

Hospice LOC Report

User Guide

Prepared for

myUnity Essentials Financial



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Overview

The Hospice LOC Report is the first step in the billing process. It identifies patients missing their Level of Care information, performs billing edit checks, and generates Per Diem and Service Intensity Add-On (SIA) amounts. For Commercial payers reimbursing a flat daily rate instead of a calculated amount, the report generates Per Diem charges if **Warn if Insurance not set for Hospice Bill Method** is unchecked on the 'More Options' tab.

Any time information is re-posted from Clinical to Billing, confirm via the Clinical Integration Log that the record(s) shows as Success.

The Hospice LOC Report should also be re-run for Exceptions for previous months to check for changes in Level of Care dates made after the LOC charge creation routine has been run and to add SIA amounts for previous dates when applicable.

Selection Criteria

Below is an overview of the options available for running the report along with the recommended selections. The report should first be run with the box checked on the More Options tab for "Only Patients with Missing LOC" so those patients can be corrected and then run a second time with that option unchecked to perform edits based on the Level of Care.

General Options tab

The screenshot shows the 'Hospice LOC Report' window with the 'General Options' tab selected. The options are as follows:

- Report Sequence:** Patient, LOC
- Selection Type:** All, Insurance, Patient, Fin-Class, Unit
- Report Detail:** Patient Detail, Diag/Cert Detail, Location Detail, Charge Detail
- Billing Period:** September 2021
- Custom Date Selection:** From: 9/1/2021 To: 9/30/2021
- Hospice Insurance Type:** All: Medicare Hospice Rev Type
- Level of Care:** All: [Dropdown]
- Financial Class:** All: [Dropdown]
- Report Type:** All Records, Exceptions Found, Ready To Bill
- Export Report
- Create/Fix LOC Charges

At the bottom, there are buttons for 'Preview', 'Print', and a help icon.

Report Sequence: Determines the sort order on the report. Available selections are Patient (recommended) and LOC (Level of Care).

Selection Type: The report can be run for All Records or narrowed down to specific Patients, Units, or Insurances via the 'Specific Includes' tab. Choose All Records to enable the Create/Fix LOC Charges option.

Report Detail: Checking any of these options controls the edit checks performed when the report is run and provides more detailed information on the report output. Although it creates a longer report, it is recommended to have ALL options checked.

Patient Detail – shows each patient's Level of Care, insurance, and rate information.

Diag/Cert Detail – shows each patient's certification start/end dates, Benefit start date and first 3 diagnosis codes.

Location Detail – shows each patient's location of care, dates, corresponding CBSA information and Facility Type and NPI.

Charge Detail – shows each patient's visits along with imported meds and per diem charges.

Billing Period: Select the current hospice billing month and year. If running for the Medicare Cost Report, set the Billing Period month to 'Custom' and enter the Custom Date Selection.

Custom Date Selection: Enabled if the Billing Period month is set to 'Custom.' Typically used for obtaining annual Medicare Cost Report figures or to view the fiscal year hospice CAP amounts.

Hospice Insurance Type: Select the Medicare Hospice Revenue Type from the dropdown if not running the report for a specific Patient/Unit/Insurance. Otherwise, leave 'All' checked.

Level of Care: Leave 'All' checked to view all patients LOC (recommended). Uncheck the box and use the dropdown to run the report for a select LOC, typically only done if running for the Medicare Cost Report.

Report Type

All Patients: Check to include all patients, including those with exceptions.

Exceptions Only: Check this box to view only patients who have exception messages needing to be addressed. It is recommended to choose this option first and after exceptions have been cleared run the Ready to Bill report.

