

Medicare Program Integrity Manual

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

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CHANGE REQUEST 1981

<u>CHAPTERS</u>	<u>REVISED SECTIONS</u>	<u>NEW SECTIONS</u>	<u>DELETED SECTIONS</u>
6	3 3.1 3.2 3.3 3.4 3.5 3.6 3.7	3.8	
Exhibits		29 30 31	

NEW/REVISED MATERIAL--EFFECTIVE DATE: May 2, 2002
IMPLEMENTATION DATE: May 2, 2002

Chapter 6, Section 3.1, Form CMS-485 - Home Health Certification and Plan of Care Data, clarifies the use of Form CMS-485 (the plan of care form) is not a CMS requirement. However, Home Health Agencies (HHAs) must have all required plan of care data elements contained in a readily identifiable location within the medical record.

Chapter 6, Section 3.2, Addendum to Form CMS-485 Plan of Care, provides HHAs the discretion to use a preprinted addendum to the plan of care when needed or any other format signed and dated by the physician.

Chapter 6, Section 3.3, Medical Review of Home Health Claims, instructs contractors to notify providers that they have 30 days to submit medical records for MR purposes but if the documentation is not received within 45 days, to make a MR determination based on available documentation. This section instructs contractors that they cannot reject the claim or return the claim to the provider when medical records are not submitted by the provider.

Chapter 6, Section 3.4.1, General, instructs contractors that once they establish that the episode met Medicare coverage requirements and was billed appropriately, it may not be necessary to continue review of the record. It instructs contractors not to conduct MR on the request for anticipated payment (RAP).

Chapter 6, Section 3.4.2, Types of Review, defines pre-claim and post-claim review. It instructs contractors to target MR primarily on a pre-claim targeted basis.

Chapter 6, Section 3.4.3, MR Process, should be conducted after validating provider/service specific billing errors.

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Table of Contents Medicare Program Integrity Manual Chapter 6

1. Understanding the eBook Medicare Program Integrity Manual Chapter 6
 - The Rise of Digital Reading Medicare Program Integrity Manual Chapter 6
 - Advantages of eBooks Over Traditional Books
2. Identifying Medicare Program Integrity Manual Chapter 6
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Medicare Program Integrity Manual Chapter 6
 - User-Friendly Interface
4. Exploring eBook Recommendations from Medicare Program Integrity Manual Chapter 6
 - Personalized Recommendations
 - Medicare Program Integrity Manual Chapter 6 User Reviews and Ratings
 - Medicare Program Integrity Manual Chapter 6 and Bestseller Lists
5. Accessing Medicare Program Integrity Manual Chapter 6 Free and Paid eBooks
 - Medicare Program Integrity Manual Chapter 6 Public Domain eBooks
 - Medicare Program Integrity Manual Chapter 6 eBook Subscription Services

- Medicare Program Integrity Manual Chapter 6 Budget-Friendly Options
- 6. Navigating Medicare Program Integrity Manual Chapter 6 eBook Formats
 - ePub, PDF, MOBI, and More
 - Medicare Program Integrity Manual Chapter 6 Compatibility with Devices
 - Medicare Program Integrity Manual Chapter 6 Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Medicare Program Integrity Manual Chapter 6
 - Highlighting and Note-Taking Medicare Program Integrity Manual Chapter 6
 - Interactive Elements Medicare Program Integrity Manual Chapter 6
- 8. Staying Engaged with Medicare Program Integrity Manual Chapter 6
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Medicare Program Integrity Manual Chapter 6
- 9. Balancing eBooks and Physical Books Medicare Program Integrity Manual Chapter 6
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Medicare Program Integrity Manual Chapter 6
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Medicare Program Integrity Manual Chapter 6
 - Setting Reading Goals Medicare Program Integrity Manual Chapter 6
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Medicare Program Integrity Manual Chapter 6
 - Fact-Checking eBook Content of Medicare Program Integrity Manual Chapter 6
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
- 14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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