Medical Care Collection Fund (MCCF) eBilling Compliance Phase 3

Claims Tracking and Health Care Services Review – Request for Review and Response (278)

Document Version 2.0

User Guide

September 2016

Revised May 2018

Department of Veterans Affairs

Office of Information and Technology (OI&T)

Revision History

Date	Revision	Description	Author
May 2018	3.0	Updated for patch IB*2*568 which added new security key IB PARAMETER EDIT. Also added new menu option “Manually Add Prosthetics to Claims Tracking” to the Supervisor’s Menu (Claims Tracking)	PM: A.I. Tech Writer: E.G.
August 2016	2.0	Updated to reference patient policy comments within the Patient Insurance Screens due to patch IB*2.0*549.	PM: T.T Tech Writer: D.W.
August 2016	1.0	Initial Document	PM: T.T Tech Writer: A. D.

Table of Contents

Table of Figures

1. Introduction

The Claims Tracking module within VistA, is designed to be used by both billing personnel and utilization review (UR) staff. Claims Tracking tracks patient care events such as inpatient admissions, outpatient appointments, prescription releases and issuances of prosthetic devices. These events are most often added to Claims Tracking automatically but they may also be added manually when necessary.

Parameters that control Claims Tracking are defined in the Medical Care Cost Recovery (MCCR) Site Parameter Display/Edit option.

Claims Tracking is used by the automated billing processes in VistA to determine when and if an event should be billed to a third-party payer.

In 1996, Congress passed into law, the Health Insurance Portability and Accountability Act (HIPAA). This Act directs providers and payers to adopt national electronic standards for automated transfer of certain healthcare data between healthcare providers and payers.

One of the standardize transactions for exchange of data is the ASC X12N Health Care Services Review – Request for Review and Response (278). The 278 transaction is designed to allow a provider to request authorization or certification of healthcare services from a Utilization Management Organization (UMO). Initiation of requests and receipt of responses are managed from within Claims Tracking.

The 278 transaction is designed to support the following business events:

- Admission certification review requests and associated responses
- Referral review requests and associated responses
- Health care services certification review requests and associated responses
- Extend certification review requests and associated responses
- Certification appeal review requests and associated responses
- Reservation of medical services review requests and associated responses
- Cancellation of service reservations review requests and associated responses

1.1. Purpose

The purpose of this user guide is to provide end-users with instructions for using the Claims Tracking software.

1.2. Overview

VistA users (UR/RUR nurses) have the ability to manage insurance reviews and hospital reviews through the Claims Tracking module.

VistA users (UR/RUR nurses) have the ability to request authorization for healthcare events such as admissions and clinic appointments for claims tracking events identified by the software. Authorization for care numbers are then added to the claims creation process so that authorization numbers are submitted to the third-party payers as part of the claims.

The implementation of the electronic 278 transaction is intended to replace the manual processes that the sites' Revenue Utilization Review (RUR) nurses use to obtain authorization numbers as

well as the manual processes the billing personnel use to look up the authorization numbers and to add them to the healthcare claims.

Claims Tracking works in conjunction with other VistA modules such as clinical, admission/discharge and transfer (ADT), pharmacy, accounts receivable (AR) and integrated billing (IB).

Outpatient encounters are added to Claims Tracking by the IB MT NIGHT COMP task that runs each night.

VistA is an existing system with a 2 color, roll and scroll interface. There are no changes to the existing architecture, security or backup processes associated with the Claims Tracking software.

The outbound 278 request transactions will be HL7 messages from a VistA site to the Financial Services Center (FSC) in Austin, TX. FSC will then convert the HL7 messages to HIPAA compliant messages which will then be sent to a health care clearing house (HCCH). The HCCH will be responsible for transmitting the messages to the third-party payers or their utilization management organization (UMO).

The inbound 278 response transactions will be HL7 messages received by a VistA site from the FSC. The HCCH will receive HIPAA compliant responses from the payers and will send the responses to FSC. FSC will convert these responses to HL7 before sending them to the originating VistA sites.

1.3. Project References

Reference	Location	Date
Health Care Services Review – Request for Review and Response (278)	http://www.wpc-edi.com/	May 2006
eBilling 278 ICD	http://tspr.vista.med.va.gov/warboard/anotebk.asp?proj=1724&Type=Active	June 2016
Integrated Billing (IB) V. 2.0 User Manual	http://www.va.gov/vdl/documents/Financial_Admin/Integrated_Billing_(IB)/ib_2_0_um.doc	September 2015

1.4. Organization of the Manual

This document contains the following sections:

- Claims Tracking Master Menu
  - Claims Tracking Menu (Combined Functions) ...
  - Claims Tracking Menu for Billing ...
  - CT ENHANCED for CODERS/MCCR MENU ...
  - Claims Tracking Menu (Hospital Reviews) ...
  - Claims Tracking Menu (Insurance Reviews) ...

1.5. Acronyms and Abbreviations

Term	Definition
ADT	Admission/Discharge/Transfer
AR	Accounts Receivable
ASC	Accredited Standards Committee
CT	Claims Tracking
ECME	Electronic Claims Management Engine is the real-time claims processing engine for prescription (RX) claims
FSC	Financial Service Center
HCCH	Health Care Clearing House
HCSR	Health Care Services Review
HIPAA	Health Insurance Portability and Accountability Act
HL7	Health Level Seven International (HL7) is a not-for-profit, ANSI-accredited standards developing organization
IB	Integrated Billing
ICD	International Classification of Diseases
Ins.	Insurance
MCCR	Medical Care Cost Recovery
MT	Means Test
NUMI	National Utilization Management Integration (NUMI)
Opt.	Outpatient
Psych	Psychiatry
QA	Quality Assurance
ROI	Release of Information
RUR	Revenue Utilization Review
RX	Outpatient Prescription for Medication
TPJI	Third Party Joint Inquiry
UR	Utilization Review
UMO	Utilization Management Organization

2. System Summary

2.1. System Configuration

There are no specific system configurations associated with this project except those mentioned previously:

- Schedule IB MT NIGHT COMP

- Schedule IBT HCSR NIGHTLY PROCESS
- Define MCCR Site Parameter Display/Edit

2.2. Data Flows

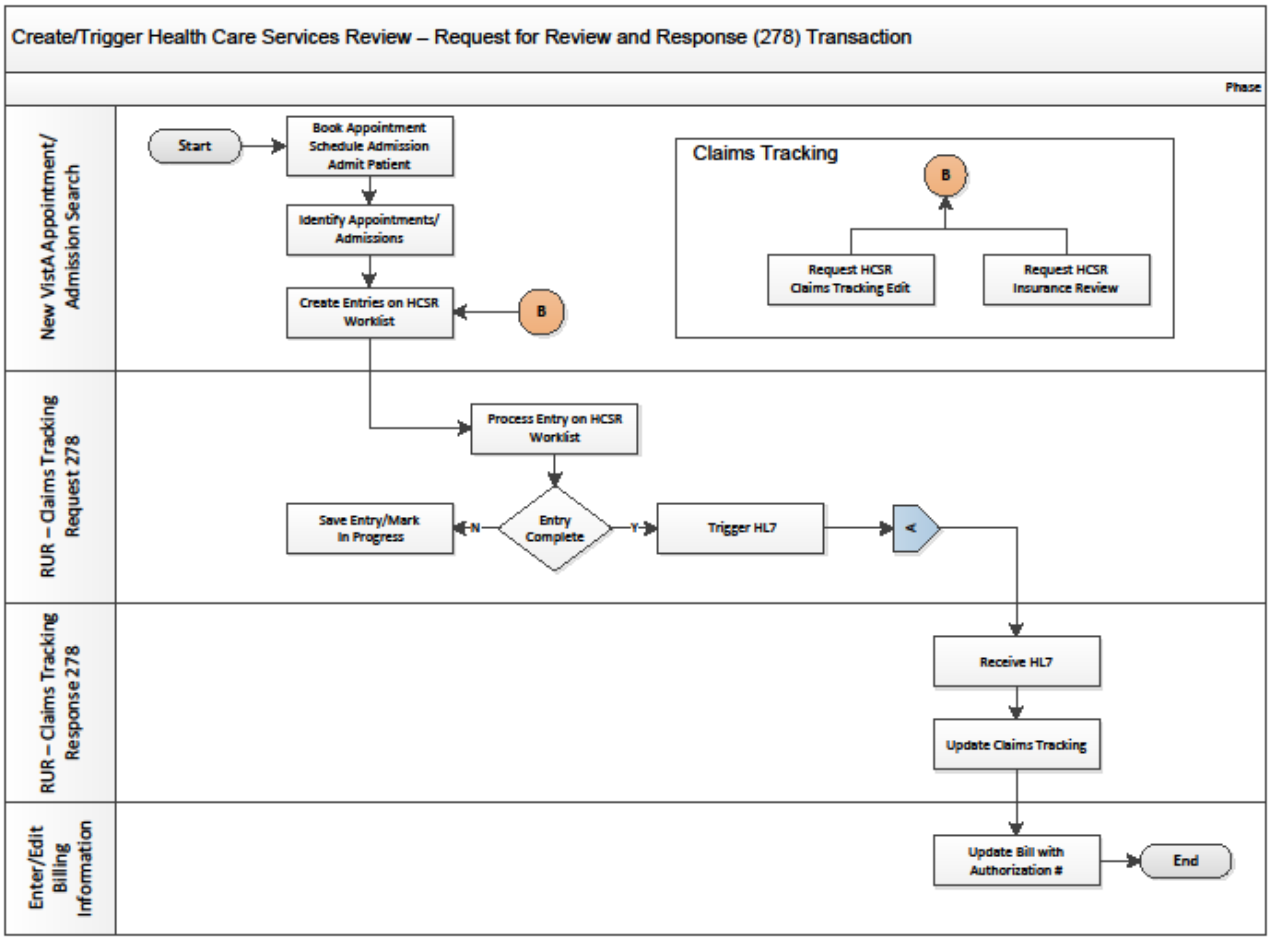

Figure 1: Health Care Services Review – Part 1

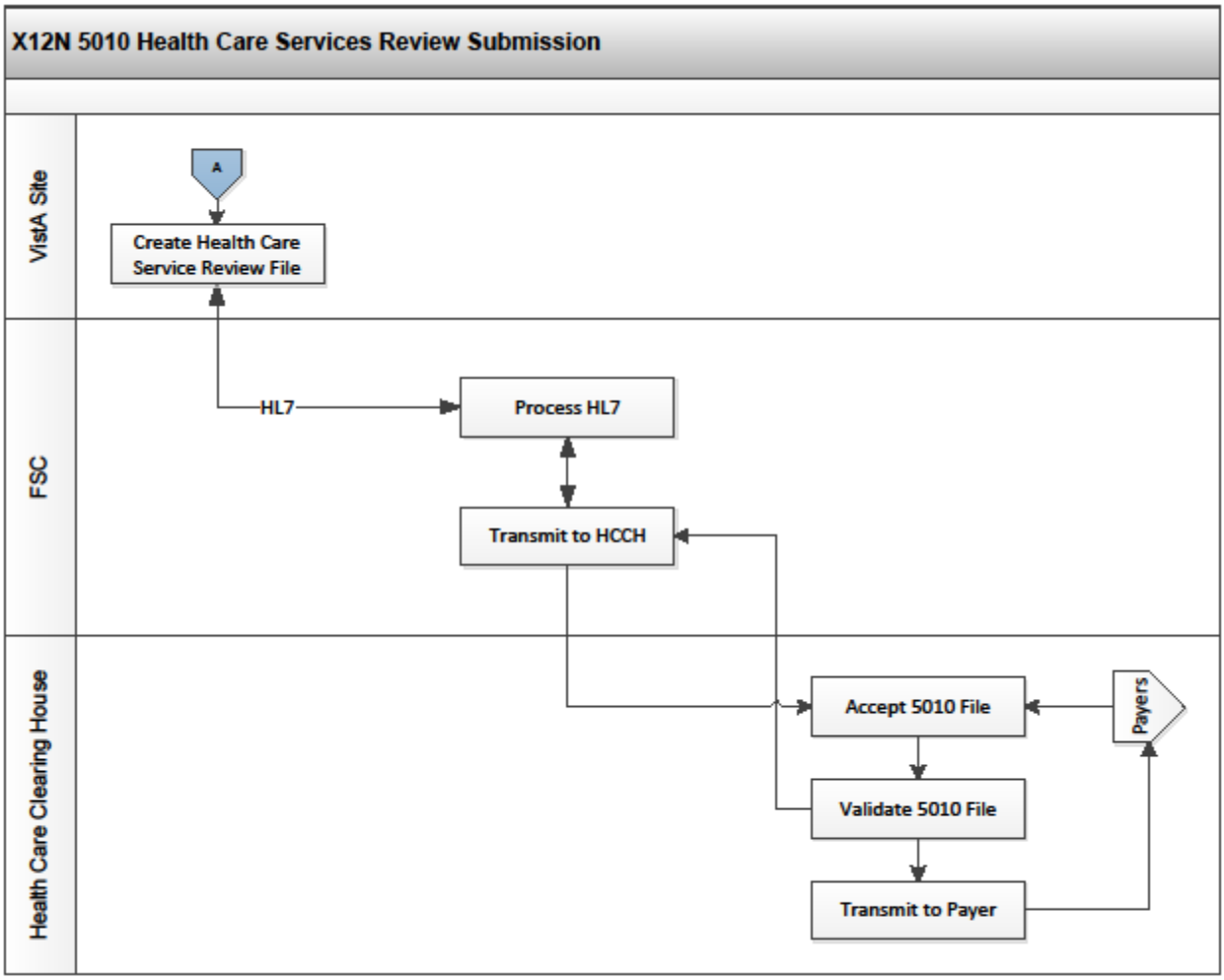

Figure 2: Health Care Services Review – Part 2

2.3. User Access Levels

This functionality is designed to be used by the RUR nurses and the billing personnel at the sites. The following security keys exist to support this functionality:

- IB PARAMETER EDIT – controls access to the MCCR Site Parameter Display/Edit option
- IB Claims Supervisor – controls access to the Supervisors Menu (Claims Tracking) ... option
- IB PARAMETER EDIT – controls access to the option Claims Tracking Parameter Edit which is located on the Supervisors Menu (Claims Tracking) parent menu option.
- IB HCSR Param Edit – controls access to the Health Care Services Review (HCSR) parameters within the MCCR Site Parameters

2.4. Contingencies and Alternate Modes of Operation

The request of authorization of health care services or events can be accomplished via the telephone and/or via some payers' websites.

