.
- Once the selection period ends, providers will not be able to make any changes to the selection.
- If no selection choice is made before the selection period ends, the default choice will be the provider's selection.

Please Remember: The last review choice selected when the selection period ends will be the one in place for the duration of the cycle, or for the duration of the demonstration depending on the choice selected.

Once the review choice selection period ends, the Review Choice Selection page will not allow users to change their review choice selection until the next section period begins. The date the next selection period begins will display.

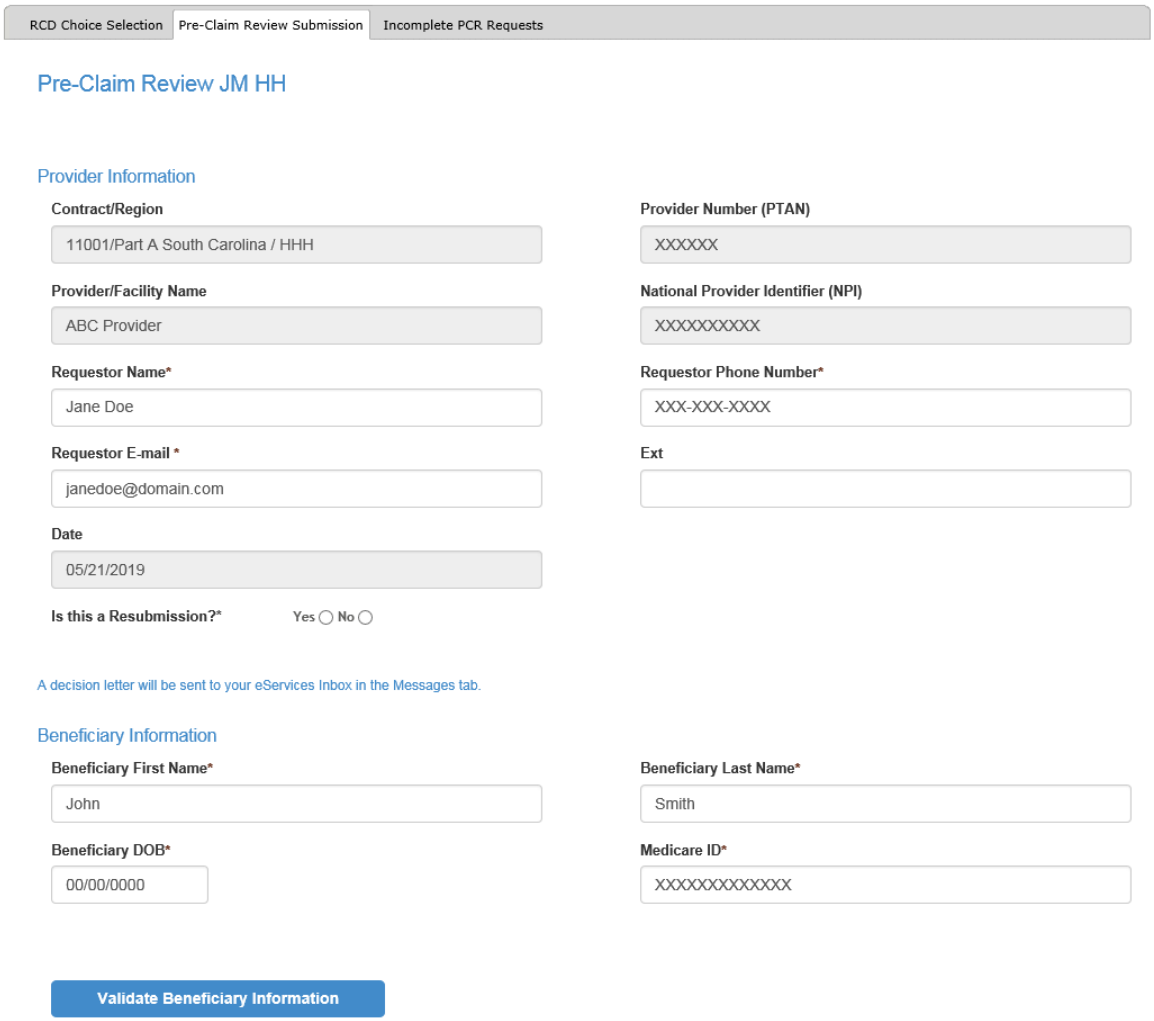
16.2 Pre-Claim Review (PCR) Submission Sub-tab

Home Health providers that have chosen Pre-Claim Review during the Review Choice Demo (RCD) will have access to send PCR requests via the eServices portal. The Pre-Claim Review Submission sub-tab is located under the RCD tab at the top of the page. If the provider selected PCR as their review choice selection, this sub-tab will display and you will be able to enter the review request in eServices. To access the form, you will need the Pre-Claim Review permission. Provider administrators will have this permission by default. Provider users needing this feature will need to have their provider administrator update their permissions to include access to this submittal request

When completing the form:

- Pay close attention to the asterisks. These symbols indicate that a field is required and your PCR submission cannot be submitted if it is left blank.
- Check the beneficiary data entered by clicking the 'Validate Beneficiary Information' button. This will perform an eligibility check against CMS's HETS 270/271 system that we are required to use for eligibility inquiries. The review cannot be successfully processed with invalid beneficiary data.
- You have the option to save, submit, or clear the form. In order to save, the user must have completed through the Beneficiary Information section. Attachments will not be saved.
- You will be presented with a dynamic question and answer section. This decision tree will lead you through a series of questions based on previously entered data.
- You may submit PDF attachments up to 40 megabytes (MB) each to a form. While there is no limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB.

Figure 111: Pre-Claim Review Submission Sub-tab



After clicking the Validate Beneficiary Information button, a message will display advising if the beneficiary was verified. While you will be able to submit the PCR form if the beneficiary is not successfully verified, please keep in mind that the review cannot be successfully processed with invalid beneficiary data.

