Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 514

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NEW/REVISED MATERIAL--*EFFECTIVE DATE: 10/01/00*
IMPLEMENTATION DATE: 10/01/00

Section 3600.1, Claims Processing Timeliness, has been amended for new HH PPS requirements.

Section 3638.30, Beneficiary-Driven Demand Billing Under HH PPS, has been created to explain demand billing under HH PPS.

Section 3656.3, PPS Pricer Program, has been amended to included data requirements specific to HH PPS, among other HCFA prospective payment systems.

Sections 3682.4, HHA Bills, *and* Section 3682.5, Denials and Conditional Payments In MSP Situations, have been amended to reflect new MSP requirements of HH PPS.

Sections 3850, Provider Specific Payment Data, Section 3850.1, Provider Specific Data Record Layout and Description, *and* Section 3850.2 Intermediary Responsibilities, have been amended for new HH PPS requirements.

Section 3885.2, The Cancel Only Adjustment Code (Action Code 4), has been amended for new HH PPS requirements.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CHAPTER VII
BILL REVIEW

Section

Physician Services

CHAPTER VII
BILL REVIEW

CHAPTER VII
BILL REVIEW

Section

Billing in Medicare
Secondary Payer Situations

Request for Information from the Public

MSP Outpatient Claims Involving Lab Charges

3600. GENERAL REQUIREMENTS

3600.1 Claims Processing Timeliness.--

A. General.--Establish a control record for timely claims processing as described below.

1. Payment Ceiling Standards.--Payment ceilings were implemented for clean claims received on or after April 1, 1987. Pay or deny "clean" claims within the applicable number of days after the date of receipt as follows:

Time Period for Claims Received	Applicable Number (Calendar Days)
01-01-93 thru 09-30-93	24 for EMC & 27 for paper claims
10-01-93 and later	30

All claims (e.g., paid claims, partial and complete denials, no-payment claims), including PIP and EMCs, are subject to the above requirements. (See §3600.1.A.3. for the definition of a clean claim.)

Start your count on the day after the receipt date except where you receive and deny the claim on the same day. (In such cases, you have 1 day's processing time.) End your count on the scheduled payment date. For example, for claims received October 1, 1993, and later, if this span is 30 days or less, you met the requirement.

Pay interest on clean claims that are not paid within the applicable number of days. The applicable number of days is also known as the payment ceiling. For example, a hospital that submits a clean electronic claim on April 1, 1993, that is paid April 27, 1993 (the 26th day after the date of receipt or day 27), receives 2 days of interest. A hospital that submits a clean paper claim on April 1, 1993, that is paid May 3 (the 32nd day after the date of receipt or day 33), receives 5 days of interest.

A hospital that submits a clean electronic claim on April 1, 1994, that is paid April 27, 1994, would not receive any interest since it is paid within the 30-day timeframe. A hospital that submits a clean paper claim on March 1, 1994, that is paid April 6, 1994 (the 36th day after the date of receipt or day 37), receives 6 days of interest.

To calculate the processing time for a claim, subtract the Julian receipt date from the Julian date of scheduled payment. When a scheduled payment date falls in the year following the year of receipt, add to the Julian date of payment 365 (366 if the year of receipt is a leap year). If this span is equal to the applicable number of days or less, no interest is payable.

According to 42 CFR 409.43, RAPs submitted by home health agencies under the HH PPS are not Medicare claims as defined under the Social Security Act. Since they are not considered claims, do not subject RAPs (records with type of bill 322 or 332 and dates of service on or after October 1, 2000) to payment ceiling standards and interest payment.

For purposes of the payment floors and ceilings:

o An "electronic claim" is one that is submitted via central processing unit (CPU) to CPU transmission, tape, diskette, direct-data entry, direct wire, dial-in telephone, digital fax, or personal computer upload or download. The term "digital fax" refers to a claim that arrives via fax but is never printed on paper. Rather, the fax is encoded while still in electronic form (generally by an optical code reader [OCR]), and electronically entered into the claims processing system, eliminating manual data entry.

Beginning January 1, 1996, claims received via digital fax/OCR will no longer be counted or paid as EMC. Beginning October 1, 1998, claims received via diskette, and touch-tone phone will no longer be counted or paid as EMC. Publicize this in your next three scheduled provider bulletins. Make sure that all billers using these modes understand the payment timing impact. (See §3602.1 for alternatives.)

o A "paper claim" is submitted and received on paper, including fax print outs. This also includes claims received on paper and read electronically with OCR technology.

2. Payment Floor Standards.--Do not issue, mail, or otherwise pay within the waiting period indicated below for any claim you receive. The length of the waiting period is determined by the date the claim is received. Payment floors began April 1, 1987. Start your count on the day after the date of receipt.

Claim Receipt Date	Waiting Period (Calendar Days)
01-01-93 thru 09-30-93	14 for EMC & 26 for paper claims
10-01-93 and later	13 for EMC & 26 for paper claims

Do not hold claims upon receipt. Process them immediately and, when necessary, delay payment to meet these requirements. For example, payment on an approved electronic claim received September 1, 1993 cannot be made before September 16, 1993. Payment on an approved paper claim received September 1, 1993 cannot be made before September 28, 1993. Payment on an approved electronic claim received October 1, 1993 cannot be made before October 15, 1993. Payment on an approved paper claim received January 3, 1994 cannot be made before January 30, 1994. Regardless of when the check is dated, show the scheduled payment date on your workload report as the actual date the check is mailed or funds are electronically transferred.

According to 42 CFR 409.43, Requests for Anticipated Payment (RAPs) submitted by home health agencies under the Home Health Prospective Payment System (HH PPS) are not Medicare claims as defined under the Social Security Act. Since they are not considered claims, do not subject RAPs (records with type of bill 322 or 332 and dates of service on or after October 1, 2000) to payment floor standards. Process these records immediately and do not delay payment.

Continue to apply existing rules governing PIP to all PIP claims (e.g., they must cover a period beginning 3 weeks after discharge). The payment floor standards do not apply to payment of PIP claims. You may notify PIP facilities of the disposition of their claims at any point in time convenient with your operation as long as you meet the claims processing timeliness requirements.

NOTE: No-payment claims are not subject to the payment floor standards.

3. Definition of "Clean" Claim.--A "clean" claim is one that does not require you to investigate or develop external to your Medicare operation on a prepayment basis.

Examples of clean claims are those that:

o Pass all edits (intermediary and Common Working File (CWF) and are processed electronically;

o Do not require external development and are not approved for payment by CWF within 7 days of your original claim submittal for reasons beyond your control or the provider's control. This includes out-of-service area claims and claims that require development by HCFA;

NOTE: Claims meeting this criterion will be excluded by your RO from CPT scoring in your Contractor Performance Evaluation Program. (See §3604, Condition Code 15.) Submit requests for CPT scoring adjustments and related supporting documentation to your RO in writing. However, report these claims as clean on your Intermediary Workload Report, HCFA-1566, pages 2-11.

- o Are investigated within your claims, medical review, or payment office without the need to contact the provider, beneficiary, SSA, or other outside source;

- o Are subject to medical review, but complete medical evidence is attached or forwarded simultaneously with EMC records in accordance with your instructions to the provider. If you need to request medical evidence, see the first example under §3600.1 A.4; or

- o Are developed on a postpayment basis.

4. Other Claims.--Claims that do not meet the definition of "clean" claims are considered "other" claims. "Other" claims require investigation or development external to your Medicare operation on a prepayment basis. Other claims include those not approved by CWF which you identify as requiring outside development. Examples are claims on which you:

- o Request additional information from the provider or other external source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies;

- o Request information or assistance from another contractor. This includes requests for charge data from a carrier or any other request for information from a carrier;

- o Develop MSP information;

- o Request information necessary for a coverage determination;

- o Perform sequential processing when the earlier claim is in development;

- o Perform outside development as a result of a CWF edit; and

Enter condition code 64 in the CWF record to indicate that the claim is not a "clean" claim, and therefore, not subject to the mandated claims processing timeliness standard.

5. Interest Payment on Clean Non-PIP Claims, Not Paid Timely.--Pay interest on clean non-PIP claims if payment is not made within the applicable number of calendar days after the date of receipt. (See §3600.1 A.1.) For example, a clean claim received on October 1, 1993, must have been paid before the end of business on October 31, 1993, to avoid interest payment. Interest is not required on the following:

- o Claims requiring external investigation or development;
- o Claims on which no payment is due;
- o Full denials; or
- o Claims for which the provider is receiving PIP;
- o HH PPS RAPs.

However, PIP on inpatient bills does not preclude interest payments on outpatient bills.

Pay interest on a per bill basis at the time of your payment. Interest is a Federal expense and is not assessed against you.