Claims can be created manually if a biller has access to data from a patient care event.

3. Getting Started

There are no special requirements for logging on to or off of VistA associated with the Claims Tracking module.

3.1. Troubleshooting

There are no specific problems or issues associated with the use of the Claims Tracking software.

If there are no events being added automatically to the Claims Tracking software, contact your site's Information Resource Management (IRM) to make sure the IB MT NIGHT COMP task is scheduled to run each night and make sure the site's Claims Tracking parameters are set as desired by the RUR and billing personnel.

If there are no events being added automatically to the HCSR Worklist, contact your site's IRM to make sure the IBT HCSR NIGHTLY PROCESS task is scheduled to run each night and make sure the site's Claims Tracking parameters are set as desired by the RUR and billing personnel.

4. Claims Tracking Master Menu

The Claims Tracking module has a master menu that provides access to claims tracking for different groups of users. Each of the following menus is tailored to the expected users' workflow:

- **Claims Tracking Master Menu**

```
Select Integrated Billing Master Menu <TEST ACCOUNT> Option: CT  Claims Tracking
 Master Menu

   BI     Claims Tracking Menu for Billing ...
   CT     Claims Tracking Menu (Combined Functions) ...
   EN     CT ENHANCED for CODERS/MCCR MENU ...
   HR     Claims Tracking Menu (Hospital Reviews) ...
   IR     Claims Tracking Menu (Insurance Reviews) ...

Select Claims Tracking Master Menu <TEST ACCOUNT> Option:
```

- **Integrated Billing Menu**

```
Select Claims Tracking Master Menu <TEST ACCOUNT> Option: bi  Claims Tracking Me
nu for Billing

   CT     Claims Tracking Edit
   PS     Print CT Summary for Billing
   RN     Assign Reason Not Billable
   TP     Third Party Joint Inquiry

Select Claims Tracking Menu for Billing <TEST ACCOUNT> Option:
```

- **Combined Menu**

```
Select Claims Tracking Master Menu <TEST ACCOUNT> Option: ct  Claims Tracking Me
nu (Combined Functions)

   PR     Pending Reviews
   CT     Claims Tracking Edit
   SP     Single Patient Admission Sheet
   IR     Insurance Review Edit
   AD     Appeal/Denial Edit
   IC     Inquire to Claims Tracking
   SM     Supervisors Menu (Claims Tracking) ...
   RM     Reports Menu (Claims Tracking) ...
   HR     Hospital Reviews
   HW     Health Care Services Review (HCSR) Worklist
   HC     Health Care Services Review (HCSR) 278 Response

Select Claims Tracking Menu (Combined Functions) <TEST ACCOUNT> Option:
```

- **Coder Menu** - ***Note:*** No longer used
- **Hospital Reviewer Menu**

```
Select Claims Tracking Master Menu <TEST ACCOUNT> Option: HR  Claims Tracking Me
nu (Hospital Reviews)

   PR     Pending Reviews
   CT     Claims Tracking Edit
   HR     Hospital Reviews
   IC     Inquire to Claims Tracking
   RM     Reports Menu (Claims Tracking) ...
   SM     Supervisors Menu (Claims Tracking) ...
   SP     Single Patient Admission Sheet

Select Claims Tracking Menu (Hospital Reviews) <TEST ACCOUNT> Option:
```

Note: Hospital reviews are no longer done using VistA Claims Tracking. National Utilization Management Integration (NUMI) is a web-based application that supports hospital reviews.

- **Insurance Reviewer Menu**

```
Select Claims Tracking Master Menu <TEST ACCOUNT> Option: HR  Claims Tracking Me
nu (Hospital Reviews)

   PR     Pending Reviews
   AD     Appeal/Denial Edit
   CT     Claims Tracking Edit
   HC     Health Care Services Review (HCSR) 278 Response
   HW     Health Care Services Review (HCSR) Worklist
   IC     Inquire to Claims Tracking
   IR     Insurance Review Edit
   RM     Reports Menu (Claims Tracking) ...
   SM     Supervisors Menu (Claims Tracking) ...
   SP     Single Patient Admission Sheet
   TP     Third Party Joint Inquiry
Select Claims Tracking Menu (Hospital Reviews) <TEST ACCOUNT> Option:
```

5. Claims Tracking Menu (Combined Functions) ...

This menu combines many of the Claims Tracking options including the Supervisors Menu and the Claims Tracking parameters. This menu would be appropriate for a supervisory RUR Nurse or a RUR Nurse with multiple duties or a Billing Supervisor.

5.1. Pending Reviews

This option uses a series of screens to display all pending reviews that have a pending review date within the last seven days. Each day, a Pending Review List, sorted by ward, patient, assignment or date, should be printed and used to perform reviews. The Pending Reviews option may then be used to perform all necessary actions on the reviews. This option is available to individuals who do Insurance Reviews, Hospital Reviews or both. If the user performs both types of reviews, a plus sign (+) will appear by the names of patients needing both types of review. On admission, appropriate reviews are automatically made pending on the day they are added. Please refer to the Insurance Reviews and Hospital Reviews option documentation for information on when reviews are automatically created.

The following screens show the actions accessed through this option and the actions available on each subsequent screen:

```
                                  Pending Reviews
-------------------------------------------------------------------------------
QE  Quick Edit                IR  Ins. Reviews              RL  Remove from List
VE  View/Edit Entry           SC  SC Conditions             DU  Diagnosis Update
CT  Claims Tracking Edit      CS  Change Status             PU  Procedure Update
PW  Print Worksheet           CD  Change Date Range         PV  Provider Update
```

```
                             Expanded Claims Tracking Entry
-------------------------------------------------------------------------------
BI  Billing Info Edit         IR  Insurance Reviews         PV  Provider Update
RI  Review Info               DU  Diagnosis Update          EX  Exit
TA  Treatment Auth.           PU  Procedure Update
```

```
                              Insurance Reviews/Contacts
--------------------------------------------------------------------------------
AI  Add Ins. Review           SC  SC Conditions           PV  Provider Update
DR  Delete Ins. Review        AE  Appeals Edit            RW  Review Wksheet Print
CS  Change Status             AC  Add Comment             CP  Change Patient
QE  Quick Edit                DU  Diagnosis Update        EX  Exit
VE  View/Edit Ins. Review     PU  Procedure Update
```

```
                            Expanded Insurance Reviews
--------------------------------------------------------------------------------
AA  Appeal Address            AI  Action Info             PU  Procedure Update
CI  Contact Info              AC  Add Comments            PV  Provider Update
CS  Change Status             VP  View Pat. Ins           RW  Review Wksheet Print
IU  Ins. Co. Update           DU  Diagnosis Update        EX  Exit
```

```
                                 Pending Reviews
--------------------------------------------------------------------------------
QE  Quick Edit                HR  Hospital Reviews        RL  Remove from List
VE  View/Edit Entry           SC  SC Conditions           DU  Diagnosis Update
CT  Claims Tracking Edit      CS  Change Status           PU  Procedure Update
PW  Print Worksheet           CD  Change Date Range       PV  Provider Update
```

```
                                 Hospital Reviews
--------------------------------------------------------------------------------
AI  Add Next Hosp.Review      VE  View/Edit Review        CP  Change Patient
DR  Delete Review             DU  Diagnosis Update        EX  Exit
QE  Quick Edit                PU  Procedure Update
CS  Change Status             PV  Provider Update
```

```
                            Expanded Hospital Reviews
--------------------------------------------------------------------------------
AI  Add Ins. Review           SC  SC Conditions           PV  Provider Update
DR  Delete Review             AE  Appeals Edit            RW  Review Wksheet Print
CS  Change Status             AC  Add Comment             CP  Change Patient
QE  Quick Edit                DU  Diagnosis Update        EX  Exit
VE  View/Edit Review          PU  Procedure Update
```

Notes:

- The View Edit Entry action will take you directly to the Expanded Insurance or Expanded Hospital Reviews Screens depending on the type of review.
- The View Pat. Ins action brings you to the Patient Insurance Screens.
- The Appeals Edit action brings you to the Appeal and Denial Tracking screen.

5.1.1. About the Screens

In the top left corner of each screen is the screen title. A plus sign (+) at the bottom left of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right on the screen. Available actions are displayed below the screen. Two question marks entered at any "Select Action" prompt displays all available actions for that screen. For more information on the use of the screens, please refer to the appendix at the end of this manual.

You may quit from any screen, which will bring you back one level or screen, or you may exit (this exits the option entirely and returns you to the menu).

5.1.2. Common Actions

The following actions are common to more than one screen accessed through this option. They are listed here to avoid duplication of documentation:

- **Quick Edit** - This action allows you to quickly edit all information about the review without leaving the Pending Review option.
- **SC Conditions** - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.
- **Change Status** - This action allows you to quickly change the status of a review. Only completed reviews are used in the report preparation and by the MCCR NDB roll-up or the QM roll-up (which is tentatively scheduled for release in June 1994).
    - Reviews have a status of ENTERED when automatically added. A status of PENDING may be used for those you are still working on or when one person does the data entry and another needs to review it.
- **Add Comment** - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.
- **Diagnosis Update** - This action allows input of ICD diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary diagnosis, secondary diagnosis and the onset date of the diagnosis for this admission. For outpatient visits this information is stored with the outpatient encounter information.
- **Procedure Update** - This action allows the input of ICD procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional for use.
- **Provider Update** - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document individual physicians if the administrative record indicates teams, or vice versa.
- **Change Patient** - This action allows you to change the selected patient without having to leave and reenter the option.
- **Review Worksheet Print** - This action prints a worksheet for use on the wards for writing notes prior to calling the insurance company and entering the review. Basic information about the patient and the visit is included. Please note that the format is slightly different for 80 and 132 column outputs.

5.1.3. Pending Reviews Screen

The following actions are available from the Pending Reviews screen:

- **View/Edit Entry** - This action allows you to jump to either the Expanded Insurance Review screen or the expanded Hospital Review screen, depending on the type of review.
- **Claims Tracking Edit** - This action allows you to jump to the expanded Claims Tracking screen and perform all necessary edits to the entry in that file. This may include the input of billing information.
- **Print Worksheet** - This action allows you to print a generic worksheet for selected entries. The latest administrative data is printed on the worksheet including patient name, ward, physicians, room-bed, etc.
- **Insurance Reviews** - This action allows you to jump to the Insurance Reviews Screen. For details see the Insurance Reviews option documentation. Please note that if you try to perform an

Insurance Review on a pending Hospital Review, the software will automatically take you to the Hospital Review screen. This action is not available on the Claims Tracking Menu (Hospital Reviews).

- **Hospital Reviews** - This action allows you to jump to the Hospital Reviews screen. For details see the Hospital Reviews option documentation. Please note that if you try to perform a Hospital Review on a pending Insurance Review, the software will automatically take you to the Insurance Review screen. This action is not available on the Claims Tracking Menu (Insurance Reviews).
- **Change Date Range** - This action allows you to change the beginning and ending date of the search for pending reviews. You can search into the past or future for pending reviews. Reviews for the past 7 days is the default.
- **Remove From List** - This action allows you to quickly remove the review from the Pending Review List by automatically deleting the Next Review Date. For Insurance Reviews, the TRACK AS INSURANCE CLAIM field is also asked. If this is set to NO, no further reviews are automatically created for this visit.

5.1.4. Expanded Claims Tracking Entry Screen

The following actions are available from the Expanded Claims Tracking screen:

- **Billing Info Edit** - This action allows you to edit the billing information about expected revenues and next auto bill date. This is useful for comparing expected revenues versus what was received.
- **Review Info** - This action allows you to review/edit whether or not a special consent release of information form (ROI) for this patient for this episode of care is required, obtained, or not necessary; and whether this review should be tracked as a random sample, insurance claim, special condition, or local addition.
- **Treatment Auth.** - This action allows you to enter whether a second opinion for this patient insurance policy was required and obtained. (If a second opinion was obtained but did not meet the insurance company's criteria, enter NO in the SECOND OPINION OBTAINED field.) This field will be used to help determine the estimated reimbursement from the insurance carrier. If a second opinion was not obtained, certain denials and penalties may be assessed.
- **Hospital Reviews** - This action accesses the Hospital Reviews Screen.
- **Insurance Reviews** - This action accesses the Insurance Reviews/Contacts Screen.