Figure 112: PCR – Beneficiary Verified

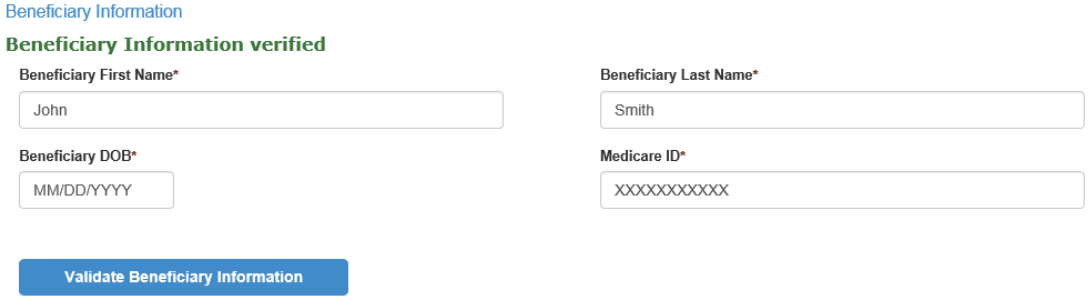
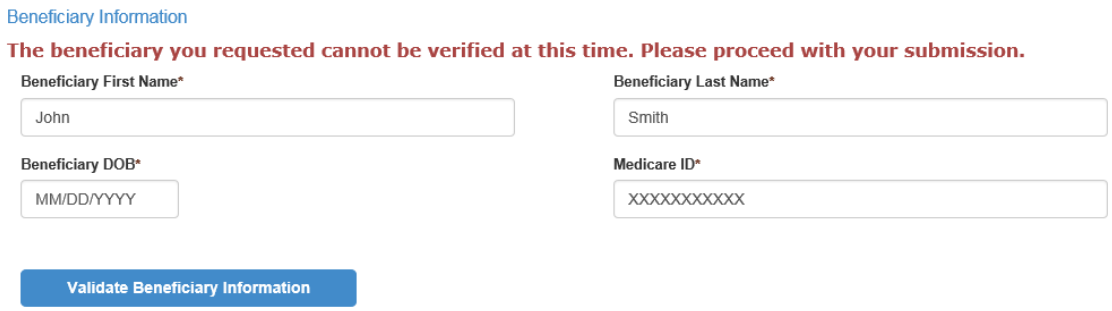


Figure 113: PCR – Beneficiary Not Verified



If you need to save your progress and return to complete the PCR form at a later time, you may use the Save button at the bottom of the form. You can then pick up with the form under the Incomplete PCR Requests sub-tab.

Note: Any attachments uploaded will not be saved. You will need to reattach them before submitting your PCR.

Figure 114: PCR – Incomplete PCR Requests Sub-tab

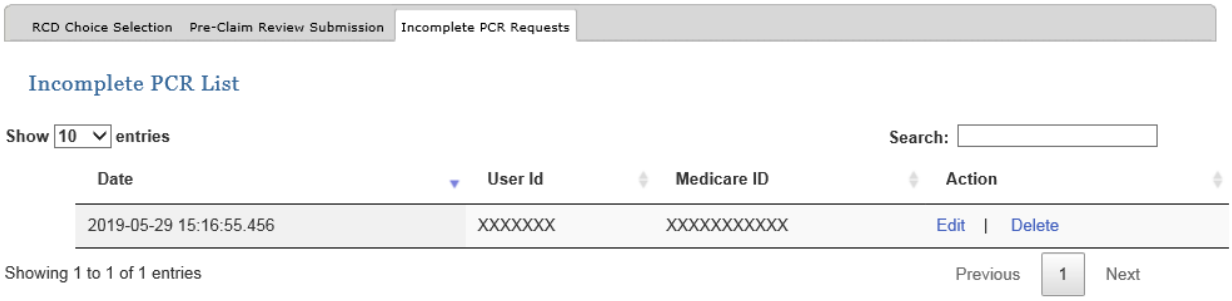
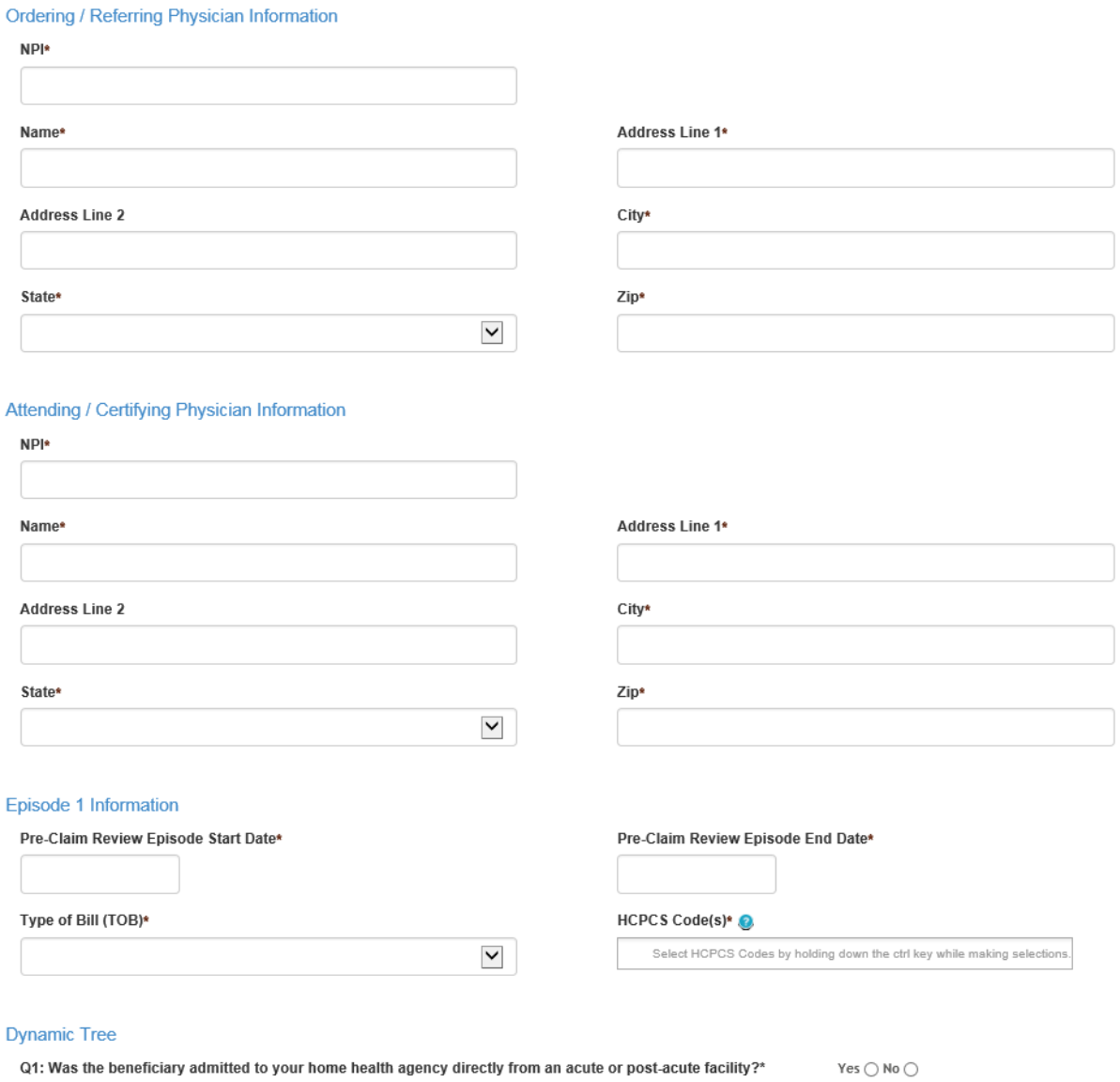
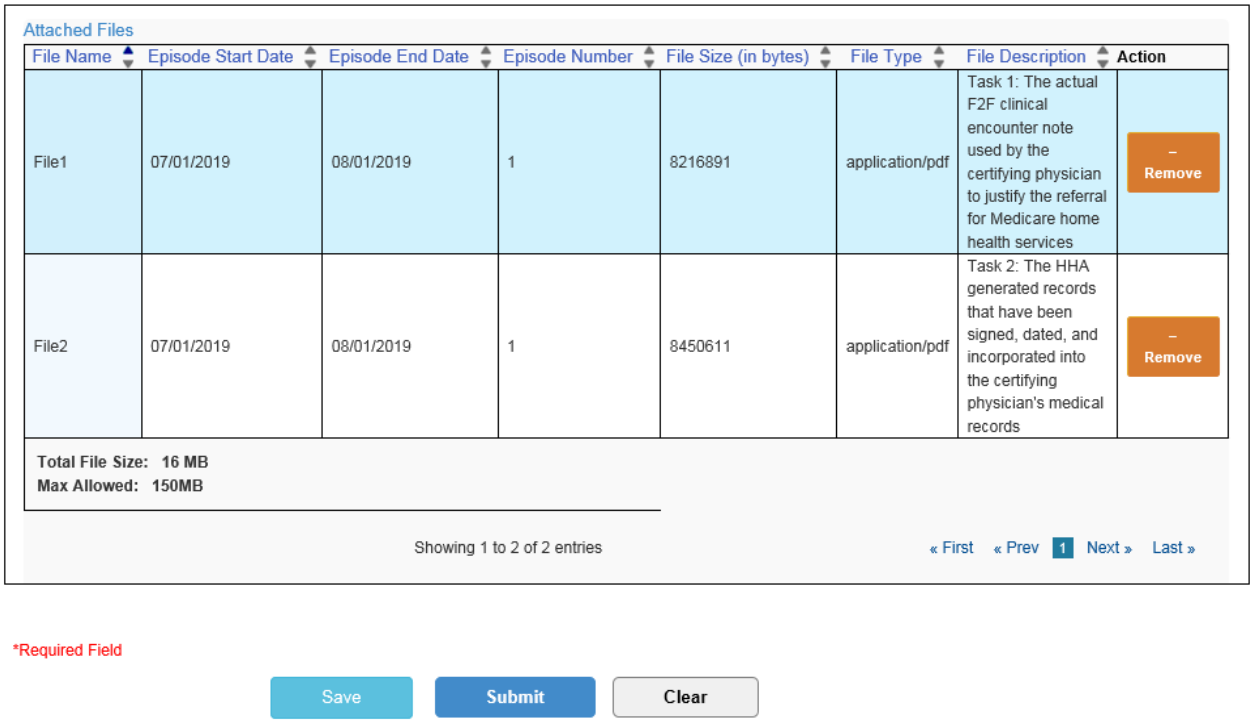