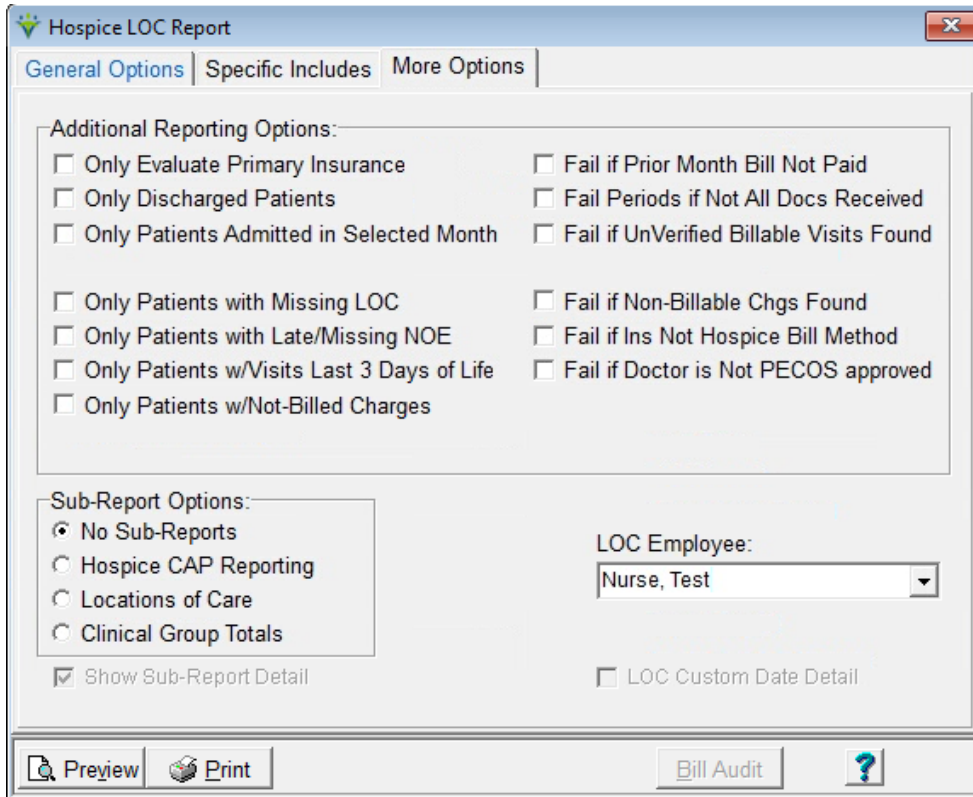
Ready to Bill: Select to identify patients who are ready for a Billing Audit. After previewing/printing this report the Bill Audit button will enable.

Create/Fix LOC Charges: This option is enabled when the Report Type is set to 'All Patients'. This selection will generate the Level of Care charges (this routine replaces the Level of Care charge generation located in the Charge>Auto Charge Generation menu). Checking this option will also correct some of the LOC errors found on the Exceptions Report.

More Options tab

It is generally recommended to leave each of these options unchecked except for “Include Sequester % in Billed Amount Calculation,” “Fail if UnVerified Visits Found,” and “Warn if Insurance Not Setup for Hospice Bill Method.” When running for Medicare Hospice, choosing the “Only Evaluate Primary Insurance” option is recommended.

In addition, the report should be run separately with the option checked for “Only Show Patient with Missing LOC” as it allows you to view the patients whose Level of Care didn’t post from Clinical and who would otherwise be omitted from the report as a result.



Additional Reporting Options

Only Evaluate Primary Insurance: Check to only include patients whose primary insurance is the selected Insurance/Hospice Insurance Type.

Only Discharged Patients: Choose to report only patients discharged within the Billing Period selected.

Only Show Patient with Missing LOC: Select to produce a list of patients missing Levels of Care

Only Show Patients Admitted in the Selected Month: Choose to only include patients that were admitted with in the report date range.

Only Show Patients with Unbilled Period Charges: Select to only show patients whose charges have not been posted to a Billing Audit.

Show Not-Billed Amounts: If selected, shows a breakout of Actual-Bill-Amt (Per Diem amount billed) and Not-Bill-Amt (Per Diem amount not billed) on the Grand Totals page of the report. Designed for agencies using a Custom Date range to determine amounts not billed.

Include Sequester % in Billed Amount Calculations: Check to reduce billed amount total calculations by the regulatory sequester percentage.