6. Continuation of PIP.--Continue PIP upon request to subsection (d) hospitals as defined in §3600.1.B. (including units excluded from PPS) that received PIP on June 30, 1987, until you meet the requirement to pay 95 percent of all clean claims (for which PIP payment is not made) in the applicable number of days for 3 consecutive months. (See §3600.1.A. for the applicable number of days.)

Regardless of your claims processing timeliness performance on clean, non-PIP bills, PIP continues, upon request, for:

- DSHs that have at least a 5.1 percent disproportionate share adjustment (as discussed below); or
- Rural hospitals with 100 or fewer beds.

The request to continue PIP by such hospitals is a one time opportunity and must have been made no later than July 1, 1987. It is limited to hospitals that:

- Received PIP on June 30, 1987; and
- Continued to meet requirements specified in regulations that were applicable on October 1, 1986. (Qualified DSHs and rural hospitals with 100 or fewer beds may receive PIP payments indefinitely provided that they continue to meet standards established by the Secretary that were applicable on October 1, 1986.)

Section 1815(e)(1)(B)(i) of the Act requires the amount of a hospital's disproportionate share adjustment percentage for purposes of this PIP provision to be based upon the data base used by HCFA to standardize the FY 1987 PPS rates. The disproportionate share adjustment is calculated by HCFA from the hospital's percentage of low income patients based on FY 1985 SSI/Medicare data and the Medicaid percentage from FY 1984 cost report data. HCFA furnished you a list of DSH payment percentages to use to determine whether a hospital meets the DSH requirement to retain PIP. Except as follows, use the listing to determine whether a hospital meets the 5.1 percent criterion. A hospital meets the criterion where it included adequate Medicaid days in its 1984 cost report but HCFA failed to properly include them in its data base when computing the 1984 Medicaid percentage. It also can meet the criterion where it had adequate Medicaid days in its 1984 cost reporting year even though it did not include them in its cost report.

In the latter situation, a hospital must submit to you previously unsubmitted Medicaid data applicable to the 1984 cost report year (cost reports beginning October 1, 1983, through September 30, 1984). Verify the accuracy of this subsequently submitted Medicaid data and take appropriate steps, including audit where necessary, to assure the data's validity.

A hospital's request and data must be received by you no later than 3 years from the date of the Notice of Program Reimbursement for the 1984 cost report. Remove from PIP after June 30, 1987, any hospital not qualifying based on the HCFA listing, or improper exclusion from the data base. Any hospital removed from PIP that has notified you of its intention to submit additional Medicaid data, or which submitted data with its request, will remain off PIP pending your evaluation of the data.

Consult your RO for specific timeframes involved, and subsequent actions required where you permit PIP for a hospital not on the listing.

For rural hospitals to continue PIP, they must be located in a rural area (as defined for PPS) and have 100 or fewer beds on July 1, 1987. A rural hospital is a hospital outside any Metropolitan Statistical Area (MSA). Use the guidelines for determining MSAs for PPS hospitals to determine whether a hospital is rural.

In determining the bed count for rural hospitals, count only beds that are general routine or intensive care type, adult or pediatric, maintained in a patient care area for inpatient lodging. Do not count beds assigned to newborns, to custodial or domiciliary care, to units excluded from PPS, to hospital based SNFs, to areas maintained and utilized for only a portion of a patient's stay, or primarily for special procedures (e.g., labor rooms, birthing rooms, postanesthesia and postoperative recovery rooms, outpatient areas or emergency rooms, or ancillary departments).

Where hospitals have significant cash flow problems as a result of removal from PIP, accelerated payments are payable in accordance with §2412 of the Provider Reimbursement Manual.

If the provider previously elected PIP and continues to qualify, continue PIP for:

- Inpatient services from hospitals other than subsection (d) hospitals;

- Hospitals which receive payment under a State hospital payment system under §1814(b)(3) or §1886(c) of the Act, if payment on a PIP basis is approved by HCFA as an integral part of such payment system;

- SNF services; or

- Home health services furnished on or before September 30, 2000. (The Balanced Budget Act of 1997 eliminated PIP for home health agencies upon the implementation of the HH PPS effective October 1, 2000.)

In addition, upon request you can implement PIP effective July 1, 1987 or later for hospices meeting the requirements to qualify for PIP.

7. Receipt Date.--The receipt date is the date you receive a claim subject to the qualifications in subsection C on whether the data are sufficiently complete to qualify as a claim. The receipt date is used to calculate interest payments when due for clean claims, to report statistical data on claims to HCFA, such as in workload reports, and to determine if a claim was received timely.

Paper claims received by 5:00 p.m. on a business day, or by closing time if you routinely end your public business day between 4:00 p.m. and 5:00 p.m., must be considered as received on that date, even if you do not open the envelopes in which the claims are received or do not enter the data into the claims processing system until a later date. Paper claims received after 5:00 p.m. or your close of business between 4:00 p.m. and 5:00 p.m. may be considered as received on your next business day.

Paper claims are considered received if delivered to your place of business by the U.S. Postal Service, picked up from a P.O. box(es), or otherwise delivered to your place of business by your normal close of business time. If you use a P.O. box for receipt of mailed claims, you must have your mail picked up from your box(es) at least once per business day unless precluded on a particular day by the emergency closing of your office or your postal box site.

As electronic claim tapes and diskettes submitted by providers or their agents are also subject to manual delivery, rather than direct electronic transmission, the paper claim receipt date establishment rule also applies to such tapes and diskettes.

Electronic claims transmitted to you, or to a clearinghouse with which you contract as your representative for the receipt of your claims, by 5:00 p.m. in your time zone, or by your closing time if you routinely close between 4:00 p.m. and 5:00 p.m., must likewise be considered as received on that day even if you do not upload or process the data until a later date.

Paper and electronic claims that do not meet the basic legibility, format, or completion requirements are not considered as received for claims processing and may be rejected from the claims processing system. Rejected claims are not considered as received until resubmitted as corrected, complete claims. You may not use the data entry date, the date of passage of front-end edits, the date the document control number is assigned, or any date other than the actual calendar date of receipt as described above to establish the official receipt date of any claim.

Where your system or hours of operation permit, you may, at your option, classify a paper or electronic claim received between 5:00 p.m. (or your closing time between 4:00 p.m. and 5:00 p.m.) and midnight, or on a Saturday, Sunday, holiday, or during an emergency closing period as received on the actual calendar date of delivery or receipt. Unless your office closes early in an isolated situation due to an emergency, your cutoff time for establishment of a receipt date may never be earlier than 4:00 p.m.

Do not make system changes, extend your hours of operation, or incur significant additional costs solely to begin to accommodate late receipts if not already equipped to do so.

The cutoff time for paper claims may not exceed the cutoff time for electronic claims. A number of intermediaries have reported that a later electronic cutoff time has been an incentive for provider use of electronic filing. You are encouraged to use this tool where your system and overnight batch run schedules permit. Likewise, at your option, you may consider electronic claims received on a weekend or holiday as received on the actual calendar date of receipt, even though paper claims received in a P.O. box on a weekend or holiday would not be considered received until the next business day.

8. Scheduled Payment Date.--The scheduled payment date is the date the check you issued is mailed, deposited by you in the provider's account, or transferred electronically. For PIP claims and no payment bills, the scheduled payment date is the date for payment bills in the same adjudication batch.

B. Systems Requirements.--

1. Determine Whether You May Remove Hospitals From PIP Based on Your Processing Timeliness.--In determining whether your processing timeliness is adequate to remove hospitals from PIP, consider all clean, non-PIP bills. Select cases based upon:

3638.25 HH PPS Claims When No RAP Was Submitted.--A RAP and a claim must be submitted for all episodes for which payment based on HIPPS codes will be made. However, there may be circumstances in which an HHA is aware prior to billing Medicare at four or fewer visits will be supplied in the episode. In these cases, since the HHA is aware that the episode will be paid a low utilization payment adjustment (LUPA) based on national standardized per visit rates, the HHA is permitted to submit only a claim for the episode. These claims will be referred to as "No-RAP LUPA" claims.

HHAs may submit both a RAP and a claim in these instances if they choose, but only the claim is required. HHAs should be aware that submission of a RAP in these instances will result in recoupment of funds when the claim is submitted. HHAs should also be aware that the receipt of the RAP or a "no-RAP LUPA" claim cause the creation of an episode record in CWF and establishes an agency as the primary HHA which can bill for the episode. If submission of a "No-RAP LUPA" delays submission of the claim significantly, the agency is at risk for that period of not being established as the primary HHA.

If the agency chooses to submit this "No-RAP LUPA" claim, the claim form should be coded like other claims as described in §3638.24.