Figure 115: Pre-Claim Review Submission Sub-tab - Continued



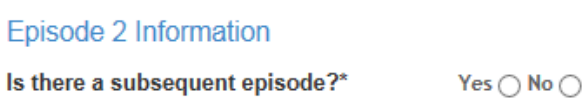
The Dynamic Tree section will dynamically expand and present questions based on information entered. In this section you will be prompted to attach corresponding documentation. You may submit PDF attachments up to 40 megabytes (MB) each to a form. While there is no limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB. Once an attachment is uploaded, it can be referenced for subsequent answers. In the 'Refer to another Task for Task# Attachment' field, select the task number that contains the uploaded attachment from the drop-down menu. A list of all attachments will be displayed in the Attached Files section at the bottom of the page.

Figure 116: PCR – Attached Files



Once the initial episode information is entered on the form, including all dynamic tree questions, the system will prompt the user to enter Episode 2 information by asking “Is there a subsequent episode?” If Yes, Episode 2 fields will populate for user entry. Once all episodes are entered, the form can be submitted.

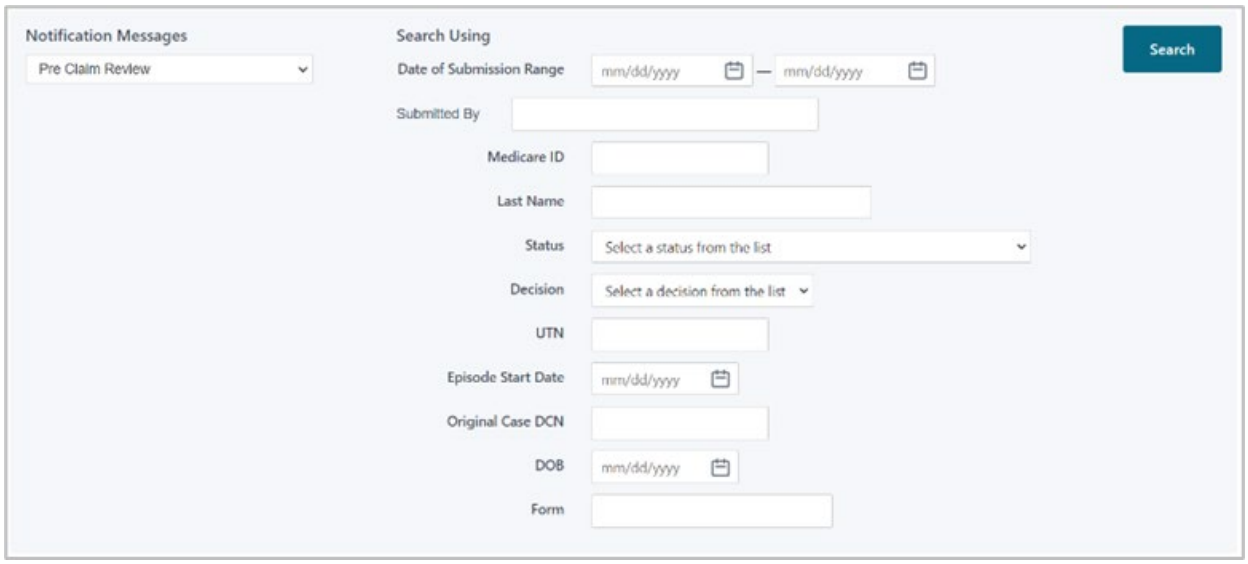
Figure 117: PCR – Multiple Episodes



Once you submit the form:

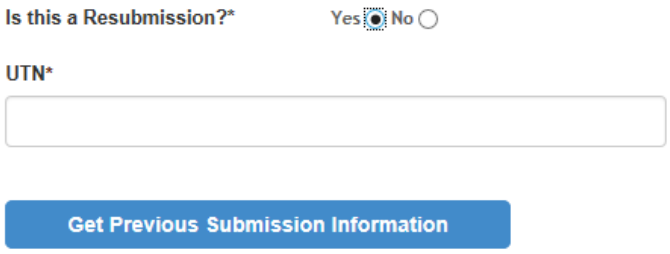
- You will receive a Notification Center inbox message.
- Additional details and the status will be included as it becomes available. For example, the document control number (DCN) for your submission will be added. This may take 24–48 hours (not including weekends or holidays) to receive.
- Subsequent details for the UTN, decision, and decision letter will generally come to follow as the request processes. Find your related PCR inbox messages easily using the secure inbox filtering feature.
- Select Pre-Claim Review from the Notification Type drop-down menu.
- Enter a sub-filter (Medicare ID, Episode Start Date, and/or UTN).
- Select the Search button.
- Refer to section 15.0 for additional information on inbox filtering.

Figure 118: PCR – Inbox Filtering



If you receive a decision of partially affirmed or non-affirmed you may enter the updated request from the Pre-Claim Review Submission tab. Notate that this request is a resubmission by selecting the 'yes' option for the 'Is this a resubmission' question in the Provider Information section. Enter the UTN for the request you are resubmitting and select 'Get Previous Submission Information'. Editable fields can be changed as applicable. Once updated, the form can be resubmitted. The resubmission will be assigned a new DCN and UTN.

Figure 119: PCR – Resubmission



16.3 RCD Cycle Results (eRCD)

The RCD Cycle Results eRCD sub-tab is located under the eReview tab at the top of the page. Medicare providers who need to make review option choices for the Review Choice Demonstration will have access to the RCD Cycle Results eRCD sub-tab.

Figure 120: RCD Cycle Results (eRCD) Sub-Tab

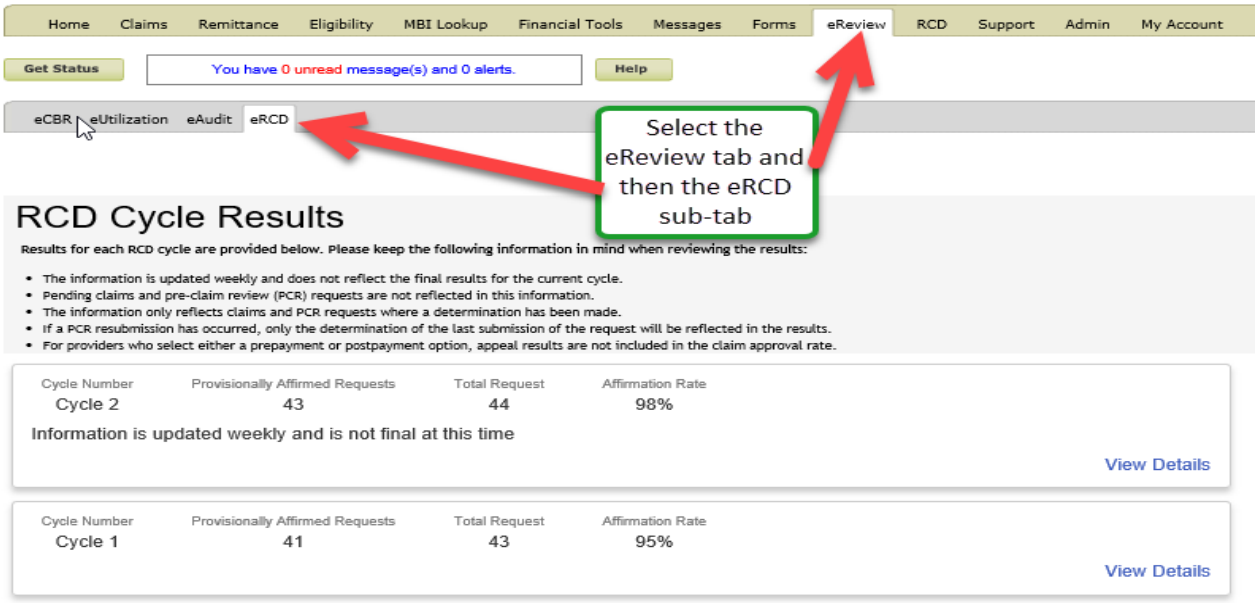
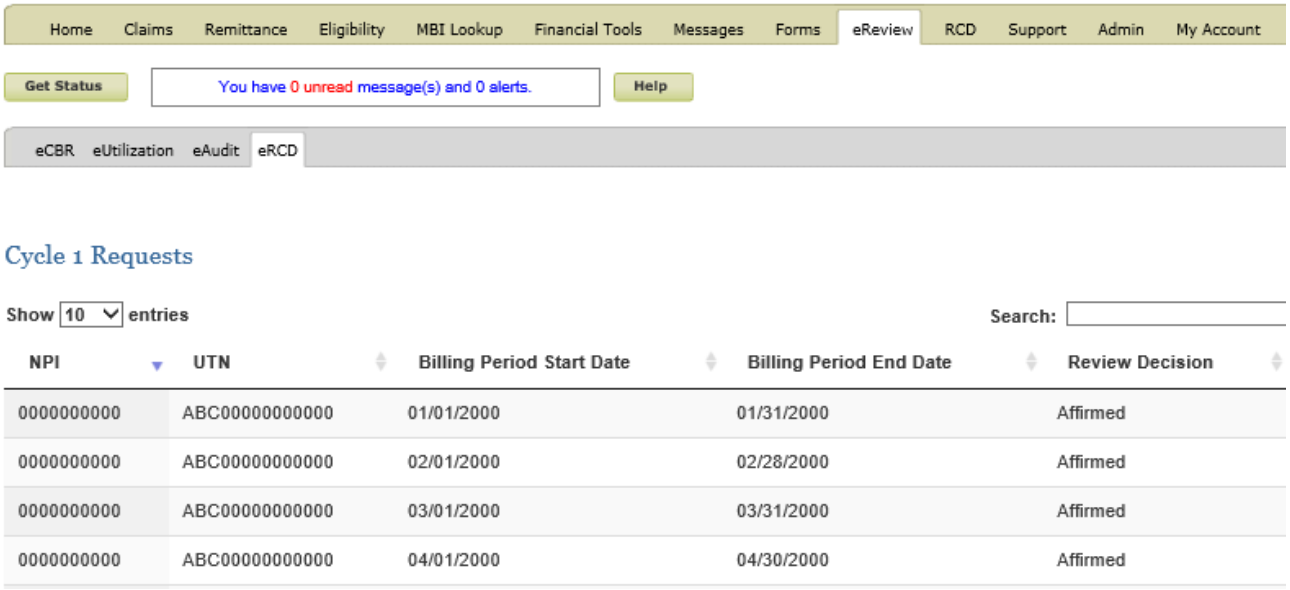