Only Patients with Late/Missing NOE: If checked, will show only patients whose NOE Date is more than 6 days after the patient's Admit Date or is blank. Used to help track patients whose NOE was submitted late and may need an exception request or whose NOE was not submitted yet.

Include UnVerified Visits/Fail: Check to edit on visits that are not marked as verified (completed). If the Fail option is selected, then a failure instead of a warning will be generated when an un-verified charge is present.

Fail if Prior Month Bill has Not Been Paid: Check for a claim to appear on the Exceptions Found report instead of Bills Ready if any prior month's claim does not have a payment posted.

Fail Certs Without All Docs Received: Check this option for an exception to be generated when the All Docs Received button in the Patient>Certify tab is not checked.

Fail if UnVerified Billable Visits Found: if checked will show an exception message for billable charges that are not marked Complete/Verified.

Fail if Non-Billable Chgs Found: if checked will show an exception message if a non-billable charge is found.

Warn if Insurance Not Setup for Hospice Bill Method: If selected a warning will appear on the report indicating the patient's insurance has not been switched to the Hospice Bill Method in Entity Maintenance.

Sub-Report Options

No Sub-Reports: When selected, none of the additional report detail from options below will be included.

Hospice CAP Reporting: Select to include CAP amounts based on patient stays with your agency. CAP information will appear at the end of the report in the Grand Totals section. When chosen, the fiscal year dates must be selected in the Custom Date Selection.

Locations of Care: Select to include a summary on the last page of the report to show by Locations of Care a Days and Patient count by Q-Code. Provides an unduplicated patient count by their first Location of Care in the period.

Clinical Group Totals: Select to include a diagnosis clinical group breakout at the end of the report for patient counts - days, patients, unduplicated patients, deaths and live discharges by location. (used for [Maryland Hospice State Survey](#), see examples below).

Show Sub-Report Detail: Check to show patient or institute detail lines for the Sub-Report option chosen above.

LOC Employee: This field is enabled when 'Create/Fix LOC Charges' is selected. Choose the LOC employee (ex. Nurse, Test) from the drop-down. All users should have the same employee selected here to avoid creation of duplicate per diem charges.

Exception Messages

####-Chgs: # <> LOC-days:#

This exception indicates that the per diem charges do not equal the number of days listed for the Level of Care. This could indicate Level of Care charge creation has not been run for this patient, the patient had duplicate levels of care entered, or the Level of Care dates were changed after the LOC Charge Generation was run.

- Review the Hospice LOC Report to confirm the correct LOC and dates are entered for the patient.
- Re-run the Hospice LOC Report for Report Type '**All Records**', choosing the **Create/Fix LOC Charges** option.
- Go to **Charge>Enter/Maintain** to delete any incorrect per diem charges.

All Docs not Received

This exception is enabled via the More Options tab.

- In your clinical software, confirm all orders are marked as sent and returned. If the documents do not have a received date in the **Patient > Docs** tab in **Billing** check the Integration log for errors.
- This option can be un-checked in the **More Options** tab if you wish to bypass it.

Bill-To Charge Not Found

This indicates that the Level of Care listed does not have a Bill-To Charge assigned in Category Maintenance.

- Go to **File>File Maintenance>Category>Level of Care Type** and select the Level of Care that received this exception (ex: *Respite*).
- In the **Bill-To Charge** select the charge code associated with that **LOC**.

Bill-To/LOC Charge Mismatch

This indicates that a charge is present that does not correlate to the Level of Care assigned to the patient (ex: a Routine charge is present for a date when the patient's Level of Care is listed as Inpatient). This scenario may occur if the patient's Level of Care was changed after the LOC Charge Creation was run or if non-per diem charges are present with a level of care revenue code. Also confirm the SIA charge code does not have a Medicare Hospice Type listed in the Revenue Code tab.

- Review the **Hospice LOC Report** to confirm the correct LOC and dates are entered for the patient.
- Re-run the **Hospice LOC Report** for **Report Type 'All Records'**, choosing the **Create/Fix LOC Charges** option.
- Go to **Charge>Enter/Maintain** to delete any incorrect per diem charges.
- Go to **File>File Maintenance>Charge Code>Revenue-Codes** tab to correct revenue codes. Make sure none of the visit charges are assigned to an LOC revenue code.