5.1.5. Insurance Reviews/Contacts Screen

The following actions are available from the Insurance Reviews/Contacts screen:

- **Add Ins. Review** - This action will add a new review for the visit. The default Review Types are:
  - Pre-admission Certification Review (a scheduled admission with no previous review)
  - Urgent/Emergent Admission Review (a scheduled admission with no previous review)
  - Continued Stay Review (for follow-up reviews)
  - Other available Review Types are:
    - DISCHARGE REVIEW
    - INPT RETROSPECTIVE REVIEW
    - OPT RETROSPECTIVE REVIEW
    - OTHER
    - OUTPATIENT TREATMENT
    - PATIENT

- SNF/NHCU REVIEW
- SUBSEQUENT APPEAL

- **Delete Ins. Review** - This action allows an insurance review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.
- **View/Edit Ins. Review** - This action allows access to the Expanded Insurance Reviews Screen.
- **Appeals Edit** - This action allows you to jump to the Appeals and Denials Screen. For details see the Appeals and Denials option. Only denials and penalties may be appealed. This action is not available on the Claims Tracking for Hospital Reviews option.

5.1.6. Expanded Insurance Reviews

The following actions are available from the Expanded Insurance Reviews screen:

- **Appeal Address** - This action allows you to edit the appeals address information for the insurance company.
- **Contact Info** - This action allows you to enter/edit the review date, person contacted, method of contact, phone and reference numbers.
- **Ins. Co. Update** - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.
- **Action Info** - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.
- **View Pat. Ins**. - This action takes you to the Patient Insurance Screens. Note: From this instance of the Patient Insurance Screen users may not add, edit, or delete Patient Policy Comments. It is in view only mode. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

5.1.7. Hospital Reviews Screen

The following actions are available from the Hospital Reviews screen:

- **Add Next Hosp. Review** - This action will add the next review and automatically set it to either an admission review or continued stay review. The day for review and review date are automatically computed but can be edited. The category of severity of illness and intensity of service that was met can be entered; or if not met, the reason it was not met.
- **Delete Review** - This action allows a hospital review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.
- **View/Edit Review** - This action allows access to the Expanded Hospital Reviews Screen.

5.1.8. Expanded Hospital Reviews Screen

The following actions are available from the Expanded Hospital Reviews screen:

- **Review Information** - This action allows you to enter/edit the type of review (admission or continued stay), review date, and the specialty and methodology for the review. There should be only one admission review for an admission. Normally, reviews are done for RUR purposes on days 3, 6, 9, 14, 21, 28, and every 7 days thereafter. Usually, the INTERQUAL method is used as

the methodology for RUR required reviews. Insurance carriers may require other review methodologies.

- **Criteria Update** - This action allows you to enter or edit data regarding criteria met/not met for an acute admission within 24 hours, such as the review date and methodology; severity of illness and intensity of service; and whether additional reviews are required

5.2. Claims Tracking Edit

This option allows you to access the Claims Tracking Editor for a selected patient. From this option, you can do the following additional tasks:

- Delete the tracking entry
- Edit the entry
- Assign the hospital review to a particular user
- Edit billing information
- View or add ROI

Sample Screen

```
Claims Tracking Editor        Oct 22, 2014@10:53:42          Page:    1 of    1
Claims Tracking Entries for: IB,PATIENT 1 IXXXX
    for Visits beginning on: 10/22/13 to 11/05/14
    Type      Urgent  Date             Ins.  UR    ROI           Bill  Ward
1   *INPT.    NO      10/21/14 1:22 pm YES                       YES   C MEDICI









          Service Connected: NO    *=Current Admission                      >>>
DT  Delete Tracking Entry SC  SC Conditions         VP  View Pat. Ins.
QE  Quick Edit            AE  Appeals Edit          RO  ROI Consent
AC  Assign Case           CP  Change Patient        EX  Exit
BI  Billing Info Edit     CD  Change Date Range
VE  View/Edit Episode     DU  Diagnosis Update
HR  Hospital Reviews      PU  Procedure Update
Select Action: Quit//
```

5.3. Single Patient Admission Sheet

This option allows you to print an admission sheet for a single visit (either the current admission or a selected admission). The admission sheet serves as a temporary cover sheet in the inpatient chart where reviewers and coders can make notes about the visit in summary form. If the facility chooses to have physicians sign the admission sheet, it can then be used as documentation to prepare inpatient bills prior to the signing of the discharge summary.

5.4. Insurance Review Edit

This option uses a series of screens to allow you to enter and edit MCCR/UR related contacts associated with a claims tracking entry.

An initial review is automatically created upon admission for all insured patients. If UR is not required for the patient, the review can be deleted, inactivated, or left in an Entered status. If reviews are performed, and contact with the insurance company is made, the following information can be documented through this option:

- Contact with the insurance company
- Action taken by the insurance company
- Relevant clinical information
- The need for further reviews

Once a review or entry is complete, its status should be updated to COMPLETE in order to be used in reporting. If further reviews are required, the NEXT REVIEW DATE should contain the date on which the next review is required. It will then appear in the Pending Reviews option.

The following screens show the actions accessed through this option and the actions available on each subsequent screen:

```
                              Insurance Reviews/Contacts
-------------------------------------------------------------------------------
AI  Add Ins. Review           SC  SC Conditions           PV  Provider Update
DR  Delete Ins. Review        AE  Appeals Edit            RW  Review Wksheet Print
CS  Change Status             AC  Add Comment             CP  Change Patient
QE  Quick Edit                DU  Diagnosis Update        EX  Exit
VE  View/Edit Ins. Review     PU  Procedure Update
```

```
                              Expanded Insurance Reviews
-------------------------------------------------------------------------------
AA  Appeal Address            AI  Action Info             PU  Procedure Update
CI  Contact Info              AC  Add Comments            PV  Provider Update
CS  Change Status             VP  View Pat. Ins.          RW  Review Wksheet Print
IU  Ins. Co. Update           DU  Diagnosis Update        EX  Exit
```

```
                              Appeal and Denial Tracking
-------------------------------------------------------------------------------
VE  View Edit Entry           DA  Delete Appeal/Denial    IC  Ins. Co. Edit
QE  Quick Edit                SC  SC Conditions           EX  Exit
AA  Add Appeal                PI  Patient Ins. Edit.
```

5.4.1. About the Screens

In the top left corner of each screen is the screen title. A plus sign (+) at the bottom left of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right on the screen. Available actions are displayed below the screen. Two question marks entered at any "Select Action" prompt displays all available actions for that screen. For more information on the use of the screens, please refer to the appendix at the end of this manual.

You may quit from any screen, which will bring you back one level or screen, or you may exit (this exits the option entirely and returns you to the menu).

5.4.2. Common Actions

The following actions are common to more than one screen accessed through this option. They are listed here to avoid duplication of documentation:

- **Quick Edit** - This action allows you to edit most of the fields in Claims Tracking, specify if there should be insurance or hospital reviews, add billing information, and assign the visit to a reviewer.

- **SC Conditions** - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.
- **Diagnosis Update** - This action allows input of International Classification of Diseases (ICD) diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis, and the onset of the diagnosis for this admission. For outpatient visits, this information is stored with the outpatient encounter information.
- **Procedure Update** - This action allows the input of ICD procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional for use.
- **Provider Update** - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document actual physicians if the administrative record indicates teams or vice versa.
- **Change Status** - This action allows you to quickly change the status of a review. Only completed reviews are used in the report preparation and by the MCCR NDB roll-up or the QM roll-up.

Reviews have a status of ENTERED when automatically added. A status of PENDING may be used for those you are still working on or when one person does the data entry and another needs to review it.

- **Add Comment** - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.
- **Review Worksheet Print** - This action prints a worksheet for use on the wards for writing notes prior to calling the insurance company and entering the review. Basic information about the patient and the visit is included. Please note that the format is slightly different for 80 and 132 column outputs.

5.4.3. Insurance Reviews/Contacts

The following actions are available from the Insurance Reviews/Contacts screen:

- **Add Ins. Review** - This action will add a new review for the visit. The default Review Types are:
  - Pre-admission Certification Review (a scheduled admission with no previous review)
  - Urgent/Emergent Admission Review (a scheduled admission with no previous review)
  - Continued Stay Review (for follow-up reviews)
  - Other available Review Types are:
    - DISCHARGE REVIEW
    - INPT RETROSPECTIVE REVIEW
    - OPT RETROSPECTIVE REVIEW
    - OTHER
    - OUTPATIENT TREATMENT
    - PATIENT
    - SNF/NHCU REVIEW
    - SUBSEQUENT APPEAL
- **Delete Ins. Review** - This action allows an insurance review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance

company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.

- **View/Edit Ins. Review** - This action allows access to the Expanded Insurance Reviews Screen.
- **Appeals Edit** - This action allows you to jump to the Appeals and Denials Screen. For details see the Appeals and Denials option. Only denials and penalties can be appealed. This action is not available on the Claims Tracking for Hospital Reviews option.
- **Change Patient** - This action allows you to change to another patient without going back to the beginning of the option.

5.4.4. Expanded Insurance Reviews

The following actions are available from the Expanded Insurance Reviews screen:

- **Appeal Address** - This action allows you to edit the appeals address information for the insurance company.
- **Contact Info** - This action allows you to enter/edit the review date, person contacted, method of contact, phone and reference numbers.
- **Ins. Co. Update** - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.
- **Action Info** - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.
- **View Pat. Ins.** - This action takes you to the Patient Insurance Screens. Note: From this instance of the Patient Insurance Screen users may not add, edit, or delete Patient Policy Comments. It is in view only mode. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

5.4.5. Appeal and Denial Tracking Screen

The following actions are available from the Appeal and Denial Tracking screen:

- **View/Edit Entry** - This action allows you to jump to the Expanded Appeal/Denial Screen where you can view much of the data for one visit and perform related actions.
- **Add Appeal** - This action allows adding an appeal to a denial or penalty. The first appeal will be an initial appeal. All other appeals will be subsequent appeals. You may enter an administrative or clinical appeal. There is no limit to the number of appeals that may be entered.
- **Delete Appeal/Denial** - This action allows deletion of appeals and denials. This was designed for use in cases of erroneous entry.
- **Patient Ins. Edit** - This action allows editing of fields in the Insurance Company file (#36) that pertain to appeals address and phone numbers.
- **Ins. Co. Edit** - This action allows you to edit patient policy information.

Note: With the exception of the Edit Pt. Ins. action, all other actions available on this screen are also available on the Expanded Insurance Reviews Screen documented on previous pages.

- **Edit Pt. Ins.** - This action brings you to the Patient Insurance Screen. Note: From this instance of the Patient Insurance Screen users may add, edit, or delete Patient Policy Comments. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

5.5. Appeal/Denial Edit

This option allows you to enter, edit, and track the appeals for either a patient or an insurance company. You can speed processing by using the following syntax: 2.<entry name> (i.e., 2.John) to enter a patient

name or 36.<entry name> (e.g., 36.GHI) to select an insurance company. If you simply enter a name, the system searches both files for the name you have entered.

This option uses a series of screens to display denials and penalties and associated appeals. It is very similar to the Insurance Review option; however, if an appeal is approved or partially approved, the amount won on appeal is tracked.

The following shows the Claims Tracking Screens accessed through this option and the actions available on each screen:

```
                              Appeals and Denial Tracking
------------------------------------------------------------------------------
VE  View Edit Entry           DA  Delete Appeal/Denial      IC  Ins. Co. Edit
QE  Quick Edit                SC  SC Conditions             EX  Exit
AA  Add Appeal                PI  Patient Ins. Edit.
```

```
                               Expanded Appeals/Denials
------------------------------------------------------------------------------
AA  Appeal Address            AI  Action Info               EX  Exit
CI  Contact Info              AC  Add Comment
IU  Ins. Co. Update           EP  Edit Pt. Ins.
```

5.5.1. About the Screens

In the top left corner of each screen is the screen title. A plus sign (+) at the bottom left of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right on the screen. Available actions are displayed below the screen. Two question marks entered at any "Select Action" prompt displays all available actions for that screen. For more information on the use of the screens, please refer to the appendix at the end of this manual.

You may quit from any screen, which will bring you back one level or screen, or you may exit (this exits the option entirely and returns you to the menu).

Following is a list of the screens accessed through this option, the actions they provide, and a brief description of each action.

5.5.2. Appeal and Denial Tracking Screen

The following actions are available from the Appeal and Denial Tracking screen:

- **View/Edit Entry** - This action allows you to jump to the Expanded Appeal/Denial Screen where you can view much of the data for one visit and perform related actions.
- **Quick Edit** - This action allows you to edit nearly all of the fields in the appeal or denial, add comments, maintain its status, and assign follow-up dates.
- **Add Appeal** - This action allows adding an appeal to a denial or penalty. The first appeal will be an initial appeal. All other appeals will be subsequent appeals. You may enter an administrative or clinical appeal. There is no limit to the number of appeals that may be entered.
- **Delete Appeal/Denial** - This action allows deletion of appeals and denials. This was designed to be used in cases of erroneous entry.
- **SC Conditions** - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.

- **Ins. Co. Edit** - This action allows editing of fields in the Insurance Company file (#36) that pertain to appeals address and phone numbers.
- **Patient Ins. Edit** - This action allows you to edit patient policy information.