3638.30 Beneficiary-Driven Demand Billing Under HH PPS.--Demand billing is a procedure through which beneficiaries can request Medicare payment for services their HHAs advised them were not medically necessary and therefore would not be reimbursed if billed. The HHA must inform the beneficiary of this assessment in an Advance Beneficiary Notice (ABN), which also must be signed by the beneficiary or appropriate representative. In short, beneficiaries pay out of pocket or third party payers cover the services in question, but HHAs in return are required to bill Medicare for the disputed services demand bills. If, after medical review, Medicare decides some or all the disputed services received on the "demand bill" were necessary and pays for them, the HHA would refund the previously collected funds for these services. If the Medicare determination upholds the HHA's judgement as to medical necessity, the HHA keep the funds collected, unless the Regional Home Health Intermediary (RHHI) determines the ABN notification was not properly executed, or some other factor changed liability for payment of the disputed services back to the HHA.

With the advent of HH PPS, the Medicare payment unit for home care changes from visits to episodes, usually 60 day in length. In order to be eligible for episode payment, Medicare beneficiaries must be: (1) under a physician plan of care, and (2) homebound, and, (3) at least one service must have been provided to the beneficiary, so that a request for anticipated payment (RAP) can be sent to Medicare and create a record of an episode in Medicare systems. Therefore, initially under HH PPS, demand billing must conform to ALL of the following criteria:

- Situations in which disputed services are called for under a plan of care, but not delivered because a HHA believes the services are not medically necessary;
- Claims sent to Medicare with a type of bill representing homebound status; and,
- Episodes on record in Medicare systems (at least one service in episode).

A. Interval of Billing.--Under HH PPS, the interval of billing will change and become standard. At most, a RAP and a claim will be billed for each episode. Providers may submit a RAP after the delivery of the first billable service in the 60-day episode, and they must submit

a claim either after discharge or after the end of the 60-day episode. This will not change in demand bill situations, so that only the claim at the end of the episode is the demand bill.

B. Timeliness of Billing.--Several HCFA memoranda to HHAs serving Medicare beneficiaries since 1998 request prompt filing of demand bills. This request should be met to the greatest degree possible, even though the HH PPS billing interval is fixed (A. above), and timely filing requirements for claims remain the same as under the cost reimbursement system. HH PPS provides a new incentive to be prompt in filing claims, since RAP payments will be automatically recouped against other payments if the claim for a given episode does not follow the RAP in the later of: (1) 120 days from the start of the episode; or (2) 60 from the payment date of the RAP. The RAP must be re-billed once payment has been recouped if the claim is to be billed unless the claim is a no-RAP LUPA as described in §3638.25.

C. Overlap with Cost Reimbursement System Billing.--Note that statute on timely filing for Medicare claims allows a period of several months after October 1, 2000 in which home health claims can be submitted under both under the interim payment system (IPS) and the prospective payment system. This is also true of demand bills, but like these other claims, demand bills must cover a discrete period in time under one or the other payment system, not spanning both systems. IPS claims must be limited to services on or before September 30, 2000; HH PPS claims for services on or after October 1, 2000.

D. Claim Requirements.--Original HH PPS claims are submitted with type of bill (TOB) 329 in form locator (FL) 4, and provide all other information required on that claim for HH PPS episode, including all visit-specific detail for the entire episode (do NOT use 3X0). When such claims also serve as demand bills, the following information must also be provided: condition code "20" in FL 24-30; and the services in dispute shown as non-covered (FL 48) line items. Provision of this additional information assures medical review of the demand bill. HH PPS adjustment bills, TOB 327, may also be submitted but must have been preceded by the submission of a 329 claim for the same episode. RAPs are not submitted with indication of demand billing.

E. Favorable Determinations and Medicare Payment.--Results of Medicare determinations favorable to the party requesting the demand bill will not necessarily result in increased Medicare reimbursement. In such cases, and even if a favorable determination is made but payment does not change, HHAs will still refund any monies collected from beneficiaries or other payers for services previously thought not medically necessary under Medicare. Medicare payment will only change with the addition of covered visits if one or more of the following conditions apply:

? An increase in the number of therapy visits results in meeting the therapy threshold for an episode in which the therapy threshold was not previously met-- in such cases, the payment group of the episode would be changed by the RHHI in medical review;

o An increase in the number of overall visits that either: (1) changes payment from a low-utilization payment adjustment to a full episode, or (2) results in the episode meeting the threshold for outlier payment (it is highly unlikely both things occur for the same episode);

o A favorable ruling on a demand bill adds days to: (1) an episode that received a partial episode payment (PEP) adjustment, or (2) a period within an episode that received a significant change in condition (SCIC) adjustment.

If a favorable determination is made, RHHIs will assure pricing of the claim occurs after medical review so that claims also serving as demand bills receive appropriate reimbursement.

F. Appeals.--Appeal of Medicare determinations made on HH PPS claims also serving as demand bills is accomplished by appealing the HH PPS claim. Such appeals are done in accordance with regulations stipulating appeals rights for Medicare home health claims. HH PPS RAPs do not have appeal rights, rather, appeals rights are tied to the claims which represents all services delivered for the entire episode unit of payment.

G. Non-Covered Charges on Demand Bills.--Demand bill final claims may be received with all non-covered charges. In such a case, assuming medical review determines that no services are in fact covered, the standard systems are to send a cancel claim to CWF with cancel only code F in order to cancel the RAP already paid, show in CWF the recovery of the RAP reimbursement and remove the episode period from the HEHH in CWF. This process is specific to entirely non-covered claims with condition code 20 only.

3638.31 No-Payment Billing and Receipt of Denial Notices Under HH PPS.--Claims for homebound Medicare beneficiaries under a physician plan of care and electing fee-for-service coverage are reimbursed under HH PPS as of October 1, 2000. After the advent of this payment system, home health agencies (HHAs) may continue to seek denials for entire claims from Medicare in cases where a provider knows all services will not be covered by Medicare. Such denials are usually sought because of the requirements of other payers (e.g. Medicaid) for providers to obtain Medicare denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment or no-pay bills, or denial notices.

A. Submission and Processing.--In order to submit a no-payment bill to Medicare under HH PPS, providers must use TOB 3x0 in Form Locator (FL) 4 and condition code 21 in FL 24-30 of the Form HCFA-1450 claim form. The statement dates on the claim, FL 6, should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported. Providers must also key in the charge for each line item on the claim as a non-covered charge in FL 48 of each line. In order for these claims to process through the subsequent HH PPS edits in the system, providers are instructed to submit a 0023 revenue line and OASIS Matching Key on the claim. If no OASIS assessment was done, report the lowest weighted HIPPS code (HAEJ1) as a proxy, a 18-digit string of the number 1, "111111111111111111", for the OASIS Claim-Matching Key in FL 63, and meet other minimum Medicare requirements for processing RAPs. If an OASIS assessment was done, the actual HIPPS code and Matching-Key output should be used. Medicare standard systems will bypass the edit that requires a matching RAP on history for these claims, then continue to process them as no-pay bills. Standard systems must also ensure that a matching RAP has not been paid for that billing period. FL 20, source of admission, and treatment authorization codes, FL 63, should be unprotected for non-pay bills.

B. Simultaneous Covered and Non-Covered Services.--In some cases, providers may need to obtain a Medicare denial notice for non-covered services delivered in the same period as covered services that are as part of an HH PPS episode. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, AND submit the appropriate HH PPS RAP and claim for the episode. If the episode billed through the RAP and claim is 60 days in length, the period billed under the non-payment bill should be the same. Medicare standard systems and the Common Working File will allow such duplicate claims to process when all services on the claim are non-covered.

File Position	Format	Title	Description
			Leave blank for hospitals if there has not been a Lugar reclassification. For hospice providers only, enter a 6, 7, 8 or 9 if the hospice is located in one of the four special hospice MSAs.
74	X	Temporary Relief Indicator	Enter a Y if this provider qualifies for a payment update under the temporary relief provision. Blank if not Y.
75	X	Federal PPS Blend Indicator	SNF: Enter the appropriate code for the blend ratio between federal and facility rates. For PPS SNF's eff. for cost reporting period beginning on or after 7/1/98. 1 = Federal 25% / Facility 75% 2 = Federal 50% / Facility 50% 3 = Federal 75% / Facility 25% 4 = Federal 100% / Facility 00% HHA: Enter the code for the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all HHA providers, effective on or after 10/01/2000. 0 = Pay standard percentages 1 = Pay zero percent
76-80	X(5)	Filler	Blank.
81-87	9(5)V9(2)	Case Mix Adjusted Cost per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state nonexcluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §3610.17 for sole community and Medicare-dependent hospitals on or after 04/01/90. Must be updated effective October 1, 1994. For PPS SNF's that qualify for the transition period eff. with cost reporting periods beginning on or after 7/1/98, enter the facility specific payment rate.
88-91	9V9(3)	Cost of Living Adjustment	Enter the appropriate cost of living adjustment for the current fiscal year as published in the Federal Register.