Bill Rate Missing

This exception indicates the Medicare Hospice Rate table may not be current.

- Go to **File>File Lists>PPS Rates**
- Enter **Date Selection** to include the billing year.
- In the **Type** drop-down list choose **Hospice**.
- If billing **Quality** leave this checked and preview the report to confirm the rates are present.
- Contact Netsmart Support if rates are not current.

CBSA code/rate missing

CBSA codes are used as part of the Per Diem rate calculation based on where the patient is receiving services (home or in a facility). CBSA rates are stored under **File > File Maintenance > Category** in the County table, Rates tab (set the Rate Type drop-down to 'Hospice').

- If the patient is receiving hospice care in the home, the **CBSA code** reads from the **Patient file>Patient tab 'County'** field.
 - If the **County** is missing, add it in the Clinical **Patient Profile** and resend the profile to Billing.
 - Confirm via the Clinical **Integration Log** that the profile exported successfully.
- If the patient is receiving hospice care in a facility, the **CBSA** is read from the setup under **File > File Maintenance > Entity > Institute type** on the **Name/Address** tab.
 - If the **County** is missing, add it in Billing.
- If hospice **CBSA** rates are missing for any of your counties, please contact Netsmart Support.

Cert-Admit Mismatch

The certification period is located in Billing in the Patient file Certify tab and is created when the Plan of Care or HIS admission assessment is sent over from Clinical. This message will appear if the patient's admit date was changed after the cert record was already created in Billing.

- Go to the **Patient file>Certify** tab and confirm the cert start date shown is prior to the patient's admit date. If the patient's admit date is correct, change the Cert From Date to the patient's admit date and adjust the Cert From date accordingly.

Cert-Period is Held

Claims whose dates fall within a Certification Period that is marked as Held in the Patient>Certify tab will show as a failure.

- If the certification period should not be marked as **Held**, un-check this setting in the **Patient>Certify** tab.
- To run the billing audit without changing the **Held** status, the claim can be posted via the **Billing Audit** menu with the **Exclude Held certs** option un-checked.

Cert-Period Missing

The certification period is located in Billing in the Patient file Certify tab and is created when the Plan of Care or HIS admission assessment is sent over from Clinical. This message will appear if the cert record has not been created in Billing.

- Go to the **Patient file>Certify** tab and confirm the cert records that cover the billing period are present keeping in mind there may be more than one cert record that covers the billing month.
- If the cert record is missing, go to the Clinical **Patient Chart** and (re)export the **HIS admission assessment** or **Plan of Care**.
 - Confirm via the Clinical **Integration Log** that the re-exported records successfully posted over.

Continuous Skilled Time Less Than ½ Total

This exception indicates that the patient has a **Continuous Level of Care**, but charges do not meet the continuous care requirement that skilled visit time equal at least half of total time.

- Confirm all visits are entered in Clinical with correct visit time and re-export to Billing if needed.
- Review the **Continuous Level of Care** dates and make corrections in Clinical and re-export to Billing if needed.
- If the patient doesn't meet the Continuous care billing criteria, change their **Level of Care** in the Clinical **Patient Profile** and re-export to Billing.
 - Re-run the Hospice LOC Report for Report Type '**All Records**', choosing the **Create/Fix LOC Charges** option.

Continuous Time Error

This exception indicates the patient has Continuous Level of Care listed but has not met the requirements for minimum 8 hours of care, half of which performed by an RN or LPN. If 'Charge Detail'

is checked when running the report, more precise warnings will appear as to whether its due to less than 8 hours of care or skilled time less than half the total time provided.

- Confirm all visits are entered in Clinical with correct visit time and re-export to Billing.
- Review the Continuous Level of Care dates and make corrections in Clinical and re-export to Billing if needed.
- If the patient doesn't meet the Continuous care billing criteria, change their **Level of Care** in the Clinical **Patient Profile** and re-export to Billing
 - Re-run the **Hospice LOC Report** for **Report Type 'All Records'**, choosing the **Create/Fix LOC Charges** option.