5.5.3. Expanded Appeals/Denials Screen

The following actions are available from the Expanded Appeals/Denials screen:

- **Appeal Address** - This action allows you to edit the name and address for a selected appeal.
- **Contact Info** - This action allows you to enter/edit the review date, person contacted, method of contact, phone and reference numbers.
- **Ins. Co. Update** - This action allows you to view/edit the billing, pre-certification, verification, claims, appeals, and inquiry phone numbers for the insurance company.
- **Action Info** - This action allows you to view/edit information pertaining to action taken on a review such as type of contact, care authorization from and to dates, authorization number, and review date and status.
- **Add Comment** - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.
- **Edit Pt. Ins.** - This action brings you to the Patient Insurance Screen. Note: from this instance of the Patient Insurance Screen users may add, edit, or delete Patient Policy Comments. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

5.6. Inquire to Claims Tracking

This option is used to display or print stored information about a single visit. You are prompted to select a patient and the Claims Tracking entry you wish to view/print. Visit, billing, and insurance information is provided, as well as all reviews performed. This output is less detailed than the Claims Tracking Summary for Billing option and does not contain the word processing fields from the reviews.

The following screen is an example of what is displayed for a patient using the Inquire to Claims Tracking option:

Sample Screen

```
Claim Tracking Inquiry                          Page 1  XXX XX, XXXX@15:55:54
IB,PATIENT 1                    XX-XX-XXXX           DOB: XXX XX, XXXX
INPATIENT ADMISSION on XXX XX, XXXX@09:30:35
--------------------------------------------------------------------------------
 Visit Information
    Visit Type: INPATIENT ADMISSION          Visit Billable: YES
Admission Date: XXX XX,XXXX@09:30:35         Second Opinion: NOT REQUIRED
          Ward: C-MEDICINE                   Auto Bill Date:
     Specialty: MEDICINE                    Special Consent: ROI OBTAINED
Discharge Date:                            Special Billing: FEDERAL OWCP
--------------------------------------------------------------------------------
  Billing Information
  Initial Bill:                       Estimated Recv (Pri): $
   Bill Status:                       Estimated Recv (Sec): $
 Total Charges: $        0             Estimated Recv (ter): $
   Amount Paid: $        0               Means Test Charges: $
--------------------------------------------------------------------------------
Diagnosis Information
      Nothing on File

  Associated Interim DRG Information
      Nothing on File
    ----------------------------------------------------------------------------

  Procedure Information
      Nothing on File
    ----------------------------------------------------------------------------

  Provider Information
      Nothing on File
    ----------------------------------------------------------------------------

Insurance Review Information
    Type Review: CONTINUED STAY REVIEW       Review Date: XX/XX/XX 1:41 pm
         Action: DENIAL                   Insurance Co.: AETNA US HEALTHCARE
    Denied From: XX/XX/XX               Person Contacted:
      Denied To: XX/XX/XX                 Contact Method: PHONE
 Denial Reasons: FAILURE TO MEET PAYER  Call Ref. Number:
                                                 Status: PENDING
                                       Last Edited By: UR,NURSE 2

    Type Review: URGENT/EMERGENT ADMIT       Review Date: XX/XX/XX
         Action:                          Insurance Co.: AETNA US HEALTHCARE
                                       Person Contacted:
                                         Contact Method:
                                       Call Ref. Number:
                                                 Status: ENTERED
                                         Last Edited By:
                                         Last Edited By:
--------------------------------------------------------------------------------
Hospital Review Information
None on file.
```

5.7. Supervisors Menu (Claims Tracking)…

5.7.1. Manually Add Opt. Encounters to Claims Tracking

Outpatient encounters that have been checked out through the Scheduling module are normally added when the IB nightly background job is run. Only primary outpatient encounters that have

been processed using the Check Out option of the Scheduling module are added in the first twenty days after the date of the encounter. This option allows you to search for outpatient encounters that were not checked out within twenty days and to automatically add them to Claims Tracking. If you choose to run the automated bill preparation portion of IB V. 2.0, you should periodically run this report to insure that all outpatient care is billed. This option is automatically queued to run in the background and a mail message is sent upon completion.

You may queue this option into the future; however, only outpatient encounters checked out at least one day prior to the actual execution will be added automatically. A message indicating any change will be added to the completion mail message.

Sample Mail Message

```
Subj: Outpatient Encounters added to Claims Tracking Complete  [#204668]
10/22/14@15:52  13 lines
From: INTEGRATED BILLING PACKAGE  In 'IN' basket.   Page 1
-------------------------------------------------------------------------------
The process to automatically add Opt Encounters has successfully completed.

              Start Date: 05/01/09
                End Date: 05/02/09

            Total Encounters Checked: 1214
              Total Encounters Added: 0
 Total Non-billable Encounters Added: 0

*The SC, Agent Orange, Southwest Asia, Ionizing Radiation,
Military Sexual Trauma, Head Neck Cancer, Combat Veteran and Project 112/SHAD
status visits have been added for insured patients but automatically
indicated as not billable.

Enter message action (in IN basket): Ignore//
```

5.7.2. Claims Tracking Parameter Edit

This option allows you to edit the MCCR Site Parameters that affect the Claims Tracking module. The parameters can also be edited in the option, MCCR Site Parameters. This option is locked with the IB PARAMETER EDIT security key.

Sample Screen

```
Claims Tracking Parameter Enter Edit
------------------------------------------------------------------------------

Initialization Date: 01/01/94
Use Admission Sheet: NO
      Header line 1: CHEYENNE VAMC
      Header line 2: 2360 E. PERSHING BLVD
      Header line 3: CHEYENNE, WY

    Track Inpatient: INSURED AND UR ONLY    Track Outpatient: INSURED ONLY
           Track Rx: INSURED ONLY          Track Prosthetics: INSURED ONLY
 Reports can Add CT: YES

    Medicine Sample:   5                      Surgery Sample:   5
Medicine Admissions:   5                   Surgery Admissions:   5

       Psych Sample:   1
   Psych Admissions:   5


INSURANCE EXTENDED HELP: ON//
CLAIMS TRACKING START DATE: JAN 1,1994//
INPATIENT CLAIMS TRACKING: INSURED AND UR ONLY//
OUTPATIENT CLAIMS TRACKING: INSURED ONLY//
PRESCRIPTION CLAIMS TRACKING: INSURED ONLY//
PROSTHETICS CLAIMS TRACKING: INSURED ONLY//
REPORTS ADD TO CLAIMS TRACKING: YES//
USE ADMISSION SHEETS: NO//
MEDICINE SAMPLE SIZE: 5//
MEDICINE WEEKLY ADMISSIONS: 5//
SURGERY SAMPLE SIZE: 5//
SURGERY WEEKLY ADMISSIONS: 5//
PSYCH SAMPLE SIZE: 1//
PSYCH WEEKLY ADMISSIONS: 5//
Inquiry can be Triggered for Appointment:  14
Inquiry can be Triggered for Admission:   0
Days to wait to purge entry on HCSR Response:  20
```

The following is a list of each parameter with a brief description:

- **Insurance Extended Help**

Should the extended help display always be on in the Insurance Management options?

ON - if you always want it to display automatically

OFF - if you do not want to see it

- **Claims Tracking Start Date**

If you choose to run the Claims Tracking module and populate the files with past episodes of care, this is the earliest visit date for which the Claims Tracking software will automatically add visits.

- **Inpatient Claims Tracking**

This field determines which inpatients will automatically be added to the Claims Tracking module. It is recommended that this field be set to INSURED AND UR ONLY.

  - OFF - no new patients will be added

- INSURED AND UR ONLY - only the insured patients and random sample patients will be added
- ALL PATIENTS -a record of all admissions will be created

If a patient is not insured, each record will be so annotated automatically on creation and no follow-up will be required. The advantage of tracking all patients is that you can determine the percentage of billable cases and make necessary adjustments if the patients are later found to have insurance. The disadvantage is that additional capacity is used.

- **Outpatient Claims Tracking**

This field determines whether outpatient visit dates will automatically be entered into the Claims Tracking module.

- OFF - no entries will be entered
- INSURED ONLY - only outpatient encounters for insured patients will be added
- ALL PATIENTS - an entry for all outpatient encounters will be added

- **Prescription Claims Tracking**

This field determines whether prescriptions will automatically be entered into the Claims Tracking module.

If a prescription or refill does not appear to be billable, Service Connected (SC) care for example, or there is a visit date associated with that prescription or refill, this will be noted in the reason not billable.

It is recommended that this field be set to INSURED ONLY.

- OFF - no prescriptions or refills will be entered
- INSURED ONLY - only prescriptions and refills will be added if the patient is insured
- ALL PATIENTS - an entry for all prescriptions will be entered

- **Prosthetic Claims Tracking**

This field will be used to determine if issuance of prosthetics should be tracked in the Claims Tracking module.

- OFF - no prosthetic items should be tracked
- INSURED ONLY - only prosthetic items for patients with insurance will be tracked
- ALL PATIENTS - prosthetic items for all patients will be tracked

- **Reports Add to Claims Tracking**

This field determines whether or not to allow the Veterans with Insurance reports to add entries to Claims Tracking. Enter YES for admissions and outpatient visits found as billable but not found in claims tracking to be added to claims tracking for billing information purposes only. No review will be set up. This is to allow the flagging of these visits as unbillable so that they can be removed from these reports.

- **Use Admission Sheets**

Indicate whether your facility is using Admission Sheets as part of the MCCR/UR functionality. If the answer to this parameter is YES, users will be asked for the device to which admissions sheets are printed. A default device can be defined in the BILL FORM TYPE file.

- **Admission Sheet Header Line 1**

Enter the text that your facility would like to print as the first line of the header on the admission sheet. This is usually the name of your medical center.

- **Admission Sheet Header 2**

Enter the text that your facility would like to print as the second line of the header on the admission sheet. This is usually the street address of your medical center.

- **Admission Sheet Header Line 3**

Enter the text that your facility would like to print as the third line of the header on the admission sheet. This is usually the city, state, and ZIP code of your medical center.

- **Medicine Sample Size**

This is the number of required Utilization Reviews that you wish to have done each week for Medicine admissions. The minimum recommended by the Quality Assurance (QA) office is one per week.

- **Medicine Weekly Admissions**

This is the minimum number of admissions that your facility usually averages for Medicine. This is used along with the Medicine Sample Size to compute a random number. Changing this number to a lower value will cause the random sample case to be selected earlier in the week. A higher number provides a more even distribution of cases during the week. If the number exceeds the admissions for the week, the possibility exists that a random sample case may not be generated for this service.

- **Surgery Sample Size**

This is the number of required Utilization Reviews that you wish to have done each week for Surgery admissions. The minimum recommended by the QA office is one per week.

- **Surgery Weekly Admissions**

This is the minimum number of admissions that your medical center usually averages for Surgery. This is used along with the Surgery Sample Size to compute a random number. Changing this number to a lower value will cause the random sample case to be selected earlier in the week. A higher number provides a more even distribution of cases during the week. If the number exceeds the admissions for the week, the possibility exists that a random sample case may not be generated for this service.

- **Psych Sample Size**

This is the number of required Utilization Reviews that you wish to have done each week for Psychiatry admissions. The minimum recommended by the QA office is one per week.

- **Psych Weekly Admissions**

This is the minimum number of admissions that your medical center usually averages for Psychiatry. This is used along with the Psychiatry Sample Size to compute a random number. Changing this number to a lower value will cause the random sample case to be selected earlier in the week. A higher number provides a more even distribution of cases during the week. If the

number exceeds the admissions for the week, the possibility exists that a random sample case may not be generated for this service.

- **Inquiry can be Triggered for Appointments**

This is the number of days after the creation of an HCSR Worklist entry from an appointment to wait before automatically triggering an X12N Health Care Services Review – Request for Review and Response (278).

- **Inquiry can be Triggered for Admissions**

This is the number of days after the creation of an HCSR Worklist entry from an admission to wait before automatically triggering an X12N Health Care Services Review – Request for Review and Response (278).

- **Days to wait to purge entry on HCSR Response**

This is the number of days an HCSR Transmission entry with a completed response status will remain on the HCSR Response Worklist.

5.7.3. Manually Add Prosthetics to Claims Tracking

Prosthetic items which have been issued through the Prosthetics module are normally added to Claims Tracking when the IB nightly background job is run based on the date of service of the item and the day of the month. On the tenth (10^{th}) of each month the date range for the IB nightly background job is T-730 days through T-3 days to pull Prosthetics items based on the date of service. On all other days of the month, the date range for the IB nightly background job is T-20 days through T-3 days. This option allows you to search for prosthetic items that have a date of service within a user-specified date range and automatically add them to Claims Tracking. If you choose to run the automated bill preparation portion of IB V. 2.0, you should run this report periodically to insure that all prosthetic items are billed. This option is automatically queued to run in the background and a mail message is sent upon completion.

You may queue this option into the future; however, only prosthetic items issued during the user-specified date range will be added automatically. A message indicating any change will be added to the completion mail message.

Sample Mail Message

```
Subj: Prosthetic Items added to Claims Tracking Complete  [#114894] 02 Feb 17 08:52
  10 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.  Page 1  **NEW**
-------------------------------------------------------------------------------

The process to automatically add Prosthetic Items has successfully completed.

              Start Date: 05/01/16
                End Date: 07/17/17
(Selected end date of 07/20/17 automatically changed to 07/17/17.)

 Total Prosthetics Items checked: 200210
Total NSC Prosthetic Items Added: 14430
 Total SC Prosthetic Items Added: 0

*The items added as SC require determination and editing to be billed
```

5.7.4. Manually Add Rx Refills to Claims Tracking

Prescription refills that have been released within ten days of the fill date are automatically added to Claims Tracking when the IB MT NIGHT COMP task is run. This option allows you to search for refills that were not released within ten days of the fill date and automatically add them to Claims Tracking. If you choose to run the automated bill preparation portion of IB V. 2.0, you should run this report periodically to insure that all outpatient care is billed. This option is automatically queued to run in the background and a mail message is sent upon completion.