File Position	Format	Title	Description
92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full-time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. You are responsible for reviewing hospital records and making any necessary changes in the count at the end of the cost reporting period. Enter zero for nonteaching hospitals.
97-101	9(5)	Bed Size	Indicate the number of adult hospital beds and pediatric beds available for lodging inpatients. (See Provider Reimbursement Manual, §2405.3G.) If there is a change during the year, make an adjustment if it would make a significant difference in the payment amount.
102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by the Medicare covered charges. Obtain Medicare operating costs from the Medicare cost report Form HCFA-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from your billing file, i.e., PS&R record. For hospitals for which you are unable to compute a reasonable cost-to-charge ratio, use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by HCFA and published in

File Position	Format	Title	Description
			the ***Federal Register***. These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the ***Federal Register***.
106-110	9V9(4)	Case Mix Index	The case mix index used to complete positions 81-87. In most cases, this is the case mix index that has been calculated and published by HCFA for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
111-114	V9(4)	Supplemental Security Income Ratio	SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
115-118	V9(4)	Medicaid Ratio	Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
119	X	Provider PPS Period	This field is obsolete as of 4/1/91. Leave blank for periods on or after 4/1/91.
120-125	9V9(5)	Special Provider Update Factor	Zero fill for all hospitals after FY91. This field is obsolete as of FY92.
126-129	V9(4)	Operating DSH	Disproportionate share adjustment percentage. PRICER calculates the operating DSH effective 10/1/91 and bypasses this field. Zero fill for all hospitals 10/1/91 and later.
130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
138-160	X(23)	Filler	Blank.
161-166	9(4)V99	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. (See Provider Reimbursement Manual §2405.2.) Used for PPS hospitals

File Position	Format	Title	Description
			prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero fill if this does not apply.
167-172	9(4)V99	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital. (See Provider Reimbursement Manual §2405.2.) Zero fill if this does not apply.
173-178	9(4)V99	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart and liver transplants. Do not include acquisition costs for bone marrow transplants. (See Provider Reimbursement Manual §2405.2.) Zero fill if this does not apply.
179-184	9(4)V99	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital. (See Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts: Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year; and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. Zero fill if this does not apply.
185	X	Capital PPS Payment Code	Type of capital payment methodology: for hospitals: A=Hold harmless-cost payment for old capital B=Hold harmless-100% Federal rate C=Fully prospective blended rate Blank if a "Y" is entered in position 207.

File Position	Format	Title	Description
186-191	9(4)V99	Hospital-Specific Capital Rate	Numeric. Hospital's allowable adjusted base year inpatient capital costs per discharge.
192-197	9(4)V99	Old Capital Hold Harmless Rate	Numeric. Hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
198-202	9V9(4)	New Capital-Hold Harmless Ratio	Numeric. Ratio of hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
203-206	9V999	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which you are unable to compute a reasonable cost-to-charge ratio, use the appropriate statewide average cost-to-charge ratio calculated annually by HCFA and published in the Federal Register. These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the Federal Register. A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. Use the hospital's ratio rather than the statewide average if you agree the hospital's ratio is justified.
207	X	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
208-212	9V9(4)	Capital Indirect Medical Education Ratio	The ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §3611.1.) Zero fill for a non-teaching hospital.

File Position	Format	Title	Description
213-218	9(4)V99	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §3611.7.)
219-240	X(22)	Filler	Blank.

NOTE: When the primary payer pays less than actual charges (e.g., under the terms of a preferred provider agreement) actual and less than the amount the sanatorium is obligated to accept as payment in full (e.g., because of imposition of a primary payer deductible and/or co-payment, but not because of failure to file a proper claim), Medicare uses the amount the sanatorium is obligated to accept as payment in full in its payment calculation. In such cases, the sanatorium reports in value code 44 the amount it is obligated to accept as payment in full. Medicare considers this amount to be the sanatorium's charges. (See Example 3 in §3682.1.B.6.) Absent a lower amount that the sanatorium is obligated to accept as payment in full, the amount of the sanatorium's actual charges is used.

The Medicare payment amount is accomplished by the formulas in §3682.1.B.6.

For examples, see §3682.1.B.6.

7. CWF Entries.--Enter in the "Utilization Days" field of the CWF RECORD the days to be charged to the beneficiary's Medicare utilization record as determined in 3.

Enter in the "Value Code" field in the value data portion of the CWF RECORD the appropriate value code to identify the primary payer.

Enter in the "Value Amount" field in the value data portion of the CWF RECORD the amount paid by the primary payer for Medicare covered services that appears in value codes (Items 46-49). (For the PS&R, record the primary payment amount minus the amount in "Total Deductions.")

Enter in field 78b of the CWF RECORD the amount the sanatorium is obligated to accept as payment in full from the primary payer when the primary payer pays a lesser amount that appears in value code 44 (Items 46-49). This amount is greater than the amount paid by the primary payer for Medicare covered services entered by the sanatorium in the identifying primary payer value code.

3682.4 HHA Bills.--Subsections A and B provide instructions for making MSP determinations on HHA bills under cost reimbursement and the Interim Payment System. These instructions apply to HHA bills with dates of service on or before September 30, 2000. See subsections C, D, E and F provide instructions for making MSP determinations on HHA RAPs and claims under the HH PPS.

A. Full Payment by Primary Payer.--If payment by the primary payer for Medicare covered services (as determined by the formula in subsection B3) equals or exceeds the HHA's charges for those services or the current Medicare interim payment amount or the HHA accepts, or is obligated to accept, the primary payer's payment as payment in full and it receives at least this amount, no payment is due from Medicare. The HHA submits a non-payment in accordance with current MSP instructions (§3682.2, Paragraph A).

Where the HHA is billing for DME or orthotic/prosthetic devices and the patient is not under a plan of treatment and it knows the individual has met the deductible, no bill is submitted. However, a bill is submitted to inform you of charges where the deductible may not yet be met. Although no payment can be made by Medicare, the expenses can be applied to the beneficiary's deductible. The HHA completes the bill in the usual manner. In addition, the HHA determines the charges as usual including those covered by the primary payer's payment.

The HHA enters the amount paid by the primary payer for Medicare covered services in the appropriate value code (Items 46-49). The HHA enters condition code 77 in Items 35-39 when it receives the amount it accepts, or is obligated to accept, from the primary payer as payment in full.

Treat the charges shown in total charges as noncovered for payment purposes.

A bill is required for crediting the deductible. Submit the bill to HCFA in accordance with CWF documentation.

Do not record the deductible on the PS&R.

B. Partial Payment by Primary Payer.--If payment by the primary payer for Medicare covered services (as determined by the formula in subsection B3) is less than the HHA's charges for those services and the current Medicare interim payment amount and the HHA does not accept, and is not obligated to accept, the primary payer payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining Charges and Visits.--The HHA enters in the charges and visits columns of the bill Medicare covered charges and visits including those covered by the primary payer's payment.

2. Special Entries on the Bill.--The identifying information is shown in Items 57-75 on the first payer line. The appropriate primary payer value code with the amount paid is shown in value codes (Items 46-49). The amount the HHA accepts, or is obligated to accept, as payment in full from the primary payer when the primary payer pays a lesser amount is shown in value code 44 (Items 46-49). The address of the primary payer is shown in Item 34 or Remarks (Item 94). In addition, the HHA enters appropriate occurrence/condition codes. (See §3604, Items 28-30 and 35-39, for an explanation of these codes.)

3. Determining Amount of Primary Payer Payment That Applies to Medicare Covered Services.--The HHA indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount it paid toward Medicare covered services in value codes (Items 46-49). Where the HHA cannot determine the services covered by the primary payer, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49). The HHA must be able to validate its ratio of covered and noncovered charges if so requested.

EXAMPLE: Total charges were $550. Medicare covered charges were $500. The primary payer's payment was $330. Since the HHA cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$500}{\$550} \times \$330 = \$300$$

The HHA enters $300 in value codes (Items 46-49).

o The HHA's charges minus the amount paid by the primary payer for Medicare covered services: $3,200 - $3,100 = $100; or

o The HHA's charges minus any applicable Medicare deductible and/or coinsurance amounts: $3,200 - $100 - $640* = $2,460.

*See Example 3 for coinsurance calculation.

Medicare pays $100. The beneficiary's Medicare deductible and coinsurance were satisfied by the primary payer's payment. (For the PS&R, record $100 deductible, $640 coinsurance and $2,360 primary payer payment.)

5. CWF Entries.--Enter in the "Value Code" field in the value data portion of the CWF RECORD the appropriate value code to identify the primary payer.

Enter in the "Value Amount" field in the value data portion of the CWF RECORD the amount paid by the primary payer for Medicare covered services that appears in value codes (Items 46-49).

Enter in the "Value Amount" field in the value data portion of the CWF RECORD the amount the provider accepts, or is obligated to accept, as payment in full from the primary payer when the primary payer pays a lesser amount that appears in value code 44 (Items 46-49). This amount is greater than the amount paid by the primary payer for Medicare covered services entered by the provider in the identifying primary payer value code.