Continuous Time More Than 24 Hours

This exception indicates that the visit time for one day has totaled more than 24 hours.

- Review the visit times in Clinical and make necessary corrections to export to Billing.
- Review the **Level of Care** dates and make any necessary corrections in Clinical and re-export to Billing.

Death Date prior to Admit

This exception indicates the patient's date of death is prior to the patient's admit date.

- In Clinical, review the **Date of Death** in the Patient Profile and confirm it is entered correctly.
- If the admission is for **Bereavement**, confirm the correct **Unit** is selected and no **Level of Care** selected.
- Make any corrections as necessary in the **Patient Chart** and/or **Patient Profile**.
 - Confirm via the Clinical **Integration Log** that the **Patient record** successfully posted over.

Diagnosis [xxxxx] Expired [date]

This indicates a diagnosis in the 485 expired in the billing period.

- Correct the diagnosis code in the Clinical form and post the Diagnosis Export to Billing. Confirm via the Clinical Integration Log that the reposted record shows as Success.

Discharge <> Death Date

This exception indicates the patient's date of death is not equal to the discharge date.

- In Clinical, review the **Date of Death** in the Patient Profile and compare this to the Discharge Date.
- Make any corrections as necessary in the **Patient Chart** and/or **Patient Profile**.

- Confirm via the Clinical **Integration Log** that the **Patient record** successfully posted over.

Facility Zip or State Invalid

This exception indicates the location of care facility is missing the State or zip code or the zip code is not 9 digits.

- In Clinical, go to **View Facility**, select the facility and edit the record to correct the State or zip code.
 - Confirm via the Clinical **Integration Log** that the Facility Library record successfully posted over.

Note: When checking the Integration Log in Clinical to confirm the Facility exported successfully, choose the “Facility” Type in the Filter selection.

Tip: the USPS.com website allows for zip code lookup if the 9-digit zip is unknown.

Gap in LOC Dates

This exception indicates that there is a gap in the start and end dates between **Levels of Care** for the Patient.

- Correct the **Level of Care** dates in Clinical and re-export the profile to Billing.

Note: When checking the Integration Log in Clinical to confirm the LOC information exported successfully, choose the “Level of Care” Type in the Filter selection.

Greater Than 5 Respite Care Days

Medicare will not pay for respite care that is more than 5 continuous days at a time, which includes the date of admission but does not count the date of discharge. If the patient has a **Respite Level of Care** that exceeds 5 continuous days, this message will be displayed.

- Go to the Clinical **Patient Profile** and adjust the **Level of Care** dates so that **Respite** is no more than 5 continuous days.
- Confirm via the Clinical **Integration Log** that the **Level of Care** record successfully posted.

Held Charge Found

Hospice claims cannot be billed if charges for the period are marked Held. Held visits are indicated by an 'h' in the Status column of the report.

- Go to Charge > Enter/Maintain and select the Patient. Uncheck the Held box for the visit.

Institution Date Error Detected

This exception indicates the location of care Facility dates are not valid (i.e. the Start date is greater than the End Date).

In Clinical, review the dates for the **Location of Care** in the **Patient Profile**. Make any necessary corrections and re-export to Billing.

- Confirm via the Clinical **Integration Log** that the **Location of Care** record successfully posted.

Note: When checking the Integration Log in Clinical to confirm the Location of Care exported successfully, choose the “Location of Care” Type in the Filter selection.

Institution Date Overlap Detected

This exception indicates there are overlapping location of care dates.

- In Clinical, review the dates for the location of care in the **Patient Profile**. Make any necessary corrections and re-export to Billing.
- Confirm via the Clinical **Integration Log** that the **Location of Care** record successfully posted.

Note: When checking the Integration Log in Clinical to confirm the Location of Care exported successfully, choose the “Location of Care” Type in the Filter selection.

Insurance Not Found

This exception indicates that insurance information is missing or invalid for the patient.