Figure 121: RCD Cycle Result Details



Note: Please keep the following in mind when reviewing the results:

- The information is updated weekly and does not reflect the final results for the current cycle.
- Pending claims and pre-claim review (PCR) requests are not reflected in the information.
- The information only reflects claims and PCR requests where a determination has been made.
- If a PCR resubmission has occurred, only the determination of the last submission of the request will be reflected in the results.
- For providers who select either a prepayment or postpayment option, appeal results are not included in the claim approval rate.

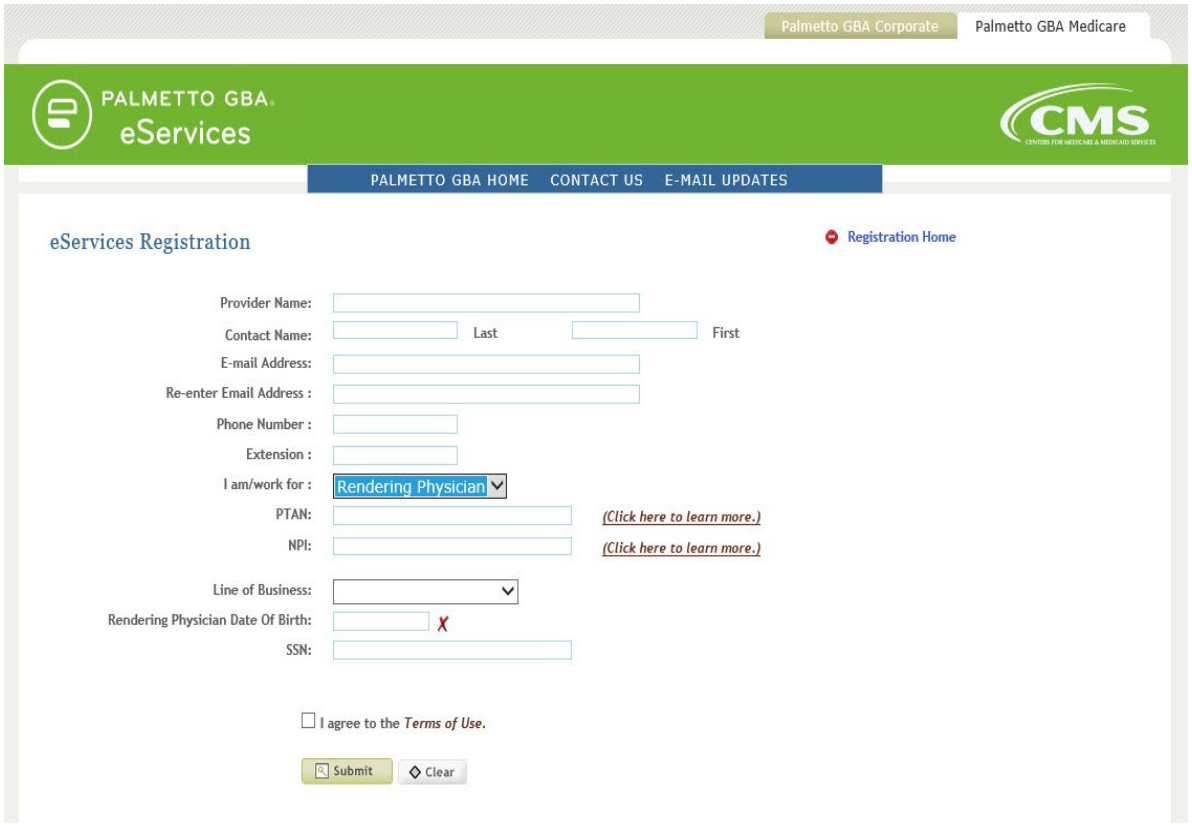
17.0 Rendering Physician Accounts

17.1 Registration

JM Part B rendering physicians who are currently listed in PECOS may register for a rendering physician account in eServices. You must enter the information listed below to register:

- Provider name
- Contact name (The person assigned to this user ID)
- Email address
- Phone number
- Extension
- Rendering physician indicator (After selecting this option from the drop-down list, the registration screen will update to show the remaining required fields for rendering physicians)
- PTAN
- NPI
- Line of business: choose from drop-down selections
- Rendering physician date of birth
- SSN

Figure 122: Rendering Physician Registration



You must also agree to the Terms of Use to register. If you have entered registration information in an incorrect format, the eServices application will display an error message in red at the top of the screen. Carefully read that error message and enter the information again. If the information you enter matches the information on file with PECOS, you will be able to choose a password and security questions and answers.

Once this is completed, you will receive an email at the email address you registered. You must access the email and click on the validation link. If you do not click on the validation link and you try to log in, you will see the profile screen where you can update or correct your email address and submit. If your email address is correct, you may click on the link to request a new email. Please make sure your email address is correct on your profile before calling Palmetto GBA for assistance.