C. MSP determinations Under HH PPS.--The following instructions apply to home health RAPs and claims with types of bill 32x and 33x and dates of service on or after October 1, 2000. HH PPS does not change the Medicare secondary payment rules. The policy contained in regulations at 42 CFR Part 411, subparts B, C, D, E, F, G AND H and found in §§3489, 3490, 3491 and 3492 continue to apply. When Medicare is secondary payer, payment is to be made on the basis of the formula contained in 42 CFR 411.33(e).

D. MSP Determinations on RAPs.--When Medicare is secondary payer and the criteria for payment on a per episode basis are met, make no payment based on a request for anticipated payment (RAP). Do not send RAPs to the MSPPAY module for calculation. Make secondary payment only based on a claim for the 60-day episode, which will show the primary payer's payment if one has been made. HHAs must send all MSP claims to the primary payer first for payment before submitting claims to you.

1. RAPs Submitted Without MSP Value Codes.--CWF will apply existing edits against the MSP auxiliary file to RAPs, whether a HUSP record is present or not, to see if the episode period service date falls within an MSP period. If an MSP period corresponding to the service dates exists, CWF will return a utilization error indicating the primary coverage exists. When your systems receive a RAP with an MSP utilization error, set a Z no-pay code and an M or N override code on the 0001 line of the RAP. Return the claim to CWF. CWF will create an episode record from the RAP and otherwise process it with zero payment. When the RAP is returned from CWF, place it in a final paid status (i.e., do not send the RAP to another post-payment location). First claim development is performed only on claims, not on RAPs.

2. RAPs Submitted With MSP Value Codes.--Create a HUSP record for all RAPs containing MSP information. This record will create or update the CWF MSP auxiliary file as appropriate. To process the RAP, set a Z no-pay code and an M or N override code on the 0001 line. Return the RAP to CWF, which will create an episode record from it and otherwise process it with

zero payment. When the RAP is returned from CWF, place it in a final paid status (i.e., do not send the RAP to another post-payment location). First claim development is performed only on claims, not RAPs. Apply this same process to RAPs submitted with MSP value codes which have zero dollar amounts associated with them and a C in the primary payer field.

E. MSP determinations on claims-- For claims for services receiving a full episode payment, or for other types of payment adjustments (e.g., when there are 4 visits or less in a sixty-day episode) apply the MSP formula to the applicable unit of Medicare payment.

Examples of MSP Calculations:

1. MSP for HH PPS payment made on 60-day episode. --A HHA furnished 25 Medicare covered visits during a 60 day episode to a beneficiary. The HHA's total charges were $2800 for the 60 days of care (25 visits at $112 each). The third party payer paid $2360. The HHA is not obligated to accept the third party payment as payment in full. The HH PPS amount for the period is $2700.

Medicare pays the lowest of the following amounts for the episode period:

The gross amount payable by Medicare minus the Medicare deductible: $2700-0=$2700

The gross amount payable by Medicare minus the third party payment: $2700-$2360= $340

The HHA's charges minus the third party payment: $2800-$2360= $440

The providers charges minus the Medicare deductible: $2800-0=$2800

Medicare's secondary payment for the 60 day episode of care is $340 (the lowest of the four calculations). Note that since Medicare payment is made on a per episode basis under HH PPS, MSP is calculated on a per episode basis and therefore there is one calculation since there is one episode of care. Educate providers as part of HH PPS that it may be advisable to track payments from payer other than Medicare on the same per-episode basis.

2. MSP for HH PPS when the criteria for per episode payment is not met and Medicare payment is on a per visit basis.-- A HHA furnished 3 Medicare covered skilled nursing visits during a 60 day episode to a beneficiary. The HHA's total charges were $336 for the care (3 visits at $112 each). The HHA is not obligated to accept the third party payment as payment in full. The third party payer paid $94.40 per visit or a total payment of $283.20 for the 3 visits. The HH PPS amount per visit is $108 or a total of $324 for the 3 visits.

Medicare pays the lowest of the following amounts for each visit:

The gross amount payable by Medicare minus the Medicare deductible: $108-0=$108

The gross amount payable by Medicare minus the third party payment: $108-$94.40= $13.60

The HHA's charges minus the third party payment: $112-$94.40= $17.6

The providers charges minus the Medicare deductible: $112-0=$112

Medicare's secondary payment for each visit is $13.60 (the lowest of the four calculations). Note that since Medicare payment is made on a per visit basis, MSP is calculated on a per visit basis and therefore there would be three calculations since there were 3 visits. Medicare's total secondary payment is $40.80 ($13.60 for each of 3 visits).

3. MSP for HH PPS Payment Made on 60 Day Episode When the Provider is Obligated to Accept the Third Party Payment as Payment in Full.--A HHA furnished 25 Medicare covered visits during a 60 day episode to a beneficiary. The HHA's total charges were $2800 for the 60 days of care (25 visits at $112 each). The third party payer paid $2360. The provider the third party payment as payment in full. The HH PPS amount for the period is $2700.

Medicare pays the lowest of the following amounts for the episode period:

The gross amount payable by Medicare minus the Medicare deductible: $2700-0=$2700

The gross amount payable by Medicare minus the third party payment: $2700-$2360= $340

The amount the HHA as payment in full minus the third party payment: $2360-$2360= $0.

The amount the HHA is obligated to accept as payment in full minus the Medicare deductible: $2360-0=$2360

Medicare's secondary payment for the 60 day episode of care is $0 (the lowest of the four calculations). Note that since Medicare payment is made on a per episode basis, MSP is calculated on a per episode basis and therefore there is one calculation since there is one episode of care.

4. MSP for HH PPS When the Criteria for Per Episode Payment is Not Met, the Provider is Obligated to Accept the Third Party Payment as Payment in Full and Medicare Payment is on a Per Visit Basis.--A HHA furnished 3 Medicare covered skilled nursing visits during a 60 day episode to a beneficiary. The HHA's total charges were $336 for the care (3 visits at $112 each). The third party payer paid $94.40 per visit or a total payment of $283.20 for the 3 visits. The HHA is obligated to accept the third party's payment as payment in full. The HH PPS amount per visit is $108 or a total of $324 for the 3 visits.

Medicare pays the lowest of the following amounts for each visit:

The gross amount payable by Medicare minus the Medicare deductible: $108-0=$108

The gross amount payable by Medicare minus the third party payment: $108-$94.40= $13.60

The amount the HHA is obligated to accept as payment in full minus the third party payment: $94.40-$94.40= $0

The amount the HHA is obligated to accept as payment in full minus the Medicare deductible: $94.40-0=$94.40

Medicare's secondary payment for each visit is $0 (the lowest of the four calculations). Note that since Medicare payment is made on a per visit basis, MSP is calculated on a per visit basis and therefore there would be three calculations since there were 3 visits. Medicare's total secondary payment is $0 ($0 for each of 3 visits).

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3682.5 Denials and Conditional Payments in MSP Situations.--The following sections describe appropriate actions to take where a primary payer denies a claim for primary benefits. They also describe situations where conditional payments are payable. No conditional payments will be made on HH PPS RAPs.

A. No-Fault Insurer Does Not Make Payment.--If services furnished are related to an accident and an insurer has been billed but does not make payment, e.g., the services are not covered under no-fault insurance or the individual's insurance coverage expired, the provider bills Medicare as usual. In addition, the proper occurrence code as indicated below is shown in Items 28-32. Occurrence code 24 is completed to show the date the other payer denied the claim, and the reason for denial is shown in Remarks (Item 94).

01 - Auto Accident
02 - No-fault Insurance Involved

If the conditions described in §3489.3.F are met, pay conditional primary benefits. The provider enters value code 14 with zero value in Items 46-49 to indicate the type of other insurer and that conditional payment is requested. The identity of the other payer is shown on line A of Item 57, and the identifying information about the insured is shown on line A of Items 65-68. The provider enters the proper occurrence code in Items 28-32 and the address of the insurer in Item 34 or Remarks (Item 94). In addition, an explanation of why the conditional payment is justified is shown in Remarks (Item 94). (See §3489.3F for an explanation of policy and procedures for conditional payment situations for contested or delayed or no-fault claims.)

Process these conditional payment bills following normal procedures. In addition, enter in the appropriate field of the CWF record value code 14 and zero value to indicate that a conditional payment was made. Show this code and zero value in fields 78a and 78b for inpatient and Christian Science Sanatorium bills and fields 64a and 64b for outpatient, HHA, and other bills.

B. WC Conditional Payments.--Conditional Medicare benefits may be paid when:

- The beneficiary has filed a claim with the WC carrier and you determine that the carrier does not pay promptly (i.e., within 120 days of receipt of the claim) for any reason except when the WC carrier claims that its benefits are only secondary to Medicare; or

- The beneficiary, because of physical or mental incapacity, failed to meet a claim filing requirement of the WC carrier.