- Confirm the correct insurance information (*i.e. Start/End dates*) is entered in the Clinical patient profile and re-export the profile to Billing.
- In Billing, go to **File>File Maintenance>Entity>Insurance Type** and confirm in the **Insurance** tab that all the information is entered and accurate.
- Make sure on the **Ins-Rates** tab the **Revenue Code** shows correctly at the bottom of the window for the LOC charges
 - If they don't appear, it could be due to bad start/end dates here or in the **Charge Code** file **Revenue Code** tab for the **Hospice Revenue Type**.
- Contact Netsmart Support if you need assistance with this step.

Less Than 8 Hrs

This message will only display if “Charge Detail” is checked on the General Options tab of the report and means the patient has Continuous Level of Care listed but has not met the requirements for minimum 8 hours of care, half of which performed by an RN or LPN.

- Go to **Charge > Enter/Maintain** in Billing and select the patient to confirm that all of the visits are present.
- In the **Clinical Patient Chart**, send over any visits that haven't been posted successfully and confirm via the Clinical **Integration Log** that the **Visit Notes** show Success.
- If the patient has not met the minimum care time requirement, correct their Level of Care in the Clinical **Patient Profile** and confirm the **Level of Care** record successfully posts over.

- Re-run the **Hospice LOC Report** for **Report Type 'All Records'**, choosing the **Create/Fix LOC Charges** option.

LOC End-Date Incorrect

This exception indicates the LOC end date does not equal the discharge date or end of the month.

- Review the patient's **LOC Dates** and **Discharge date** to confirm which is correct.
 - If the **Discharge date** is incorrect, make the correction in Clinical and export patient profile to Billing.
- If the **LOC dates** are incorrect in Clinical, correct the **Level of Care** dates in Clinical and re-export the profile to Billing.

Note: When checking the Integration Log in Clinical to confirm the LOC information exported successfully, choose the "Level of Care" Type in the Filter selection.

- Re-run the **Hospice LOC Report** for **Report Type 'All Records'**, choosing the **Create/Fix LOC Charges** option.

LOC Start-Date <> Admit

This exception indicates the LOC start date does not equal the admit date.

- Review the patient's **LOC Dates** and **Admit Date** to confirm which is correct.
 - If the **Admit date** is incorrect, make the correction in Clinical and export patient profile to Billing.
- If the **LOC dates** are incorrect in Clinical, correct the **Level of Care** dates in Clinical and re-export the profile to Billing.

Note: When checking the Integration Log in Clinical to confirm the LOC information exported successfully, choose the "Level of Care" Type in the Filter selection.

- Re-run the **Hospice LOC Report** for **Report Type 'All Records'**, choosing the **Create/Fix LOC Charges** option.

Missing/Bad Death Date

This exception indicates either the patient has a discharge reason of **Expired**, but the date of death is not present in the Patient file in Billing, or the patient has been discharged with an Expired reason code, but the Date of Death is *after* the claim period.

- In Clinical, confirm the **Date of Death** is entered for the patient in the **Patient Profile** and re-export the profile to Billing.
 - Confirm via the Clinical **Integration Log** that the **Patient Profile** posted successfully.
- If the **Date of Death** is after the billing period, the discharge reason for this admit record cannot be Expired.

- Change the **Discharge Reason** and confirm via the **Clinical Integration Log** that the **Patient Profile** posted successfully.

Missing Discharge Status

This exception indicates that there is a **Date of Death** that falls within the billing period but the patient does not have a valid hospice Expired discharge code (ex. 40 for expired at home) .

- Correct the **Discharge** reason in the Clinical patient profile and re-export profile to Billing.
 - Confirm via the **Clinical Integration Log** that the **Patient Profile** posted successfully.

Missing LOC

This message will only display if “**Only Show Patients with Missing LOC**” is checked on the **More Options** tab of the report and means the patient’s **Level of Care** has not posted over from Clinical to Billing.

- Go to the Clinical **Patient Profile** and confirm a **Level of Care** is present and post it over to Billing.
 - Confirm via the **Clinical Integration Log** that the **Level of Care** record successfully posted over.

No Charges Found

This message will display if the patient is listed as active for the billing period but no visits or per diem records exist.