You may queue this option into the future; however, only outpatient encounters checked out at least one day prior to the actual running will be added automatically. A message indicating any change will be added to the completion mail message.

Sample Mail Message

```
Subj: Rx Refills added to Claims Tracking Complete  [#114894] 02 Feb 94 08:52
  10 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.  Page 1  **NEW**
-------------------------------------------------------------------------------

The process to automatically add Rx Refills has successfully completed.

              Start Date: 01/22/94
                End Date: 01/29/94
(Selected end date of 02/01/94 automatically changed to 01/29/94.)

  Total Rx fills checked: 0
Total NSC Rx fills Added: 0
 Total SC Rx fills Added: 0

*The fills added as SC require determination and editing to be billed


Select MESSAGE Action: IGNORE (in IN basket)//
```

5.7.5. Reports Menu (Claims Tracking)…

The following is a list of the reports available through the Reports Menu (Claims Tracking):

```
   SR     278 Statistical Volume Report
   CR     278 Certification Report
   DR     278 Deletion Disposition Report
   BI     Print CT Summary for Billing
   DD     Days Denied Report
   IC     Inquire to Claims Tracking
   MS     MCCR/UR Summary Report
   RC     List Visits Requiring Reviews
   RW     Review Worksheet Print
   SA     Scheduled Admissions w/Insurance
   SP     Single Patient Admission Sheet
   TODO   Pending Work Report
   UA     Unscheduled Admissions w/Insurance
   UR     UR Activity Report

Select Reports Menu (Claims Tracking) <TEST ACCOUNT> Option:
```

- **278 Statistical Volume Report**

This report is used to monitor the X12 278 transaction process including statistics based on outgoing request, inquiry and incoming responses of authorization received, pending received and rejection received. You can print a statistical report based on the following:

- Report by Staff (All Staff Members or Selected Staff Members)
- Report by Patient (All Patients or Selected Patient)
- Report by Date Range

Sample Report

```
 278 Statistical Volume Report          Nov 10, 2015@00:57:39          Page: 1
 Sort by: Staff
                            Report Timeframe:
                          03/01/2015 - 11/10/2015
                              All Staff

Staff             Date     #278s #217  #215  #215  #Auth #Rej  #Pend AAA   Await
                           Submitted   Man   Auto  Recd  Recd
================================================================================
IB,STAFF 1        03/05/15   2     2                1                        1
IB,STAFF 1        03/26/15   1     1                                         1
IB,STAFF 1        03/31/15   3     3                      1                  2
IB,STAFF 1        04/02/15   1     1                            1
IB,STAFF 1        04/27/15   2     2                                         2
IB,STAFF 1        08/04/15   1     1                                         1
IB,STAFF 1        09/09/15   1     1                                         1
IB,STAFF 1        11/04/15   1     1                                         1
                           ------------------------------------------------
   Total                    12    12     0     0     1     1     1     0     9




 278 Statistical Volume Report          Nov 10, 2015@00:57:39          Page: 2
 Sort by: Staff
                            Report Timeframe:
                          03/01/2015 - 11/10/2015
                              All Staff

Staff             Date     #278s #217  #215  #215  #Auth #Rej  #Pend AAA   Await
                           Submitted   Man   Auto  Recd  Recd
================================================================================
IB,STAFF 2        03/26/15   1     1                                         1
IB,STAFF 2        04/02/15   1     1                                         1
                           ------------------------------------------------
   Total                     2     2     0     0     0     0     0     0     2

                           ================================================
Grand Total                14    14     0     0     1     1     1     0    11

                            *** END OF REPORT ***
```

- **278 Certification Report**

This report provides information based on the X12 278 transaction based on the outgoing request, inquiry and incoming responses with all types of certification. You can print a certification report based on the following:

- Report by Payer (All Payers or Selected Payers)
- Report by Staff (All Staff Members or Selected Staff Members)

- Report by Patient (All Patients or Selected Patient)
- Report by Date Range

This report is formatted to print 132 columns.

Sample Report

278 Certification Report — Nov 10, 2015@01:16:01 — Page: 1
Sort by: Payer — Detail: Excluded

Report Timeframe:
01/01/2015 - 11/10/2015
All Payer(s)

Payer	#278s	#A1	#A2	#A6	#A4	#A3	#C	CT	NA
AETNA US HEALTHCARE	1								1
BLUE CROSS/BS WY	4	1			2	1			
CIGNA	1	1							
Grand Total	6	2	0	0	2	1	0	0	1

*** END OF REPORT ***

- **278 Deletion Disposition Report**

This report provides information on the deleted entries. You can print a deletion disposition report based on the following:

- Report by Staff (All Staff Members or Selected Staff Members)
- Report by Patient (All Patients or Selected Patient)
- Report by Date Range

Sample Report

```
 278 Deletion Disposition Report        Nov 10, 2015@09:14:36          Page: 1
 Sort by: Staff
                              Report Timeframe:
                            03/01/2015 - 11/10/2015
                                Selected Staff

Staff                         Date       #278s Submitted           #Delete Reasons
================================================================================
IB,STAFF 1                  11/02/15           0                          2
IB,STAFF 1                  10/14/15           1                          1
   Total                                       1                          3


                               *** END OF REPORT ***
```

- **Print CT Summary for Billing**

You can print a Claims Tracking Summary which can be used for preparation of a bill/claim. The content of the summary is based upon the type of Claims Tracking event.

Sample Report 1 – Inpatient Admission

```
Bill Preparation Report                          Page 1  Oct 23, 2014@14:53:41

IB,PATIENT 78               XX-XX-XXXX            DOB: XXX XX, XXXX
INPATIENT ADMISSION on XXX XX, XXXX@13:22:16
-------------------------------------------------------------------------------
 Visit Information
    Visit Type: INPATIENT ADMISSION          Visit Billable: YES
Admission Date: XXX XX,XXXX@13:22:16         Second Opinion: NOT REQUIRED
          Ward: C MEDICINE                   Auto Bill Date: XXX XX,XXXX
     Specialty: MEDICINE                   Special Consent: ROI NOT DETERMINED
Discharge Date:                            Special Billing:
    ---------------------------------------------------------------------

  Insurance Information
          Ins. Co 1: AETNA US HEALTHCARE     Pre-Cert Phone: 800/523-7978
             Subsc.: IB,PATIENT 78                    Type: COMPREHENSIVE MAJO
          Subsc. ID: WXXXXXXXX                     Group: GRP NUM 8802
          Coord Ben: SECONDARY               Billing Phone: 800/523-7978
     Filing Time Fr:                          Claims Phone: 800/523-7978
Group Plan Comments:
    ---------------------------------------------------------------------
  Billing Information
  Initial Bill:                        Estimated Recv (Pri): $
   Bill Status:                        Estimated Recv (Sec): $
 Total Charges: $        0             Estimated Recv (ter): $
   Amount Paid: $        0               Means Test Charges: $
    ---------------------------------------------------------------------
```

```
  Eligibility Information
       Primary Eligibility: NSC, VA PENSION
         Means Test Status:
 Service Connected Percent: Patient Not Service Connected
    ------------------------------------------------------------------------
  Diagnosis Information
      Nothing on File

  Associated Interim DRG Information
      Nothing on File
    ------------------------------------------------------------------------

  Procedure Information
      Nothing on File
    ------------------------------------------------------------------------

  Provider Information
      Nothing on File
    ------------------------------------------------------------------------

  Insurance Review Information
    Type Review: CONTINUED STAY REVIEW       Review Date: XX/XX/XX@1:41 pm
         Action: DENIAL                   Insurance Co.: AETNA US HEALTHCARE
    Denied From: XX/XX/XX               Person Contacted:
      Denied To: XX/XX/XX                 Contact Method: PHONE
 Denial Reasons: FAILURE TO MEET PAYER  Call Ref. Number:
                                                 Status: PENDING
                                       Last Edited By: UR,NURSE
Comment:
   ------------------------------------------------------------------------
    Type Review: URGENT/EMERGENT ADMIT       Review Date: XX/XX/XX
         Action:                           Insurance Co.: AETNA US HEALTHCARE
                                        Person Contacted:
                                          Contact Method:
                                        Call Ref. Number:
                                                 Status: ENTERED
                                          Last Edited By:
Comment:
   ------------------------------------------------------------------------
```

Sample Report 2 – Prescription Refill

```
Bill Preparation Report                          Page 1  Oct 23, 2014@15:10:38

IB,PATIENT 37            XX-XX-XXXX              DOB: XXX XX, XXXX
PRESCRIPTION REFILL on Jan 13, 2011
-------------------------------------------------------------------------------
 Visit Information
    Visit Type: PRESCRIPTION REFILL          Visit Billable: NO-NO PHARMACY COVE
Prescription #: XXXXXXX                      Second Opinion: NOT REQUIRED
   Refill Date: XXX XX, XXXX                 Auto Bill Date:
          Drug: LISINOPRIL 20MG TAB         Special Consent: ROI NOT DETERMINED
      Quantity:       90                    Special Billing:
   Days Supply:       90
          NDC#: 00904-5809-89
     Physician: IB,DOCTOR C
    ------------------------------------------------------------------------

  Insurance Information
          Ins. Co 1: NORTHWEST ADMINISTRATOR Pre-Cert Phone: 800/872-5439
             Subsc.: IB,PATIENT 37                    Type: RETIREE
          Subsc. ID: XXXXXXXXX                      Group: GRP NUM 13377
```

```
          Coord Ben: SECONDARY                Billing Phone: 800/872-5439
     Filing Time Fr:                           Claims Phone: 800/872-5439
     Policy Comment:  POLICY EFF 3-1-03
Group Plan Comments:
         PER NOTE, EFF 090103 ALL RX ARE PD @ 20% UNDER MEDICAL
         PLAN.  SAYS SHOULD'VE NEVER PROCESSED UNDER PRESCRIPTION
         PLAN.

         POLICY PAYS 70% MEDICARE INPT DEDUCTIBLE.

         HAS RX COVERAGE.  EFF 010196, NO RX DEDUCTIBLE.  INSURANCE
         WILL REIMBURSE A MAXIMUM 34-DAY SUPPLY.  LARGER AMTS
         REIMBURSE 0--DON'T BILL UNLESS THE RX MEETS THIS CRITERIA.
         051598:  RX PAY @ 20% ALLOWABLE AFTER DEDUCTIBLE.  NO
         COVERAGE FOR ASCORBIC ACID 500 MG, NUTRITION SUPL ENSURE,

         SMOKING DETERRENTS, MULTIVITAMIN/MINERALS CAP/TAB 011200:
         PER APRIL, THIS POLICY WILL COVER RX 20% ALLOWABLE AFTER
         DEDUCTIBLE; HOWEVER, CLMS APPEAR TO BE PAYING IN EXCESS OF
         THAT.  DIABETIC & OTHER SUPPLIES ARE COVERED.

         122700:  PER TAUSHA, EFFECT. 100100 VA IS CONSIDERED
         IN-NETWORK AND WE WILL BE REIMBURSED 60% ON BRAND NAME RX.
         INS WILL TAKE $8 COPAY OUT OF OUR REIMBURSEMENT ON GENERIC
         RX FOR IN-NETWORK.   PRIOR TO THAT DATE VA WAS CONSIDERED
         OUT-OF-NETWORK AND OUR REIMBURSEMENT SHOULD'VE BEEN 50%
         FOR BRAND NAME RX. THERE IS NO RX DEDUCTIBLE.

         NO ROUTINE CARE INCL VISION.  NO PRECERT REQ'D VERIFIED
         W/BLAINE 013098.

         WHEN BILLING ANESTHESIA, INCL TIME PER DEE-DEE 032400.

                              ----------------------------------
--------------------------------------------------------------------------------
  Billing Information
  Initial Bill:                        Estimated Recv (Pri): $
   Bill Status:                        Estimated Recv (Sec): $
 Total Charges: $        0             Estimated Recv (ter): $
   Amount Paid: $        0               Means Test Charges: $
Reason Not Billable: NO PHARMACY COVERAGE
Additional Comment:
    ----------------------------------------------------------------------

  Eligibility Information
       Primary Eligibility: SERVICE CONNECTED 50% to 100%
         Means Test Status: NO LONGER REQUIRED
 Service Connected Percent: 100%

     Service Connected Conditions:
          LIMITED MOTION OF ANKLE                10%
          FLAT FOOT CONDITION                     0%
          COLD INJURY RESIDUALS                  20%
          COLD INJURY RESIDUALS                  20%
          TINNITUS                               10%
          DEGENERATIVE ARTHRITIS OF THE SPINE    10%
          TRAUMATIC ARTHRITIS                    10%
          TRAUMATIC ARTHRITIS                    10%
          IMPAIRED HEARING                        0%
          COLD INJURY RESIDUALS                  20%
          LIMITED MOTION OF ANKLE                10%
          LIMITED MOTION OF ARM                  20%
          COLD INJURY RESIDUALS                  10%
```

```
         TRAUMATIC ARTHRITIS                    10%
         POST-TRAUMATIC STRESS DISORDER         30%
         TRAUMATIC ARTHRITIS                    10%
         TRAUMATIC ARTHRITIS                    10%
   ------------------------------------------------------------------------
```

- **Inquire to Claims Tracking**

You can display or print stored information about a single visit. You are prompted to select a patient and the Claims Tracking entry you wish to view/print.
The following information is displayed:

- Visit,
- Billing
- Insurance information
- Reviews performed

Note: This report does not contain the word processing fields from the reviews.