The provider requests conditional payment by entering occurrence code 04 and the associated date in Items 28-32, occurrence codes and condition code 02 in Items 35-39. The provider enters value code 15 with zero value in Items 46-49 to indicate the type of other insurer and that conditional payment is requested. The identity of the other payer is shown on line A of Item 57, the identifying information about the insured is shown on line A of Items 65-68 and the address of the WC plan is shown in Item 34 or Remarks (Item 94). In addition, an explanation of why the conditional payment is justified is shown in Remarks (Item 94).

Process conditional payment bills following normal procedures. In addition, enter in the appropriate field of the CWF record value code 15 and zero value to indicate that a conditional payment was made. Show this code and zero value in fields 78a and 78b for inpatient and Christian Science Sanatorium bills, and in fields 64a and 64b for outpatient, HHA, and other bill types.

C. Conditional Liability Claims.--If the services are related to an accident, as defined in §3419.2, or a diagnosis/trauma code listed in §3419.2 is shown, and there is no potential primary payer other than a liability insurer, the provider may bill Medicare for conditional primary payments. The claim is completed and processed in accordance with the last two paragraphs of subsection A. (See §3419.10 for liability insurance and §§3489-3489.9 for no-fault insurance.

D. ESRD-EGHP Denies Claim for Primary Benefits.--Pay primary Medicare benefits (if the beneficiary is not appealing the ESRD-EGHP denial) when an ESRD-EGHP denies a claim for primary benefits because:

- The beneficiary is under age 65 and not in a Medicare coordination period as defined in §3490;
- The beneficiary became eligible for Medicare on a basis other than ESRD during the Medicare coordination period (i.e., the coordination period terminated);
- The beneficiary is not entitled to benefits under the plan;
- Benefits under the ESRD-EGHP are exhausted for the services involved; or
- The services are not covered by the ESRD-EGHP.

3850. PROVIDER-SPECIFIC PAYMENT DATA

Submit a file of provider-specific payment data to CO every 3 months for PPS and non-PPS hospitals, SNF's, and hospices, including those in Maryland. Regional Home Health Intermediaries (RHHIs) submit a file of provider specific data for all home health agencies. Intermediaries serving as the audit intermediary for hospital based HHAs do not submit a file of provider specific data for HHAs. Create a new record any time a change occurs for a provider. Report data for the following periods: October 2 - January 1, January 2 - April 1, April 2 - July 1, and July 2 - October 1. This file must be received in CO within 7 calendar days after the end of the period being reported.

NOTE: Submit your latest available provider-specific data for the entire reporting period to CO by the 7 calendar day deadline. If CO fails to issue applicable instructions concerning changes or additions to the file fields by 10 calendar days before the end of the reporting period you may delay reporting of data related to the CO instructions until the next file due date. For example, if CO instructions changing a file field are issued on or after September 21 with an effective date of October 1, you may exclude the October 1 CO-required changes from the file you submit by October 9. Include the October 1 CO-required changes, and all subsequent changes through January 1 in the file submitted in January.

A. PPS Hospitals.--Submit all records (past and current) for all PPS providers every 3 months. Duplicate the provider file used in the "PRICER" module of your claims processing system.

B. Non-PPS Hospitals and Exempt Units.--Create a provider specific history file using the listed data elements for each non-PPS hospital and exempt hospital unit. Submit the current and the preceding fiscal years every 3 months. Code Y in position 49 (waiver code) if you want to maintain the record in your PRICER PROV file.

C. Hospice.--Create a provider specific history file using the following data elements for each hospice. Submit the current and the preceding fiscal years every 3 months. Code Y in position 49 (waiver code) if you want to maintain the record in your PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for this provider type.

D. Skilled Nursing Facility (SNF).--Create a provider specific history file using the following data elements for each SNF beginning with their first cost reporting period that starts on or after July 1, 1998. Submit the current and the preceding fiscal years every 3 months. Code Y in position 49 (waiver code) if you want to maintain the record in your PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, 19, and 21 are required. All other data elements are optional for this provider type.

E. HHA.--Create a provider specific history file using the following data elements for each HHA. RHHIs submit the current and the preceding fiscal years every 3 months. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13 and 19 are required. All other data elements are optional for this provider type. All fields must be zero filled if not completed. Update the effective date in data element 4 annually. Ensure that the current census division in data element 11 is not zero. Ensure that the waiver indicator in data element 8 is N. Ensure that the MSA code reported in data element 13 is a valid MSA code.

Send a paper listing copy to your RO. If you service providers outside of your area, submit a hardcopy of the file to the RO in which the facility is located. (For example, Mutual of Omaha submits a hardcopy of the file to the Denver, San Francisco, Atlanta, and Dallas ROs.)

NOTE: The intermediary servicing Indian Health Facilities needs to submit a hardcopy of the file only to the Dallas RO.

The provider specific file (PSF) should be transferred to CO using the Network Data Mover (NDM) system, COPY TO and RUN JOB statements, which will notify CO of PSF file transfer. You must setup an NDM transfer from your system for which you are responsible. It is critical that the provider specific data is copied to the HCFA Data Center using the following input data set names. 99999 should be changed to your five digit intermediary number.

Data set Name ---**COPY TO**: --**MU00.@FPA2175.FI99999**
DCB=(**HCFA1.MODEL,BLKSIZE=2400,LRECL=2400,RECFM=FB)**
Data set Name ---**RUN JOB**: --**MU00.@FPA2175.CLIST(FI99999)**

3850.1 Provider-Specific Data Record Layout and Description.--Complete all fields below. Use the space bar to indicate a (blank). Do not enter zeroes, nines or nulls in these fields.

	Field	Format	Location	Coding and Edits
1.	National Provider Identifier (NPI)	X(8)	1-8	NA
2.	NPI - Filler	X(2)	9-10	NA
3.	Provider Oscar No.	X(6)	11-16	Alpha/Numeric - Cross check to Item 10, provider type. Positions 3 and 4 of: Provider # — Type (see field 10) 00-08 — Blanks, 00, 07-11, 13-17, 21-22 12 — 18 13 — 23, 37 20-22 — 02 30 — 04 33 — 05 40-44 — 03 50-64 — 32-34, 38 15-17 — 35 70-84, 90-99 — 36 Codes for special units S, T, U, V, W, Y and Z are in the third position of the provider number and should be type 06 (hospital distinct parts).
4.	Effective Date	9(8)	17-24	Month 01-12, day 01-31, year greater than 82 but not greater than current year. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. This must be equal to or greater than the Fiscal Year Begin Date for this record. Must be numeric, CCYYMMDD.

	Field	Format	Location	Coding and Edits
5.	Fiscal Year Beginning Date	9(8)	25-32	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 Year: Greater than 81 but not greater than the current year. Must be updated annually to show the current year. Must be equal to or less than the effective date (Field #4 above).
6.	Report Date	9(8)	33-40	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to HCFA CO.
7.	Termination Date	9(8)	41-48	Must be numeric, CCYYMMDD. Termination in this context is the date on which the reporting intermediary ceased servicing the provider. Must be zeros or contain a termination date. If you terminate or transfer the provider to another intermediary, place a termination date in the file to reflect the last date you serviced the provider. Likewise, if the provider identification number changes, you must place a termination date in the PROV file you transmit to HCFA for the old provider identification number.
8.	Waiver Indicator	X	49	Provider waived from PPS? Must be Y (yes) or N (no). Y = Provider is not under PPS N = Provider is under PPS
9.	Intermediary Number	9(5)	50-54	Assigned intermediary number
10.	Provider Type	X(2)	55-56	Must be blank or 00, 02-08, 13-18, 21-23 or 32-38. Blanks or 00 Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric

Field		Format	Location	Coding and Edits
				06 Hospital Distinct Parts 07 Rural Referral Center 08 Indian Health Center 13 Cancer Facility 14 Medicare Dependent Hospital (for cost reporting periods that began on or after 4/1/90, except FY 95-97.) See §3610.17B. 15 Medicare Dependent Hospital/Referral Center (for cost reporting periods that began on or after 4/1/90, except FY 95-97.) See §3610.17B. 16 Rebased Sole Community Hospital 17 Rebased Sole Community Hospital/Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital(EACH) 22 EACH/Referral Center 23 Rural Primary Care Hospital 32 NHCMQ-II (SNF only) 33 NHCMQ-III (SNF only) 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) -For non demo PPS SNFs- eff. for cost reporting periods beginning on or after 7/1/98
11.	Current Census Division	9	57	Must be numeric (1-9). The census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, change the census division to reflect the new standardized amount location. Used to select the payment rates. See §3656.3B for valid codes.
12.	Change Code for Reclassification	X	58	Enter "Y" if the hospital's wage index location has been reclassified for this year. Enter "N" if not reclassified for this year. Adjust annually.
	Wage Index			