- Go to **Charge > Enter/Maintain** in Billing and select the patient to confirm which charges, if any, are showing in Billing.
- In the Clinical **Patient Chart**, send over any visits that haven’t been posted successfully.
 - Confirm via the **Clinical Integration Log** that the **Visit Notes** show **Success**.
- If the patient has no visits because they have been discharged from the agency, make sure they have a **Discharge status** and **Discharge Reason** in the Clinical **Patient Profile**.
 - Resend the Patient Profile to Billing.
 - Confirm via the **Clinical Integration Log** that the **Profile** has posted successfully.

NOE Date

The NOE date will be displayed in red for any patients who have a late NOE date present in the **Patient >Admit > Addt’l Dates** tab.

- If the date is the correct one, no action is required as long as the **Patient > Insurance > Bill Data** has been entered for **LateNOE**.
- If the date is incorrect, change it under **Patient > Insurance > Bill Data** on the **LateNOE** line or under **Patient > Admit > Addt’l Dates** tab.

Non-Billable Chgs

This failure is enabled via the **More Options** tab and is produced if a non-billable charge is present that hasn't been posted via a billing audit and no billable charges are present to be billed.

- To post the audit, unbill the previously billed billable charges via Payments. Uncheck the "Fail NonBillable Chgs Found." The patient should then show as Ready to Bill. Once the Billing Audit has been posted, the checkbox can be checked again.

Non-Hospice Bill Method

This warning message is enabled via the **More Options** tab. If an insurance has the same billing requirements and reimburses the same as Medicare, the payer should be set up for the Hospice Bill Method.

- If you wish to switch a payer to the **Hospice Bill Method** setup contact Billing Support.

NPI Missing for Facility

This exception indicates the patient's Facility is missing the NPI.

- In Clinical, go to **View Facility**, select the facility and edit the record to add the NPI.
 - Confirm via the Clinical **Integration Log** that the **Facility** record successfully posted.

Note: When checking the Integration Log in Clinical to confirm the Facility exported successfully, choose the "Facility" Type in the Filter selection.

Order-Doctor Not Found

This exception indicates the Order record is missing in Billing or posted from Clinical with no Doctor information attached.

- Check the Clinical Integration Log for Fail or Decline messages for the Physician records and address any messages found.
- Repost the Diagnosis record from Clinical once the Physician information is corrected.

Order-Doctor is Not PECOS Approved

This exception indicates the doctor on the Order record isn't listed as PECOS enrolled.

- The Order Doctor is read from the Patient file, Certify tab, Orders sub-tab.
- Go to Clinical and run the PECOS check on the physician record to make sure they are listed as PECOS certified.
- Repost the Diagnosis record from Clinical once the Physician information is corrected.

Orphan Charge Found

This exception indicates there is a charge that is after the patient's discharge date. This could indicate either the discharge date or the visit date is incorrect.

- In Billing, run the **Charge Detail** List including claim date range, choosing **Orphans** as the **Subset Selection**, and choose **All** for the **Billed selection**.
- After identifying the orphaned charges, make the necessary corrections in your clinical software and confirm via the **Integration Log** that the changed records are successfully exported.
- Confirm billable visits are present in **Charge>Enter/Maintain**.
- If charges are present and fall within a valid admit/discharge date range:
 - Correct the Orphans by going to **Charge > Enter/Maintain** and select the patient in the dropdown on the **Summary** tab.
 - Go to the **Preferences** tab and press the “**Orphans**” button.
 - If a patient’s discharge and admission dates were updated after charges were already on file, some charges may be linked to the wrong admit record. They are considered “**Orphans**” and running this utility finds them and links them to the correct admission.

Overlapping Level of Care Dates Found

This exception indicates there are overlapping dates for the Levels of Care. Correct the dates in the Clinical Patient Profile.

Primary Diagnosis is not Valid

Diagnosis codes are read from the patient's Plan of Care record. This message will appear if the POC hasn't made it from Clinical to Billing successfully or if an invalid diagnosis code is present on the POC.