Generic user names are ***not*** permitted. Each user of eServices must have a unique user ID and password. This means that we expect each user to have a legitimate first and last name. Generic first and last names are not permitted. Examples of generic user names are: Front Desk, Account Coordinator, Billing Department, User A, or the name of your provider office. No sharing of user IDs and passwords is permitted. Palmetto GBA will delete, without notice, any user names we find that are generic.

17.1.1 Minimum System Requirements

To optimize usability of eServices, we recommend that users verify their system adheres to the requirements outlined in section 1.11.

17.1.2 Password Requirements

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 meet the requirements outlined in section 2.2.

17.1.3 Choosing Security Questions

You will be prompted to select security questions and input your answers as part of the registration process. These questions will be used in the event that you forget your password. Please refer to section 2.3 for additional information regarding security questions and their requirements.

17.1.4 Validating Your Registration

After successfully entering your registration information, you will be redirected to the eServices login page and prompted to verify your profile. An email will be sent to the email address provided during registration and will contain a verification link. You will need to click the link or copy and paste it into your browser's address bar to verify your email address and complete the registration process. The link will direct you to the eServices login page. A message will display on the page advising you that your account has been successfully verified and you may now log in.

If you are sure your email address is correct, but you do not receive your email, your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email address you will be receiving the validation email from is ops.no.reply@palmettogba.com.

17.1.5 Registration Troubleshooting

In the event that your registration attempt is unsuccessful, an error message will display advising you of the issue. Correct your entries as needed and try again. Failure to successfully register eight times in a row will result in being locked out of the registration process for one hour. Once the registration lockout period has expired, you may try to register again. Continued failed registration attempts will result in a full registration lockout and an error message advising you to verify your identity. Please contact your Medicare Contractor for assistance.

17.2 Login

Once you have successfully registered for your eServices rendering physician account and verified your profile, you will be able to log into eServices with the user ID assigned to you during your registration. Access our eServices introduction screen and enter your user ID and password. You will then be directed to the multifactor authentication (MFA) screen to request an MFA verification code and complete the login process.

NOTE

A log out link is located in the upper right of each screen, once you have logged in. You must log out to end your session. If you do not log out, your user ID will be locked for one hour.

17.2.1 Multi-factor Authentication (MFA)

To enhance the security of Medicare data, CMS requires the use of multi-factor authentication (MFA) in eServices. After successfully entering your user name and password, you will be

directed to the MFA verification screen where you will need to enter an MFA verification code to complete the login process. Please review section 3.12 for additional information on MFA.

17.2.2 Access Expiration

Palmetto GBA and CMS are dedicated to keeping your information safe. To achieve this, access to eServices must be limited to users who use the system on a regular basis. Palmetto GBA will disable any user ID that has not been used in 30 days per CMS security requirements. It is recommended that all users log into their account at least once every 30 days to keep their access current.

17.2.3 Session Timeouts

To be in compliance with CMS security requirements, your eServices session will timeout after 30 minutes of inactivity. A notification box will display when you are approaching your inactivity limit.

17.2.4 Login Troubleshooting

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 eServices introduction screen. You will be presented with two security questions to answer. You must answer both security questions correctly to reset your password. Please refer to section 3.5 for additional information on using the forgot your password tool.

If you attempt to log in incorrectly three times in a 120 minute period, you will be locked out of eServices. To unlock your account, you must contact your Medicare Contractor to verify your identity and regain access.

You can verify or change your security questions and answers 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 that if you are logged into eServices and you want to exit, click on the log out link in the upper right of every page. If you do not do this, you will be locked out for one hour. We do not unlock accounts that are in the one hour lockout period.

If you cannot find your user ID, please contact your Medicare Contractor for assistance.

Rendering physician accounts only have access to the eReview functions in eServices. If you need access to additional features in eServices i.e., eligibility lookup, form submission, electronic remittances, etc., you will need access to an eServices account associated with the PTAN/NPI combination that matches your billing provider's EDI enrollment agreement with Palmetto GBA.

17.3 eReview

Palmetto GBA gives rendering physicians access to eReview functions to review and analyze their Medicare billing activity.

The electronic Comparative Billing Reports (eCBRs) are an educational tool for providers to use in order to provide insight into your billing patterns and utilization of services in comparison to your peers. Providers can use this information to conduct a self-audit to ensure they are in compliance with the Medicare regulations and prevent improper claims submission in order to avoid possible pre or post-pay medical review. Please see section 11.1 for additional information on eCBR.

Electronic Utilization (eUtilization) reports offer rendering providers access to their personal data. This data can be reviewed to ensure you are aware of when and by whom your NPI is being used for billing Medicare services and when you are notated on a Medicare claim as the ordering referring physician. This will provide you with the ability to identify possible misuse of your NPI. Please refer to section 11.2 for more information on the eUtilization reports.

Electronic Audit (eAudit) reports offer a dashboard of audit results for claims which have been sampled by review contractors for Complex Medical Review. eAudit gives providers the opportunity to see what claims may be pending a complex medical review currently and the results of any recent medical review activities. This information can be used for self-assessment of provider performance on Medicare audits utilizing the dashboard containing common denial reasons. Please reference section 11.3 for further information on eAudit reports.

17.3.1 eReview Troubleshooting

Rendering physicians may not have eReview data available for the reports, topics, and/or timeframes available in eServices. In these instances an error message will display advising you no data is available. If you receive an error message advising that the system eServices access for eReview information is not available, please try your request again later. If you continue to receive the error, please contact your Medicare Contractor.

17.4 Profile Verification

Palmetto GBA and CMS are dedicated to ensuring that access to Medicare data is secure. To do this, CMS requires that all users regularly verify and/or update the information on their eServices profile. This includes validating the user's email address listed on their profile. This must occur for Palmetto GBA to continue to offer eServices. We appreciate your effort to help us keep Medicare data secure.

If you have not completed profile verification for your user ID within the last 240 days, your ID will move into the profile verification period. You will be prompted to complete the profile verification process when you log into eServices. If your profile has not been verified and/or updated within 10 days of entering the profile verification period, your access will be restricted to your My Account tab until this process is completed. If your profile has still not been verified within 250 days of your last profile verification, your user ID will become permanently deactivated and you must re-register.