Sample Report

```
Claim Tracking Inquiry                          Page 1  Jan 14, 1994@15:55:54
IB,PATIENT 1                    XX-XX-XXXX            DOB: XXX XX,XXXX
INPATIENT ADMISSION on XXX XX,XXXX@09:30:35
--------------------------------------------------------------------------------
 Visit Information
    Visit Type: INPATIENT ADMISSION          Visit Billable: YES
Admission Date: XXX XX,XXXX@09:30:35         Second Opinion: NOT REQUIRED
          Ward: 11-B MEDICINE XREF           Auto Bill Date:
     Specialty: MEDICINE                    Special Consent: ROI OBTAINED
Discharge Date:                            Special Billing: FEDERAL OWCP

  Billing Information
  Initial Bill:                       Estimated Recv (Pri): $
   Bill Status:                       Estimated Recv (Sec): $
 Total Charges: $        0             Estimated Recv (ter): $
   Amount Paid: $        0               Means Test Charges: $

  Insurance Review Information
    Type Review: INITIAL APPEAL              Review Date: XX/XX/XX
    Appeal Type: ADMINISTRATIVE           Insurance Co.: IB INS. CO. 30
    Case Status: OPEN                   Person Contacted: UMO,CONTACT
No Days Pending: 3                        Contact Method: Letter
  Final Outcome:                       Call Ref. Number:
                                                Status: COMPLETE
                                       Last Edited By:

    Type Review: CONTINUED STAY REVIEW       Review Date: XX/XX/XX
         Action: DENIAL                   Insurance Co.: IB INS. CO. 1
    Denied From: XX/XX/XX                Person Contacted: SPOUSE
      Denied To: XX/XX/XX                  Contact Method: PHONE
 Denial Reasons: NOT MEDICALLY NECESSAR Call Ref. Number: XXXXXXSS
 Denial Reasons: TREATMENT PROVIDED NOT           Status: COMPLETE
                                       Last Edited By: UR,NURSE

Type Review: URGENT/EMERGENT ADMIT           Review Date: XX/XX/XX
         Action: APPROVED                 Insurance Co.: IB INS. CO. 14
Authorized From: XX/XX/XX                Person Contacted: UMO,CONTACT
  Authorized To: XX/XX/XX                  Contact Method: VOICE MAIL
Authorized Diag: 259.0 - DELAY SEXUAL D Call Ref. Number: XXXXXXXXXA
   Auth. Number: 88889354A                       Status: COMPLETE
                                       Last Edited By: UR,NURSE
```

```
Hospital Review Information
   Review Date: XX/XX/XX                  Day of Review: 3
   Review Type: CONTINUED STAY REVIEW  Severity of Ill: Generic
     Specialty: MEDICINE              Intensity of Svc: Generic
   Methodology: INTERQUAL             Non-Acute Reason:
        Status: ENTERED
Last Edited By: UR,NURSE
```

- **Days Denied Report**

You can print a summary or a detailed listing of denials. The report can be sorted by the following:

- Patient
- Attending physician, or
- Bed service (i.e., surgery, psychiatry, medicine).

The summary report shows the number of denials, the total days denied, the dollar amount of the denials, and the days won on appeal by service.

The detail section includes the following:

- Inpatient Admission's Service, which is the Service the patient was under at either the admission, if that date is included in the report, or the Service the patient was under on the begin date of the report. This Service is used to provide the summary.
- The Amount Denied is also displayed for each denied stay in the detail section. The Amount Denied is either the full charge of the admission, if the entire admission was denied and the entire stay is within the date range of the report, or an average charge based on the full charge and the number of denied days on the report, if only a partial denial. The charges displayed as the Amount Denied are the current active charges per Reasonable Charges.

This report is formatted to print 132 columns.

Sample Report

MCCR/UR DENIED DAYS INPATIENT Denials Dated Jan 01, 2005 to Jan 01, 2006 Page 1 Mar 21, 2013@20:41:30

Patient	PtID	Dates of Care	Attending	Dates Denied	Denial Reason	Appealed	Days Approved on Appeal	SRVS	Amount
IB,PATIENT 1	XXXX	01/24/05 to 01/27/05	520634204	ALL (3)	OBSERVATION IS MORE APPRO	NO	0	SURG	$19,224
IB,PATIENT 23	XXXX	02/24/05 to 02/28/05	1404	ALL (4)	NOT MEDICALLY NECESSARY	YES	2	NHCU	$2,777
IB,PATIENT 54	XXXX	12/27/04 to 01/02/05	520629761	ALL (1)	NOT MEDICALLY NECESSARY	NO	0	NHCU	$629
IB,PATIENT 6	XXXX	09/13/05 to 09/15/05	520644029	ALL (2)	NOT MEDICALLY NECESSARY	NO	0	MEDI	$13,109
				10					

MCCR/UR DENIED DAYS OUTPATIENT Denials Dated Jan 01, 2005 to Jan 01, 2006 Page 2 Mar 21, 2013@20:41:30

Patient	PtID	Episode Date	Outpatient Treatment	Appealed	Approved	Amount
IB,PATIENT 7	XXXX	12/25/05@13:20	OPT OPHTHALMOLOGY ST	NO	NO	$0
IB,PATIENT 288	XXXX	10/9/05@08:30		YES	YES	$126
IB,PATIENT 67	XXXX	10/17/05@15:54	Physical Therapy	NO	NO	$0
			3			

MCCR/UR DENIED DAYS PROSTHETIC Denials Dated Jan 01, 2005 to Jan 01, 2006 Page 3 Mar 21, 2013@20:41:30

Patient	PtID	Episode Date	Outpatient Treatment	Appealed	Approved	Amount
IB,PATIENT 23	XXXX	1/27/05	Av Prosth Auto Blood	NO	NO	$25
IB,PATIENT 1	XXXX	10/1/05	Delivery/Labor	NO	NO	$150
			2			

MCCR/UR DENIED DAYS PRESCRIPTION Denials Dated Jan 01, 2005 to Jan 01, 2006 Page 4 Mar 21, 2013@20:41:30

Patient	PtID	Episode Date	Outpatient Treatment	Appealed	Approved	Amount
IB,PATIENT 6	XXXX	1/27/05	Av RxFill #: 7399X89	NO	NO	$0
IB,PATIENT 45	XXXX	10/7/05	Rx #:76699X9	NO	NO	$45
			2			

MCCR/UR DENIED DAYS Summary Report for Reviews Dated Jan 01, 2005 to Jan 01, 2006 Page 5 Mar 21, 2013@20:41:30

Service	Number Denials	Days Denied	Amount Denied	Days won on Appeal

MEDICINE	1	2	$13,109	0	
NHCU	2	5	$2,839	2	
SURGERY	1	3	$19,224	0	

		10			

Service	Number	Amount Denied	Appealed	Appeals Approved
OUTPATIENT	3	$126	1	1
PRESCRIPTION	2	$45	0	0
PROSTHETICS	2	$175	0	0

- **MCCR/UR Summary Report**

You can print a summary of hospital activity by either admission or discharge for a specified date range. A Penalty Report is included and, if appropriate, a Days Approved Report, and a Days Denied Report. These are sorted by specialty.

Sample Report

```
                              MCCR/UR SUMMARY REPORT
                                      for
                                   ALBANY (500)

                                   for Discharges
                                 From: AUG 18, 1993
                                   To: FEB 14, 1994

                               Date Printed: FEB 14, 1994
                                        Page: 1
                               --------------------------

                          Total Discharges:         29
               Total Discharges with Insurance:      5
                     Total Billable Discharges:      4
           Total Discharges Requiring Reviews:       4
                     Total Discharges Reviewed:      4
Total Discharges Reviewed, Multi Carrier:            0

                           Total Reviews Done:       5
                      Number of Days Approved:      10
 Amount Collectible Approved for Billing:     $3,370

                         Number of Days Denied:      4
                     Amount Denied for Billing:     $1,348

                          Total Cases Appealed:      0
                     Number of Initial Appeals:      0
                Number of Subsequent Appeals:        0

                              Penalty Report: Number of cases              Dollars
                              --------------  ------------------------------------
               No Pre Admission Certification:         0                        $0
   Untimely Pre Admission Certification:               0                        $0
                           VA a Non-Provider:          0                        $0

                    Reason Not Billable Report: Reason                        Count
                    --------------------------  ------------------------------------
                                                OTHER                             1

                    Days Approved by Specialty: Specialty         No. Days   Dollars
                    --------------------------  ------------------------------------
                                                ALCOHOL               10      $3,370

                      Days Denied by Specialty: Specialty         No. Days   Dollars
                      ------------------------  ------------------------------------
                                                ALCOHOL                4      $1,348
```

- **List Visits Requiring Reviews**

You can print a list of visits based on the following:

- Insurance Review,
- Hospital Review
- Both

Only inpatient admission visits are included in the report. This report can be used to list the random sample cases being tracked for hospital reviews by selecting only hospital reviews for admissions.

Sample Output

```
LIST OF VISITS FROM: 01/01/94 TO: 02/18/94 REQUIRING REVIEWS                                  FEB 18,1994  14:40    PAGE 1
                                          VISIT                    INS. RANDOM  SPECIAL  LOCAL  HOSP
PATIENT              PT. ID       WARD        TYPE      DATE         CASE  CASE    COND.   CASE   REVIEWER       INS REVIEWER
-------------------------------------------------------------------------------------------------------------------------------

IB,PATIENT 2          XX-XX-XXXX  8C ORTHO S  ADMIT     FEB  7,1994  YES   YES                                    UR,NURSE
IB,PATIENT 52         XX-XX-XXXX              SCH ADM.  FEB  4,1994  YES   NO      COPD     NO                    UR,NURSE
IB,PATIENT 111        XX-XX-XXXX              OUTPT     FEB 11,1994  YES                                           UR,NURSE
IB,PATIENT 77         XX-XX-XXXX  7A(NHCU)    ADMIT     FEB  7,1994  NO    YES                                    UR,NURSE
IB,PATIENT 9          XX-XX-XXXX  11-B MEDIC  ADMIT     JAN 13,1994  YES   YES     NONE     NO                    UR,NURSE
----  ---     ----     ---
COUNT                                                               4     3       1        0
```

- **Review Worksheet Print**

This option is similar to the Review Worksheet action on the Insurance Review screen. A worksheet for a current inpatient can be printed containing demographic data and information about current room/bed, ward, and provider.

Sample Worksheet

```
INSURANCE REVIEW WORKSHEET
XXX XX, XXXX@15:33:37

          Specialty: MEDICINE                          Ward: 11-B MEDICINE

               Name: IB,PATIENT 34                  Insurance Co: IB INS. CO. 12
             Pt ID: XX-XX-XXXX
               DOB: XXX XX, XXXX

     Admission Date: XXX XX,XXXX@09:30:35          DC Date: _________  LOS: _____

       Attending MD: IB,DOCTOR A                Primary MD: IB,DOCTOR P

     Complaint/Hist: _____________________________________________________________

                     _____________________________________________________________

          Treatment: _____________________________________________________________

                     _____________________________________________________________

     ================================================================================
     |Date     |Diagnosis                |Procedure                  |DRG   |LOS    |
     |         |                         |                           |      |       |
     |_________|_________________________|___________________________|______|_______|
     |         |                         |                           |      |       |
     |_________|_________________________|___________________________|______|_______|
     |         |                         |                           |      |       |
     |_________|_________________________|___________________________|______|_______|
     |         |                         |                           |      |       |
     |_________|_________________________|___________________________|______|_______|
     |         |                         |                           |      |       |
     |_________|_________________________|___________________________|______|_______|
     |         |                         |                           |      |       |
     |_________|_________________________|___________________________|______|_______|

     ================================================================================
     |Insurance Contact: _____________________________  Phone: ____________________|
     |_______________________________________________________________________________|
     |Date     |Comments (#day approved, next review date, etc.)                     |
     |         |                                                                     |
     |_________|_____________________________________________________________________|
     |         |                                                                     |
     |_________|_____________________________________________________________________|
     |_________|_____________________________________________________________________|
     |_________|_____________________________________________________________________|
     |         |                                                                     |
     |_________|_____________________________________________________________________|
     ================================================================================

     Reviewer: ____________________________________  Date: ____________________
```

- **Scheduled Admissions w/Insurance**

You can print a list of scheduled admissions in Claims Tracking for insured patients. Included are patients with past scheduled admissions and scheduled admissions up to three days into the future. This differs from the Scheduled Admission List from MAS, as it does not contain all scheduled admissions from MAS. Scheduled admissions are normally moved to Claims Tracking four days prior to the scheduled admission date so that reviews can be completed prior to admission. Included are the number and type of reviews performed and the insurance company actions.

This report is formatted to print 132 columns.