- Go to the **Patient file>Certify** tab.
- Select the cert for the billing period.
- On the ‘**Orders**’ tab on the lower half of the screen confirm a plan of care is present.
 - Do this for each cert that covers the billing month as there may be more than one.
- If a **POC** is missing, go to the Clinical Patient Chart and (re)export it.
 - Confirm via the Clinical **Integration Log** that the **Plan of Care** successfully posted.
- If the **POC** is present, confirm that the primary diagnosis code meets the **Medicare** guidelines for acceptable primary coding (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf>).
 - Make any corrections as needed in Clinical and re-export the plan of care to Billing.
 - Confirm via the Clinical **Integration Log** that the **Plan of Care** successfully posted.

Prior Bill xx/xx/xxxx has not been paid

This is an optional failure that can be chosen in the **More Options** tab. This message is shown if any months prior to the report month have claims with \$0 paid. This is to prevent claims from being returned to the provider as out of sequence.

- Go to **A/R>Payments/Transfers** and locate the prior claim.
 - Confirm it is marked with a **Submit-Date**.
- After confirming the claim was submitted, check **999/277 files** via the **Claim Status** menu to confirm the file was accepted.
- Check for **Medicare payment files** and **process/post any payments**.
 - Contact **Medicare** if the claim shows as submitted and accepted and you are unable to locate the payment.
- If the claim was processed in **Medicare** but no payment has been applied yet in Billing, the user can go to the **Hospice LOC Report>More Options** tab to bypass this exception.

Q-Code not Valid for 0655/0656

Q-codes (designating location of care) **Q5001/Home**, **Q5002/ALF**, and **Q5003/LTC** (allowed for GIP) may not be reported on the claim for **Respite Care** (rev code 0655) or **GIP** (rev code 0656). If this warning message appears, it may be due to the wrong **Level of Care** or dates on file for the patient, incorrect **Facility information**, or incorrect **Facility setup**.

- Go to the **Patient file 'Other'** tab to confirm the proper **Level of Care** and dates are present.
 - Make any changes in the Clinical **Patient Profile** and resend to Billing.
 - Confirm via the Clinical **Integration Log** that the **Level of Care** successfully posted.
- Go to the **Patient file>Assign** tab and confirm the proper Institute and dates are present.
 - Make any changes in the Clinical **Patient Profile** under **Location of Care** and resend to Billing.
 - Confirm via the Clinical **Integration Log** that the **Location of Care** successfully posted.
- Go to the **Facility setup** in Clinical and confirm the proper Facility Type is listed

Note: 'Other' cannot be used for hospice.

- Make any changes and resend to Billing.
- Confirm via the Clinical **Integration Log** that the **Facility** successfully posted.

Revenue Code Not Valid

This exception indicates that the revenue code assigned to the per diem charge code is missing or not valid. For example, if this message appears under **Respite Home Care** on the report, the **Bill-To Charge** linked to this **LOC** does not have the revenue code set up completed properly.

- In Billing, go to **File>File Maintenance>Charge Code** and select the charge code linked to the **Level of Care** with this message (ex. *RESPITE*).
- Go to the **Revenue-Codes** tab and confirm the correct **Insurance Types** are entered (ex. *Medicare Hospice Rev type*) with the correct **Code** (ex. *0655*) and with correct **Start** and **End Dates**.

Zero Gross Charge Found

This message indicates that a visit charge is missing a bill rate. The charge will be indicated on the report with the text “**Bad**” in red next to it.

- Go to **File>File Maintenance>Charge Code** and select the “**Bad**” charge.
- On the **Bill-Rate** tab enter the appropriate gross and net rates.
 - If the charge is non-billable make sure that option is checked on the **Charge** tab and the charge is assigned to the correct modality.

Zero Time Charge Found

This exception indicates that a visit charge is missing visit time. To identify the visit missing time, locate the visit charge(s) with 0.00 Tot-Time.

- If the charge originated in **Clinical** confirm the **In and Out times** for that visit were entered and re-post visit note.
 - Confirm via the **Integration Log** that the visit exported successfully.
- If the charge was entered manually in Billing the visit time can be corrected in **Charge>Enter/Maintain**.