	Field	Format	Location	Coding and Edits
13.	Actual Geographic Location-MSA	X(4)	59-62	Must be (blank)(blank) 2-digit code if rural or MSA # 0040 - 9360.
14.	Wage Index MSA Location--MSA	X(4)	63-66	The appropriate code for the 0040-9965, or the rural area, (blank) (blank) (2-digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. PRICER automatically defaults to the actual location MSA if this is left blank.
15.	Standardized Amount MSA Location--MSA	X(4)	67-70	The appropriate code for the 0040-9965, or the rural area, (blank) (blank) (2-digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location MSA (field 13) if not reclassified. PRICER automatically defaults to the actual location MSA if this is left blank.
16.	Sole Community Medicare Dependent Hospital --Base Year	X(2)	71-72	Leave blank if not an SCH or effective with cost reporting periods that began on or after 4/1/90, except FY 95-97. If an SCH or an MDH, must show the base year for the operating hospital specific rate, either 82 or 87. Must be left blank if an SCH or a MDH did not operate in 82 or 87.
17.	Change Code for Lugar Reclassification	X	73	"L" must be entered if the wage index was reclassified under the Lugar Amendment for ASC-approved services provided on an outpatient basis. Blank if not reclassified under the Lugar Amendment or hospice provider. For hospice providers only, from 10/1/97-9/30/99, enter a “6”, “7”, “8” or “9” if the hospice is located in one of the four special hospice MSAs.

	Field	Format	Location	Coding and Edits
18.	Temporary Relief Indicator	X	74	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision. Blank if not "Y".
19.	Federal PPS Blend Indicator	X	75	SNF: The appropriate code for the blend ratio between federal and facility rates. For PPS SNF's eff. for cost reporting period beginning on or after 7/1/98. If present, must be 1, 2, 3 or 4. 1 = Federal 25% / Facility 75% 2 = Federal 50% / Facility 50% 3 = Federal 75% / Facility 25% 4 = Federal 100% / Facility 00% HHA: Effective for all HHA providers on and after 10/01/2000, the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all HHA providers. 0 = Pay standard percentages 1 = Pay zero percent Must be a numeric value of 0 – 9. Values not listed above are unassigned.
20.	Filler	X(5)	76-80	Blank.
21.	Case Mix Adjusted Cost Per Discharge/ Facility Specific Rate	9(5)V9(2)	81-87	For PPS hospitals and waiver State nonexcluded hospitals, enter the PPS base year cost per discharge divided by the case mix index. Enter zero for new providers. See §3610.17 for sole community and Medicare-dependent hospitals on or after 04/01/90. For PPS SNF's that qualify for the transition period eff. with cost reporting periods beginning on or after 7/1/98, enter the facility specific payment rate. For all others, see §3610.B. Verify if figure is greater than $10,000.
22.	Cost of Living Adjustment	9V9(3)	88-91	For PPS hospitals report the adjustment in these positions of your

Field	Format	Location	Coding and Edits
			PROV file. All hospitals except Alaska and Hawaii use 1.000.
23. Intern-Bed Ratio	9V9(4)	92-96	See §3656.3B for the calculation of the provider's intern-to-bed ratio. Does not include residents in anesthesiology employed to replace anesthetists or those assigned to PPS excluded units. Enter zeros for non-teaching hospitals.
24. Bed Size	9(5)	97-101	Enter the number of hospital beds available. See §3656.3B for definition. Must be greater than zero.
25. Operating Cost-to-Charge Ratio	9V9(3)	102-105	Derived from latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare Operating Cost (from the cost report) by the Medicare Covered Charge (from the billing file, i.e., the PS&R record). For hospitals for which you are unable to compute a reasonable cost-to-charge ratio, use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by HCFA. Use these average ratios to calculate cost outlier payments for hospitals where you compute cost-to-charge ratios that are not within the limits published in the Federal Register.
26. Case Mix Index	9V9(4)	106-110	For PPS hospitals, enter the case mix index used to compute field 21. Zero fill for all others.
27. Supplemental Security Income Ratio	V9(4)	111-114	SSI ratio used to determine if the hospital qualifies for the disproportionate share adjustment, and to determine the size of the capital and operating DSH adjustments.
28. Medicaid Ratio	V9(4)	115-118	Medicaid ratio used to determine if the hospital qualifies for the disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29. Provider PPS Period	X	119	This field is obsolete as of 4/1/91. Leave blank for periods on or after 4/1/91.

	Field	Format	Location	Coding and Edits
30.	Special Provider Update Factor	9V9(5)	120-125	Zero fill for all hospitals after FY91. This filed is obsolete as of FY92.
31.	Operating DSH	V9(4)	126-129	Disproportionate share adjustment percentage. PRICER calculates the operating DSH effective 10/1/91 and bypasses this field. Zero fill for all hospitals 10/1/91 and later.
32.	Fiscal Year End	9(8)	130-137	This field is no longer used. If present, must be CCYYMMDD.
33.	Filler	X(23)	138-160	Blank.
34.	Pass Through Amount for Capital	9(4)V99	161-166	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C.
35.	Pass Through Amount For Direct Graduate Medical Education	9(4)V99	167-172	Per diem amount based on the interim payments to the hospital. Zero fill if this does not apply.
36.	Pass Through Amount for Organ Acquisition	9(4)V99	173-178	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart and liver transplants. Do not include acquisition costs for bone marrow transplants. (See Provider Reimbursement Manual §2405.2.) Zero fill if this does not apply.
37.	Total Pass Through Amount, Including Miscellaneous	9(4)V99	179-184	Per diem amount based on interim payments to the hospital. Must be equal to or greater than the sum of the 3 pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts: Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year; and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical

	Field	Format	Location	Coding and Edits
				Education, Hemophilia Clotting Factors, or DSH adjustments. Zero fill if this does not apply.
38.	Capital PPS Payment code	X	185	Type of capital payment methodology for hospitals: A=Hold harmless-cost payment for old capital B=Hold harmless-100% Federal rate C=Fully prospective blended rate Must be present unless a "Y" is entered in location 49 or 207, or 08 is entered in location 55-56 or a termination date is present in location 41-48.
39.	Hospital Specific Capital Rate	9(4)V99	186-191	The FY 93 hospital specific rate should be entered in this field. Do not update this field after FY 93, except to reflect the effects of a hospital specific rate redetermination. PRICER applies the appropriate update factor automatically after 10/01/93. Numeric. Hospital's allowable adjusted base year inpatient capital costs per discharge.
40.	Old Capital-Hold Harmless Rate	9(4)V99	192-197	Numeric. Hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired by December 31, 1990 (or incurred subsequent to December 31, 1990, but allowed as "obligated" capital) for capital PPS. Must be updated annually.
41.	New Capital-Hold Harmless Ratio	9V9(4)	198-202	Numeric. Ratio of hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Must be updated annually.
42.	Capital Cost-to-Charge Ratio	9V999	203-206	Computed by dividing the Medicare capital costs by the Medicare covered charges in the PS&R record. For hospitals for which you cannot calculate a capital cost-to-charge ratio, use the appropriate statewide

	Field	Format	Location	Coding and Edits
				average cost-to-charge ratio calculated annually by HCFA, or an alternate justified capital cost-to-charge ratio. (See §3656.3B.)
43.	New Hospital	X	207	Enter "Y" if a hospital is in its first 2 years of operation under the capital regulation. Otherwise leave blank.
44.	Capital Indirect Medical Education Ratio	9V9(4)	208-212	Enter the ratio of residents to the hospital's average daily census. Zero fill for a non-teaching hospital.
45.	Capital Exception Payment Rate	9(4)V99	213-218	Enter the per discharge exception payment to which a hospital is entitled.
46.	Filler	X(22)	219-240	Blank.

3850.2 Intermediary Responsibilities.--Create a new record when a change occurs for a provider. You may have multiple records for a single provider within a quarter.

Prior to submitting the file to HCFA, print and review the data. Edit all items for accuracy. Correct any errors before submitting the file. Some edit examples:

- Effective date other than CCYYMMDD;
- Facility has two or more records with different provider numbers for the same month;
- Non-PPS facility with incorrect provider type;
- Incorrect census division for a redesignated facility;
- MSA field with other than (blank) (blank) (2-digit State number) for a rural provider; and
- Questionable pattern of coding, e.g., all provider types in field 10 are identical, all case mix indexes in field 26 are identical.

Provider-specific payment data must be received in CO within 7 calendar days of the end of the reporting period. The data will be evaluated based on the following criteria:

- Files conform to specifications;
- Files reflect data from all required providers; and
- Files are submitted in the correct record format.

CO will forward an error listing to you for correction. Submit corrected data files to CO within 10 calendar days of notification.