17.4.1 Profile Verification Troubleshooting

Once you register or update your profile, you will receive an email with a link to validate your access. Make sure that you are logged out of your account before clicking on the link in your email. Once this is completed, you will be able to log in to eServices. If you do not click on the validation link and you try to log in, you will see your profile screen where you can update or correct your email address and submit.

If your email address is correct but you did not receive the email, you may use the request new email button to have another email sent. The process of receiving the email may take a while and is based on your email client configuration and the security configuration of your network. You may have to refresh your inbox to make sure all emails have been received.

If you are sure your email address is correct, but you do not receive your email, your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email address you will be receiving the validation email from is ops.no.reply@palmettogba.com.

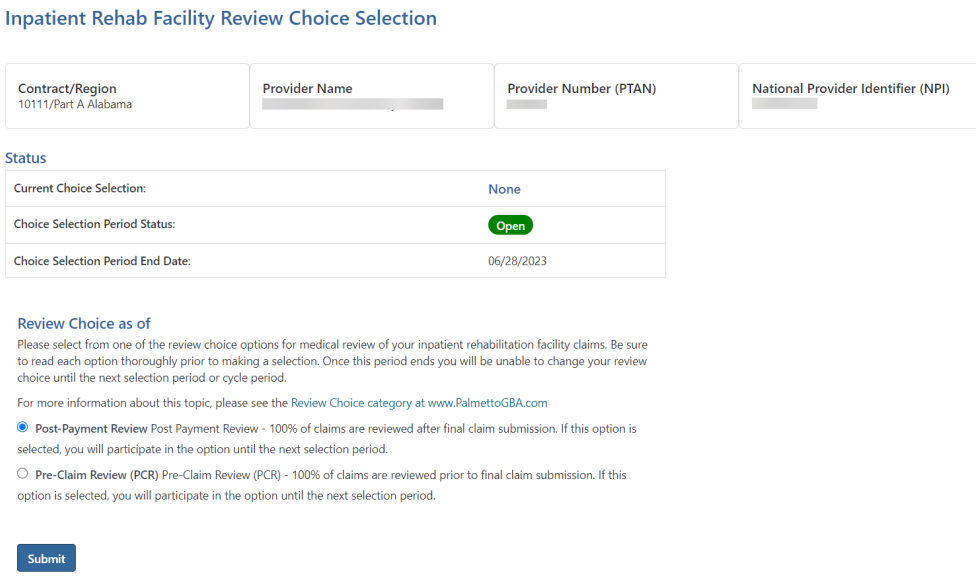
If you still do not receive your validation email, please contact your Medicare Contractor for further assistance. Please make sure your email address is correct on your profile before calling Palmetto GBA for assistance.

18.0 Review Choice Demostration (RCD) Inpatient Rehabilitation Facility (IRF)

The Review Choice Demonstration – Inpatient Rehabilitation Facility program initiated by CMS to review claims/services for inpatient rehab services. The demonstration will help ensure that payments for inpatient rehab services are appropriate through either pre-claim, prepayment or post payment review.

Multiple sub-tabs will display under the RCD tab depending on the provider's review choice selection and the user's permissions.

Figure 123: Review Choice Selection Page (IRF)



18.1 RCD Choice Selection Sub-tab

The RCD Choice Selection sub-tab is where IRF providers will make their review choice selection. AT the beginning of the demonstration, providers will have two review choices, Pre-Claim Review and Post Payment.

Important information about RCD selection:

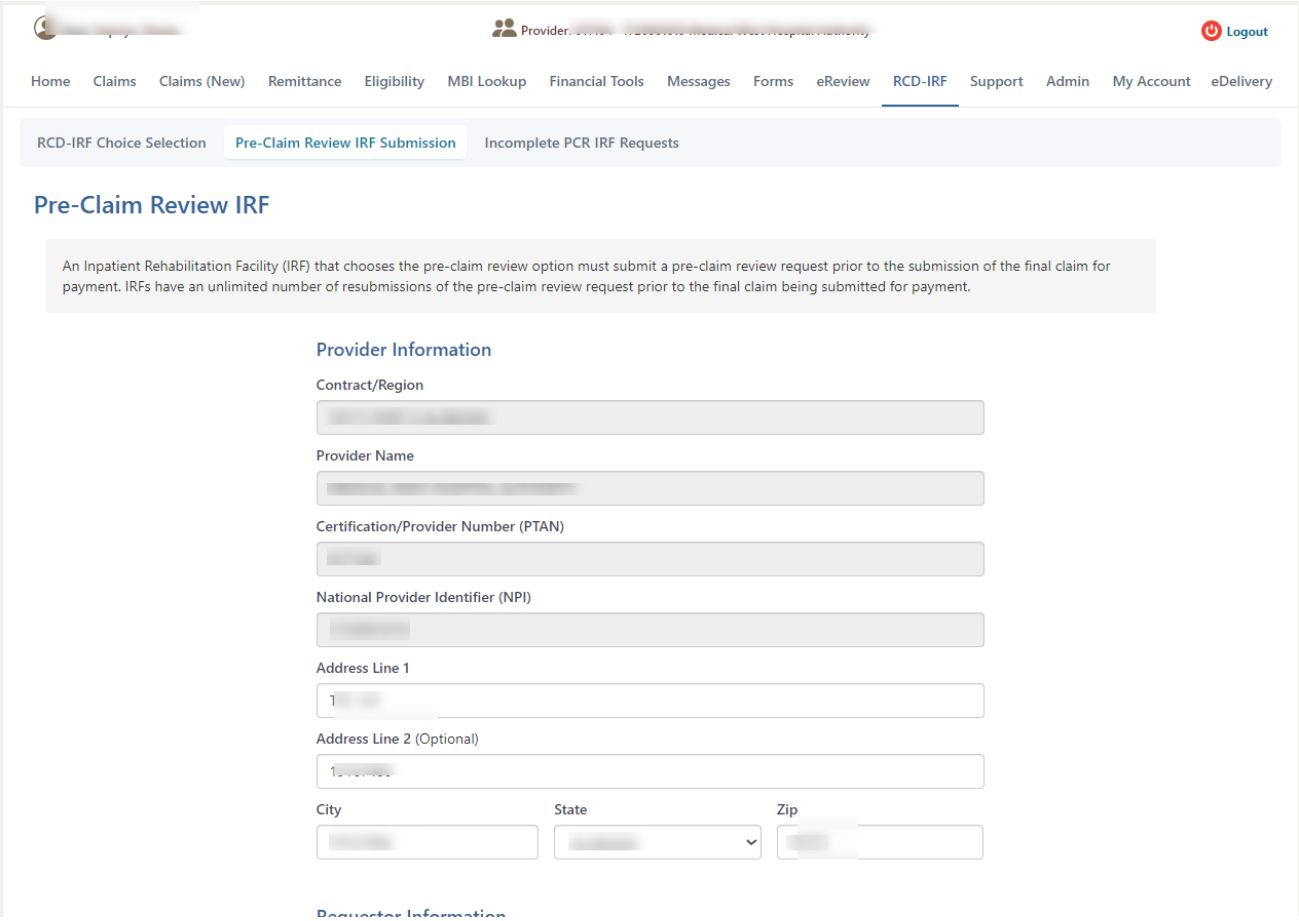
- Providers should read each option thoroughly prior to making a selection as some review choice selections require the provider to remain in that choice for the duration of the demonstration.
- Only eServices provider administrators are able to make the review choice selection.
- The selection period will last for multiple weeks and the page will inform providers when the selection period ends. Providers can change their selection as often as they wish during the selection period.
- Multiple selections can be made in one day. Only the last one of the day will be processed.
- The page will indicate the selection is In Processing until the selection updates overnight.
- Under History, the last five selections can be viewed.
- Once the selection period ends, providers will not be able to change the review choice selection until the next selection period begins. The page will display the start of the next selection period.
- If no selection choice is made before the selection period ends, the default choice will be the provider's selection.