Sample Report

```
Scheduled Admissions with Insurance                                          Page 1  Feb 11, 1994@09:05:48
For Period beginning on XX/XX/XX to XX/XX/XX
Patient                    Pt. ID         Adm. Date            Billable                   Ward           Type
-------------------------------------------------------------------------------------------------------------
IB,PATIENT 33              XX-XX-XXXX     XX/XX/XX  1:00 pm     YES                         5D SURG        SCHEDULED
IB,PATIENT 33              XX-XX-XXXX     XX/XX/XX  2:40 pm     YES                         9D MED         SCHEDULED
IB,PATIENT 33              XX-XX-XXXX     XX/XX/XX 11:40 pm     YES                         2D CARD        SCHEDULED
IB,PATIENT 33              XX-XX-XXXX     XX/XX/XX 10:11 am     NO                          4a nurs        SCHEDULED
IB,PATIENT 33              XX-XX-XXXX     XX/XX/XX  9:00 am     YES                         9D MED         SCHEDULED
IB,PATIENT 33              XX-XX-XXXX     XX/XX/XX  2:52 pm     YES                         2B ICU         SCHEDULED

------------------
TOTAL = 6
```

- **Single Patient Admission Sheet**

You can print an admission sheet for a single visit (either the current admission or a selected admission). The admission sheet serves as a temporary cover sheet in the inpatient chart where reviewers and coders can make notes about the visit in summary form. If the facility chooses to have physicians sign the admission sheet, it can then be used as documentation to prepare inpatient bills prior to the signing of the discharge summary.

Sample Worksheet

```
                              ADMISSION SHEET
                                 ALBANY VAMC
                               113 HOLLAND AVE
                                  ALBANY,NY

      Patient: IB,PATIENT 456                    Address: 123 TEST ST.
        Pt ID: XX-XX-XXXX
          Dob: XX XX, XXXX
           SC: YES - 20%                                TROY, NY  12180
          Sex: MALE                                Phone:
-------------------------------------------------------------------------------
    Adm. Date: XXX XX, XXXX@09:30:35          Adm. Type: URGENT
     Provider: IB,PATIENT 456                 Specialty: MEDICINE
         Ward: 11-B MEDICINE                   Room/Bed:
    Adm. Diag: 466.0 - ACUTE BRONCHITIS
-------------------------------------------------------------------------------
     Employer:                                E-Cont.:

        Phone:                                  Phone:
-------------------------------------------------------------------------------
    Ins. Co 1: IB INS. CO, 44                   Phone: 555-555-4312
       Subsc.: IB,PATIENT 456                    Type: MAJOR MEDICAL EXPENS
    Subsc. ID: WXXXXXXXX                        Group: 4446333
-------------------------------------------------------------------------------
    Date    Diagnosis               Procedure              Final   DRG  LOS
         |                       |                      |         |     |
    _____|_______________________|______________________|_________|_____|_____
         |                       |                      |         |     |
    _____|_______________________|______________________|_________|_____|_____
         |                       |                      |         |     |
    _____|_______________________|______________________|_________|_____|_____

    Service Connected Conditions:                    Treated
    NONE STATED

I attest that these are the diagnoses and procedures for which the
Patient was treated during this episode of care.

MD: _____________________________________    Date: ___________________

Patient: IB,PATIENT 456      XX-XX-XXXX               Printed: XXX XX, XXXX@13:18
```

- **Pending Work Report**

You can print a Pending Work List similar to the Pending Reviews option.

The report can be sorted by the following:

- Assigned to
- Due Date,
- Patient,
- Type of Review
- Current Ward

You can print the report for either Insurance Reviews, Hospital Reviews, or both. A plus sign (+) before the patient's name indicates there is both a hospital and insurance review on the list for that patient.

This report is formatted to print 132 columns.

Sample Report

```
Pending Reviews Report for Division ALBANY                                          Page 1  Feb 11, 1994@09:44:52
For Period Feb 01, 1994 to Feb 11, 1994
Patient               Pt. ID  Ward        Review Type            Due Date  Status    Assigned to   Visit   Date
-------------------------------------------------------------------------------------------------------------------
+IB,PATIENT 22         XXXX    8C ORTHO SU Hosp Review-Admission  XX/XX/XX  ENTERED   UR,NURSE      ADMIT   02/07/94 2:42 pm
 IB,PATIENT 22         XXXX    2B ICU      Hosp Review-Admission  XX/XX/XX  ENTERED   Unassigned    ADMIT   02/01/94 2:01 am
 IB,PATIENT 22         XXXX    11-B MEDICI Hosp Review-CONT. STAY XX/XX/XX  ENTERED   UR,NURSE      ADMIT   01/13/94 9:30 am
 IB,PATIENT 22         XXXX    2D ICU      Ins. Review-URG ADM    XX/XX/XX  ENTERED   Unassigned    ADMIT   02/01/94 2:01 am
 IB,PATIENT 22         XXXX    11-B MEDICI Ins. Review-URG ADM    XX/XX/XX  COMPLETE  UR,NURSE      ADMIT   01/13/94 9:30 am
+IB,PATIENT 22         XXXX    8C ORTHO SU Hosp Review-Admission  XX/XX/XX  ENTERED   UR,NURSE      ADMIT   02/07/94 2:42 pm
```

Unscheduled Admissions w/Insurance

You can print a list of patients who had active insurance on the date of their unscheduled admission. The report prints information about the number of reviews completed and the insurance companies' actions.

This report is formatted to print 132 columns.

Sample Report

```
Unscheduled Admissions with Insurance                                    Page 1  Feb 11, 1994@10:05:06
For Period beginning on 02/01/94 to 02/11/94
Patient                   Pt. ID         Adm. Date            Billable                  Ward           Type
-------------------------------------------------------------------------------------------------------------
IB,PATIENT 22             XX-XX-XXXX     XX/XX/XX 5:07 pm     YES                       9D MED
IB,PATIENT 221            XX-XX-XXXX     XX/XX/XX 11:00 am    YES                       13B PSYCH
IB,PATIENT 3              XX-XX-XXXX     XX/XX/XX 2:42 pm     YES                       8C ORTHO SUR   URGENT
IB,PATIENT 66             XX-XX-XXXX     XX/XX/XX 11:38 a     YES                       2D ICU         URGENT
IB,PATIENT 987            XX-XX-XXXX     XX/XX/XX 2:01 am     YES                       5D SURGICAL    URGENT
------------------
TOTAL = 5
```

- **UR Activity Report**

The UR Activity Report includes the **total** activity during a date range. It provides a detailed listing of the following:

- Insurance Reviews
- Hospital Reviews
- Both
- Summary Report by Admission
- Summary Report by Specialty

All completed Insurance Reviews are included. For Hospital Reviews, it lists each case reviewed indicating whether it met admission criteria and the number of days that met/did not meet the criteria for acute care.

The detailed report can be sorted by the following:

- Reviewer
- Specialty
- Patient

When the report is sorted by reviewer, it sorts within reviewer by type of review.

This report is formatted to print 132 columns.

Sample Report

UR Insurance Review Activity Report Page 1 Feb 15, 1994@10:17:10
For Insurance Reviews Dated 01/01/94 to 02/15/94

Patient	Pt. ID	Dates of Care	Review Type	Review Date	Ins. Co.	Action	Last Reviewer
IB,PATIENT 22	XX-XX-XXXX	XX/XX/XX	URG ADM	02/07/94	ABC INS	APPROVED	UR,NURSE
IB,PATIENT 67	XX-XX-XXXX	XX/XX/XX to XX/XX/XX	PRE-ADM	01/07/94	CDPHP	APPROVED	UR,NURSE
IB,PATIENT 456	XX-XX-XXXX	XX/XX/XX to XX/XX/XX	URG ADM	02/11/94	BLUE SHIELD	APPROVED	UR,NURSE

UR ACTIVITY SUMMARY REPORT
for Insurance Reviews
ALBANY (500)

From: JAN 1, 1994
To: FEB 15, 1994

Date Printed: Feb 15, 1994@10:17:10
Page: 2

Total Admissions:	15
Total Admissions to NHCU:	4
Total Admissions to Domiciliary:	1
Total Admissions Requiring Reviews:	0
Number of Scheduled Adm. Reviewed:	0
Total Admissions with Insurance:	4
Total Billable Admissions:	3
Cases with Pre-Cert and Follow-up:	0
Cases with Pre-Cert no Follow-up:	0
Number of Closed Cases:	0
Number of Billable Closed Cases:	0
Number of Unbillable Closed Cases:	0
Number of New Case Still Open:	0

```
                          Number of Previous Cases:         0
          Number of Previous Cases Closed and Billable:         9
        Number of Previous Cases Closed, not Billable:         0
                  Number of Previous Cases still Open:         0

                  Number of Outpatient Cases Reviewed:         0


                       Reason Not Billable Report: Reason             Count
                       ---------------------------  ------------------------
                                                    NOT INSURED            1
```

```
INSURANCE REVIEW SPECIALTY SUMMARY REPORT            Feb 15, 1994@10:17:10   Page 3
For Insurance Reviews Dated 01/01/94 to 02/15/94

                          Days             Days          Amount          Amount
Specialty                 Approved         Denied        Approved        Denied
-------------------------------------------------------------------------------
GENERAL MEDICINE                0              0             $0              $0
MEDICINE                        5             10         $4,135          $8,270
ORTHOPEDIC SURGERY              0              0             $0              $0
UROLOGY                         0              1             $0          $1,164
Unknown                         0              0             $0              $0
-------------------------------------------------------------------------------
                                5             11         $4,135          $9,434
```

```
UR Hospital Review Activity Report                                                    Page 4  Feb 15, 1994@10:17:10
For Hospital Reviews Dated 01/01/94 to 02/15/94

                                  Dates of                        Admission      Days Met    Days Not Met
Patient                Pt. ID       Care          Review Type     Met Criteria   Criteria    Criteria      Assigned
Reviewer
-------------------------------------------------------------------------------------------------------------------
IBpatient,one          000-11-1111  02/07/94      RANDOM          YES                    1           0      JOHN

IBpatient, two         000-22-2222 12/23/93       RANDOM          YES                    1           0      ED

IBpatient, three    000-33-3333 02/01/94 to       COPD            YES                    1           0      STEVE
                                   02/09/94
IBpatient, four     000-44-4444  12/29/93         LOCAL                                  1           0      SEAN
```

UR ACTIVITY SUMMARY REPORT
for Hospital Reviews
ALBANY (500)

From: JAN 1, 1994
To: FEB 15, 1994

Date Printed: Feb 15, 1994@10:17:10
Page: 5

Total Admissions:	15
Total Cases Reviewed:	14
Number of New Case Still Open:	0
Number of Previous Cases:	3
Number of Previous Cases still Open:	0
Total Random Sample Cases:	12
Total Special Condition Cases:	1
COPD:	1
CVD:	0
TURP:	0
Total Locally Added Cases:	1
Total Cases Meeting Criteria on Adm.:	13
Total Cases Not Meeting Crit. on Adm.:	1
Total Days Reviewed:	20
Total Days Meeting Criteria:	14
Total Days Not Meeting Criteria:	6

HOSPITAL REVIEW SPECIALTY SUMMARY REPORT Feb 15, 1994@10:17:10 Page 6

For Hospital Reviews Dated 01/01/94 to 02/15/94

Specialty	Admissions Met Criteria	Admissions Not Met Crit.	Days Met Criteria	Days Not Met Crit.
GENERAL MEDICINE	5	0	0	5
MEDICINE	1	0	2	1
NEUROLOGY	0	0	1	0
ORTHOPEDIC SURGERY	3	0	0	3
PSYCHIATRY	1	0	0	1
SURGERY	2	0	1	2
UROLOGY	1	1	2	1
	13	1	6	14

5.8. Hospital Reviews

Note: Hospital reviews are no longer done using VistA Claims Tracking. National Utilization Management Integration (NUMI) is a web-based application that supports hospital reviews.

This option is designed to allow the entry of the utilization management information required by the Quality Management office. The Claims Tracking module will automatically identify a random sample of admissions (see the Claim Tracking Parameter Edit option) that require review. Hospital reviews are the application of Interqual criteria to determine if the admission or continued stay meets specific criteria. This module will allow entry of the category of criteria that was met for Severity of Illness and Intensity of Service or the reasons that criteria was not met. An entry for every day being reviewed is required. This can easily be accomplished by using the Add Next Review action which is designed to reduce the data entry time by duplicating the entries for days where the information is identical.

The following screens show the Claims Tracking screens accessed through this option and the actions available on each screen:

```
                                  Hospital Reviews
-------------------------------------------------------------------------------
AI  Add Next Hosp.Review      VE  View/Edit Review          CP  Change Patient
DR  Delete Review             DU  Diagnosis Update         EX  Exit
QE  Quick Edit                PU  Procedure Update
CS  Change Status             PV  Provider Update
```

```
                               Expanded Hospital Reviews
-------------------------------------------------------------------------------
AI  Add Ins. Review           SC  SC Conditions            PV  Provider Update
DR  Delete Review             AE  Appeals Edit             RW  Review Wksheet Print
CS  Change Status             AC  Add Comment              CP  Change Patient
QE  Quick Edit                DU  Diagnosis Update         EX  Exit
VE  View/Edit Review          PU  Procedure Update
```

5.8.1. About the Screens

In the top left corner of each screen is the screen title. A plus sign (+) at the bottom left of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right on the screen. Available actions are displayed below the screen. Two question marks entered at any "Select Action" prompt displays all available actions for that screen. For more information on the use of the screens, please refer to the appendix at the end of this manual.

You may quit from any screen, which will bring you back one level or screen, or you may enter the Exit action.

5.8.2. Common Actions

The following are actions common to both screens accessed through this option:

- **Change Status** - This action allows you to quickly change the status of a review. Only completed reviews are used in the report preparation and by the MCCR NDB roll-up or the QM roll-up (which is tentatively scheduled for release in June, 1994).

Reviews have a status of ENTERED when automatically added. A status of PENDING may be used for those you are still working on or when one person does the data entry and another needs to review it.