There are six batch types identified by the entry of the Batch-Type Code (see §3879.3) in location l9 of the Batch Control Record (see §3979.6). All inpatient hospital/SNF bills, outpatient bills, Christian Science bills, and Home Health Agency bills, with the exception of Final Nonpayment and RTI VOID bills are to be batched according to billing form of origin, i.e., HCFA-l453, HCFA-l483, HCFA-l486, HCFA-l487. All Final Nonpayment bills (Forms HCFA-l453 and HCFA-l486) are to be batched in a Final Nonpayment bill batch with detail records in abbreviated format as delineated in §3880.6. All RTI VOID bills are to be batched in a VOID batch independent of billing form of origin and with detail record in abbreviated format as delineated in §3880.7. When applicable, special bill types must be designated on the individual bill data records by entry of a special bill type code (E -Patient Filed bill or N - PIP bills) in location 937 on the Inpatient hospital/SNF and Christian Science bill data records, and (N - PIP bills) in location 37l on the Home Health Agency bill data record. See §3885 and §3886 for coding of Adjustment and RTI bills.

3885. ADJUSTMENT BILLS

Adjustment bills must conform to all edit specifications contained herein and identified by the action codes (see §3880.l), i.e., 2 - cancel by credit adjustment; 3 -secondary debit adjustment; 4 - cancel only adjustment; 9 - payment requested adjustment (Code P). See §3884 for batching instructions. See section §3885.3 for credit adjustments relative to HH PPS RAPs and claims.

3885.l The Association Adjustment Code.--All adjustment bills must have an association code you assigned. The association code is to be entered for adjustment bills only in locations 5-6 of the data records. The code is to consist of an alpha (A through J) in location 5 of the data record followed by a numeric (l through 9) in location 6. For example, the first adjustment bill or bill pair (if "Debit/Credit" adjustment) in any given batch would be identified by an "A" followed by a numeric "l", i.e., "Al." Subsequent bills or bill pairs (if "Debit/Credit" adjustment) in the same batch would be identified by A2, A3, ... A9, Bl, ...J9.

3885.2 The Cancel Only Adjustment Code (Action Code 4).--A Cancel Only Adjustment bill is used to delete a bill which has been accepted by SSA. This code is described in §38l6. The code is to be given in location 3 of the bill data detail record. The valid codes follow:

C - Coverage Only Code
P - Plan Transfer
S - Scramble
D - Duplicate Billing
H - Other

For the home health prospective payment systems (HH PPS - see §3639 and §3640 for background information on this payment system), new cancel only adjustment code values have been established. Standard system (SS) software in Medicare claim processing systems populates these codes in the electronic claim record based on specific events. These new codes may result in: (1) cancellation of a HH PPS claim or request for anticipated payment (RAP); and/or, (2) removal of an HH PPS episode history file from the Common Working File (CWF) as follows:

Value	Description	CWF-Specific Action	SS- Specific Action	Provider Payment
B	A HH PPS RAP (TOB 3x2) is cancelled because it has **NOT** been followed by a provider submitted HH PPS claim (TOB 3x9) for a specific episode within the later of: 120 days from the start of the episode OR 60 days from the processing of the RAP	HUHH received from RHHI; episode is **NOT** removed; cancellation indicator is set to "1"; DOEBA/DOLBA dates are removed	Value "B" for the cancel only adjustment code placed in the data record as described above; auto-cancel the RAP	RAP payment is recouped against other payments, no payment for this episode
E	A HH PPS RAP or claim is cancelled by a provider with submission of a cancellation RAP or claim (TOB 328 or 338)	HUHH received from RHHI; episode is removed	Value "E" for the cancel only adjustment code placed in the RAP or claim record as described above upon receipt of the cancellation; auto-cancel the RAP or claim	RAP or claim payment is recouped, but episode may be re-billed
F	A HH PPS RAP or claim is cancelled by a RHHI with adjustment of a provider submitted HH PPS RAP or claim (TOB 32I or 33I **AND** transaction code "C")	HUHH received from RHHI; episode is removed	Value "F" for the cancel only adjustment code placed in the RAP or claim record as described above upon receipt of the adjustment; auto-cancel the RAP or claim	RAP or claim payment is recouped, ability to re-bill may vary in each case (i.e., if fraud suspected)

3885.3 The Credit/Debit Adjustment Action (Action Codes 2 and 3).-- In a credit cancel, debit adjustment action, both bills must be in the same batch and must be identified as companion bills by the same association adjustment code (see §3885.l). All adjustment bills may be batched together in the same batch, however, according to bill type (see §3879.3). For HH PPS, RAP cancellations and 3X9 claims together process as credit/debit adjustments, adjusting the original HH PPS RAP which began the episode period. Absent cancel-only codes representing specific HH PPS adjustments, a 3X9 HH PPS claim is a debit adjustment to a RAP, with identifying action code 3, and containing the original RAP ICN. This claim must be received on or within 120 days of the start of the episode, and will result in cancellation of the RAP and 100% payment of the episode amount between both the RAP and the claim. In such cases, a HUHH record is received by CWF from the Regional Home Health Intermediary, CWF does not remove the episode from the episode file, nor does CWF set a cancellation indicator in that file.

3885.4 Code R and Code P Adjustment Bills.--For a Cancel Only or Credit/Debit Adjustment of a Code R or Code P adjustment, action codes 8 and 9 can no longer be used to identify the action as well as the bill type. Consequently, the required adjustment of a Code R or Code P type bill is to be effected by (l) the proper entry of the required action code (Code 2, 3, or 4) on the applicable bill record; (2) the entry of R or P in the R/P bill-type adjustment bill code location on the applicable record (viz., position 600 on the Hospital/SNF or 339 on the HHA data record). Code R and Code P adjustment bills are to be batched on adjustment batches.

3885.5 RIT Adjustment Bills.--Adjustment bills are not currently under RTI control at SSA. Consequently, for the present, RTI adjustment bills returned to SSA need not contain an RTI control number. However, when a adjustment bill is returned to you for corrective action, an RTI number is assigned for your use only, e.g., in the case of a "Credit/Debit" adjustment requiring RTI action both bills are returned, each with its own RTI control number. Currently your should not submit an RTI VOID bill for an RTI adjustment bill not returned to SSA.

3855.6 Adjustment Batch Balancing.--Adjustment bills are identified by the action code in location 2 of the Bills Tape Bill-Type Records. Although all "reimbursement amounts" are unsigned, credit actions are considered negative, the units position of the "total reimbursement amount" of the Bills Tape Batch Summary Record must be zoned "minus." Otherwise, the units position of the "total reimbursement amount" must be zoned "plus."

3886. THE BILLS TAPE RIT ACTION.

RTI (Returned to Intermediary) bills may require either a correction or a VOID action.

3886.l The RTI Control Number.--The RTI control number is the primary means for the identification of the RTI action and the ensuing purge from SSA's pending RTI control file. The l0 character RTI control number assigned by SSA shall consist of the following two items in tandem in the order given:

l. Batch number (see §3879.2).

2. A two digit SSA-assigned sequence number.

3886.2 RTI Correction Action Bills.--Correction action requires (l) the correction of the error; (2) the return to SSA of all data originally submitted with correction; and (3) the addition of SSA's RTI control number to the bill data detail record. RTI correction items must be batched (maximum 90 items per batch) by batch-type designated for bills with the required billing form of origin. RTI control is achieved by the entry of the RTI control number (§3886.l) on the appropriate data records.

3886.3 RTI VOID Action Bills.--See §3880.7 for description of the VOID action data record, explanation of usage, and batching requirements.

3886.4 TAPE DELETIONS--BATCHES, ITEMS, BATCH NUMBERS.

To delete bill detail records from a prepared tape prior to submission to SSA, delete the desired bill and adjust the item and reimbursement amounts in the batch summary record.

To delete an entire batch from a prepared tape prior to submission to SSA, you may delete all the bill items from the batch in question and forward to SSA the batch control and batch summary records for the deleted batch. The batch summary record should be adjusted to show zero items and zero reimbursement with the constant VOID entered in positions 44-47 of the batch summary record.

To delete one or more batch numbers from the system, you should forward to SSA the batch control and batch summary records for the deleted batch(es). The batch summary record for each batch number deleted from the system should be adjusted to show zero items and zero reimbursement with constant VOID entered in locations 44-47 of the batch summary record.

When one or more of the above deletions have been made, the tape trailer and summary totals for the tape must be adjusted.

Each batch of bills you submit is assigned a batch number for control purposes (see §3879.2). The four position batch control portion of the batch number should be countably sequenced in order of batch creation to ensure coverage of all permissible numbers.

(Ultimately all batch numbers within the coverage must be accounted for by each intermediary). Should you inadvertently skip one or several batch numbers on a given tape, the skipped numbers should be accounted for on a subsequent tape submission. If more than one intermediary reports via the same tape, each must ultimately account for all batch numbers falling within his range of coverage.

3886.5 EXHIBITS.

l - Transmittal and Report Form
2 - Summary Totals Report