18.2 Pre-Claim Review (PCR) Submission Sub-tab

Inpatient Rehabilitation Facilities that have chosen Pre-Claim Review Selection Choice Demo will have the ability to send PCR requests in eServices. The Pre-Claim Review Submission sub-tab is located under the RCD tab at the top of the page. To access the form, you will need the Pre-Claim Review permission. Provider administrators will have this permission by default and can grant this permission to other users.

- You have the option to save, submit, or clear the form. In order to save, the user must have completed through the Beneficiary Information section.
- You may submit PDF attachments up to 40 megabytes (MB) each to a form. While there is no limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB.
- The questions in the second portion of the form must be answered as Yes or No. Within the questions you will be asked to upload attachments as tasks. You must upload at least one document. You can reference documents previously uploaded in other tasks. A list of all attachments will be displayed in the Attached Files section at the bottom of the page.

Figure 124: Pre-Claim Review Form



- Immediately upon submission of the form, you will receive a message that the form was received.

18.3 Tracking the status of a Pre-Claim Review (PCR) Submission

Within 24 hours, Monday through Friday, you will receive official acknowledgement of receipt when a Document Control Number (DCN) is assigned for tracking.

The Messages Function allows you to track the progress/status of your PCR submission. Besides displaying the DCN, it will be updated with the UTN and Decision. See Section 15 of the User Guide for more information on the Messages Inbox Function.

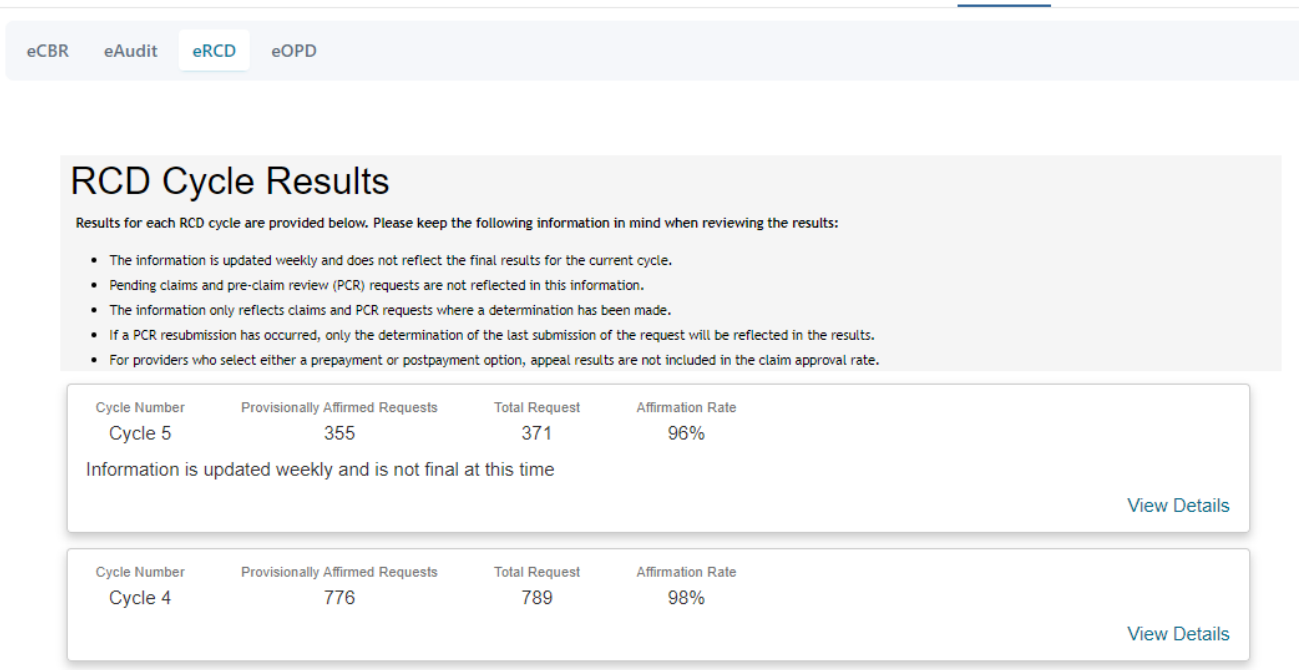
If you receive a decision of non-affirmed, you may submit a resubmission. On the PCR form click the radio button “Yes”, that the request is a resubmission. You will be prompted to enter the UTN. Once you enter the UTN, click the Get Previous Submission button to retrieve all of the information you entered on the initial form submission. For a resubmission, information must be changed and/or

additional documentation must be uploaded to the initial submission.

18.4 RCD Cycle Results

The RCD Cycle Results eRCD sub-tab is located under the eReview tab at the top of the page. You can view your results during the current cycle and also see your results for prior cycles.

Figure 125: RCD Cycle Results



- Note: Pending claims and PCRs without determinations are not included.

If you click on the View Details link, you can see the specific claims that contributed to the results.

Figure 126: RCD Cycle Results Details