- **Diagnosis Update** - This action allows input of ICD diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis and the onset date of the diagnosis for this admission. For outpatient visits this information is stored with the outpatient encounter information.
- **Procedure Update** - This action allows the input of ICD procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional for use.
- **Provider Update** - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document individual physicians if the administrative record indicates teams, or vice versa.

5.8.3. Hospital Reviews Screen

This following actions are available from the Hospital Reviews screen:

- **Add Next Hosp. Review** - This action allows you to add the next review and automatically set it to either an admission review or continued stay review. The day for review and review date are automatically computed but can be edited. The category of severity of illness and intensity of service that was met can be entered; or if not met, the reason it was not met.
- **Delete Review** - This action allows a hospital review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It can be as important to document that no review is required as it is to document the required reviews.
- **Quick Edit** - This action allows you to quickly edit all information about the review without leaving the Pending Review option.
- **View/Edit Review** - This action allows you to access to the Expanded Hospital Reviews Screen.
- **Change Patient** - This action allows you to change the selected patient without leaving the option.

Sample Screen

```
Hospital Reviews              Feb 03, 1994 13:49:45          Page:   1 of    1
 Hospital Review Entries for: IB,PATIENT 77     XXX   ROI: OBTAINED
                         for: INPATIENT ADMISSION on 01/13/94 9:30 am
    Review Date    Type       Ward      Status     Specialty   Day  Next Review
1   01/15/94       CONT. STA  11-B ME   COMPLETE   MEDICINE     3   01/17/94
2   01/14/94       CONT. STA  11-B ME   COMPLETE   MEDICINE     2
3   01/13/94       Admission  11-B ME   COMPLETE   MEDICINE     1




          Random Sample                                                  >>>
AN  Add Next Hosp. Review VE  View/Edit Review      CP  Change Patient
DR  Delete Review          DU  Diagnosis Update     EX  Exit
QE  Quick Edit             PU  Procedure Update
CS  Change Status          PV  Provider Update
Select Action: Quit//
```

5.8.4. Expanded Hospital Reviews Screen

The following actions are available from the Expanded Hospital Reviews screen:

- **Review Information** - This action allows you to enter/edit the type of review (admission or continued stay), review date, and the specialty and methodology for the review. There should be only one admission review (pre-certification or urgent/ emergent admission review) for an admission. Normally, reviews are done for UR purposes on days 3, 6, 9, 14, 21, 28, and every 7 days thereafter. (Usually, the INTERQUAL method is used as the methodology for UR required review. Insurance carriers may require other review methodologies.)
- **Add Comment** - This action allows you to edit the word processing (comments) field in Hospital or Insurance Reviews without having to edit other fields.
- **Criteria Update** - This action allows you to enter or edit data regarding criteria met/not met for an acute admission within 24 hours, such as the review date and methodology; severity of illness and intensity of service; and whether additional reviews are required.

Sample Screens

```
Expanded Hospital Reviews     Feb 03, 1994 13:55:38          Page:   1 of    3
Expanded Review for: IB,PATIENT 77      XXXX   ROI:OBTAINED
                for: CONTINUED STAY REVIEW on 01/15/94

  Visit Information                          Review Information
    Visit Type: INPATIENT ADMISSION             Review Type: CONTINUED STAY REVI
Admission Date: XXX XX,XXXX@09:30:35            Review Date: XX/XX/XX
          Ward: 11-B MEDICINE XREF                Specialty: MEDICINE
     Specialty: MEDICINE                        Methodology: INTERQUAL
                                                 Ins. Action:

  Criteria Information
    Day of Review: 3
  Severity of Ill: CARDIOVASCULAR
 Intensity of Svc: CARDIOVASCULAR
   Apply all Days:
 Non-Acute Reason:
   No. Acute Days:
   Non-Acute Days:

+         Enter ?? for more actions
RI  Review Information    CU  Criteria Update       PV  Provider Update
CS  Change Status         DU  Diagnosis Update      EX  Exit
AC  Add Comments          PU  Procedure Update
Select Action: Quit// Next Page

Expanded Hospital Reviews     Feb 03, 1994 13:58:13          Page:   2 of    3
Expanded Review for: IB,PATIENT 77     XXXX   ROI:OBTAINED
                for: CONTINUED STAY REVIEW on 01/15/94
+
  Status Information                         Clinical Information
    Review Status: ENTERED                        Provider: IBprovider,one
       Entered by: UR,NURSE 3                Admitting Diag: 101.0 - VINCENTS ANG
       Entered on: XX/XX/XX 2:51 pm            Primary Diag:
     Completed by: UR,NURSE 3                 1st Procedure: 89.44 - CARDIAC STRE
     Completed on: XX/XX/XX 2:53 pm           2nd Procedure:
 Next Review Date: XX/XX/XX                     Interim DRG: 0 -  on
                                               Estimate ALOS:   0.0
                                              Days Remaining:   0.0

  Review Comments
   Patient not doing well, consult to psych is recommended.
+         Enter ?? for more actions
RI  Review Information    CU  Criteria Update       PV  Provider Update
CS  Change Status         DU  Diagnosis Update      EX  Exit
AC  Add Comments          PU  Procedure Update
```

```
Select Action: Quit// Next Page

Expanded Hospital Reviews     Feb 03, 1994 14:09:46          Page:   3 of    3
Expanded Review for: IBpatient,one     1111   ROI:OBTAINED
                for: CONTINUED STAY REVIEW on 01/15/94
+

  Visit Information                          Review Information
     Visit Type: INPATIENT ADMISSION            Review Type: CONTINUED STAY REVI
 Admission Date: XXX XX,XXXX@09:30:35           Review Date: XX/XX/XX
           Ward: 11-B MEDICINE XREF               Specialty: MEDICINE
      Specialty: MEDICINE                       Methodology: INTERQUAL
                                                Ins. Action:

  Criteria Information
    Day of Review: 3
  Severity of Ill: CARDIOVASCULAR
 Intensity of Svc: CARDIOVASCULAR
   Apply all Days:
 Non-Acute Reason:
   No. Acute Days:
+         Enter ?? for more actions
RI  Review Information    CU  Criteria Update       PV  Provider Update
CS  Change Status         DU  Diagnosis Update      EX  Exit
AC  Add Comments          PU  Procedure Update
Select Action: Quit//
```

6. Claims Tracking Menu for Billing ...

This Claims Tracking menu is intended for Billing personnel. Billing personnel sometimes need to obtain Claims Tracking data for the preparation of third-party bills. You may also need to update Claims Tracking if you determine, for example, that an event is not billable though this capability has also been added to IB.

Sample Menu

```
   CT     Claims Tracking Edit
   PS     Print CT Summary for Billing
   RN     Assign Reason Not Billable
   TP     Third Party Joint Inquiry

Select Claims Tracking Menu for Billing <TEST ACCOUNT> Option:
```

6.1. Claims Tracking Edit

This option allows you to enter a patient's name and then view all of the patient's current Claims Tracking events.

The following screens show the actions accessed through this option and the actions available on each subsequent screen:

```
                              Claims Tracking Editor
--------------------------------------------------------------------------------
BI  Billing Info Edit         CP  Change Patient           EX  Exit
VE  View/Edit Episode         CD  Change Date Range
SC  SC Conditions             VP  View Pat. Ins.
```

```
                          Expanded Claims Tracking Entry
------------------------------------------------------------------------------
BI  Billing Info Edit         TA  Treatment Auth.          EX  Exit
RI  Review Info               SE  Submit Claim to ECME
```

6.1.1. About the Screens

In the top left corner of each screen is the screen title. A plus sign (+) at the bottom left of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right on the screen. Available actions are displayed below the screen. Two question marks entered at any "Select Action" prompt displays all available actions for that screen. For more information on the use of the screens, please refer to the appendix at the end of this manual.

You may quit from any screen, which will bring you back one level or screen, or you may enter the Exit action.

6.1.2. Common Actions

The following are actions common to both screens accessed through this option:

- **Billing Info Edit** – This action allows you to enter the reason for which an event is determined to be unbillable. You will also need to enter a comment if you enter a reason equal to Other.

6.1.3. Claims Tracking Editor Screen

The following actions are available from the Claims Tracking Editor screen:

- **View/Edit Episode** – This action allows you to jump to the Expanded Claims Tracking Entry screen.
- **SC Conditions** – This action allows you to see what, if any, service connected conditions are recorded for the patient.
- **Change Patient** – This action allows you to change the selected patient without having to leave and reenter the option.
- **Change Date Range** – This action allows you to change the date range of events without having to leave and reenter the option.
- **View Pat. Ins. –** This action takes you to the Patient Insurance Screens. Note: From this instance of the Patient Insurance Screen users may not add, edit, or delete Patient Policy Comments. It is in view only mode. For more detailed information on Patient Insurance Menu, refer to the IB V. 2.0 User Manual.

Sample Screen

```
Claims Tracking Editor        Oct 27, 2014@17:16:01          Page:    1 of    1
Claims Tracking Entries for: IB,PATIENT 300  IXXXX
    for Visits beginning on: 10/27/13 to 11/10/14
    Type      Urgent  Date             Ins.  UR    ROI           Bill  Ward
1   *INPT.    NO      07/16/14 1:48 pm YES                       YES   C MEDICI
2   INPT.     NO      05/06/14 9:25 am YES                       NO
3   Sch Adm   NO      01/07/14 10:00 a YES                       YES
4   OPT.      NO      01/06/14 4:00 pm YES                       YES

          Service Connected: NO    *=Current Admission                      >>>
BI  Billing Info Edit     CP  Change Patient        EX  Exit
VE  View/Edit Episode     CD  Change Date Range
SC  SC Conditions         VP  View Pat. Ins.
```

```
Select Action: Quit//
```

6.2. Print CT Summary for Billing

You can print a Claims Tracking Summary which can be used for preparation of a bill/claim. The content of the summary is based upon the type of Claims Tracking event.

Sample Report

```
Bill Preparation Report                          Page 1  Oct 23, 2014@14:53:41

IB,PATIENT 78               XX-XX-XXXX            DOB: XXX XX, XXXX
INPATIENT ADMISSION on XXX XX, XXXX@13:22:16
--------------------------------------------------------------------------------
 Visit Information
    Visit Type: INPATIENT ADMISSION          Visit Billable: YES
Admission Date: XXX XX,XXXX@13:22:16         Second Opinion: NOT REQUIRED
          Ward: C MEDICINE                   Auto Bill Date: XXX XX,XXXX
     Specialty: MEDICINE                    Special Consent: ROI NOT DETERMINED
Discharge Date:                             Special Billing:
    ----------------------------------------------------------------------

  Insurance Information
          Ins. Co 1: AETNA US HEALTHCARE     Pre-Cert Phone: 800/523-7978
             Subsc.: IB,PATIENT 78                     Type: COMPREHENSIVE MAJO
          Subsc. ID: WXXXXXXXX                      Group: GRP NUM 8802
          Coord Ben: SECONDARY               Billing Phone: 800/523-7978
     Filing Time Fr:                          Claims Phone: 800/523-7978
Group Plan Comments:
    ----------------------------------------------------------------------
  Billing Information
  Initial Bill:                        Estimated Recv (Pri): $
   Bill Status:                        Estimated Recv (Sec): $
 Total Charges: $        0             Estimated Recv (ter): $
   Amount Paid: $        0               Means Test Charges: $
    ----------------------------------------------------------------------

  Eligibility Information
       Primary Eligibility: NSC, VA PENSION
         Means Test Status:
 Service Connected Percent: Patient Not Service Connected
    ----------------------------------------------------------------------
  Diagnosis Information
      Nothing on File

  Associated Interim DRG Information
      Nothing on File
    ----------------------------------------------------------------------

  Procedure Information
      Nothing on File
    ----------------------------------------------------------------------

  Provider Information
      Nothing on File
    ----------------------------------------------------------------------

  Insurance Review Information
    Type Review: CONTINUED STAY REVIEW       Review Date: XX/XX/XX@1:41 pm
         Action: DENIAL                   Insurance Co.: AETNA US HEALTHCARE
    Denied From: XX/XX/XX               Person Contacted:
      Denied To: XX/XX/XX                 Contact Method: PHONE
 Denial Reasons: FAILURE TO MEET PAYER  Call Ref. Number:
                                                 Status: PENDING
```

```
                                        Last Edited By: UR,NURSE
Comment:
   ------------------------------------------------------------------------
    Type Review: URGENT/EMERGENT ADMIT       Review Date: XX/XX/XX
         Action:                          Insurance Co.: AETNA US HEALTHCARE
                                       Person Contacted:
                                         Contact Method:
                                       Call Ref. Number:
                                                 Status: ENTERED
                                         Last Edited By:
Comment:
   ------------------------------------------------------------------------
```

6.3. Assign Reason Not Billable

This option provides the ability to enter a patient's name and the Claims Tracking event which has been determined to be non-billable. This option also provides the ability for you to enter the following data:

- REASON NOT BILLABLE:
- EARLIEST AUTO BILL DATE: OCT 22,2014//
- OTHER TYPE OF BILL: OTHER//
- ESTIMATED INS. PAYMENT (PRI):
- ESTIMATED INS. PAYMENT (SEC):
- ESTIMATED INS. PAYMENT (TER):
- ESTIMATED MT CHARGES:
- ESTIMATED TOTAL CHARGES:
- ADDITIONAL COMMENT:
- Current BILLABLE FINDINGS: <none existing>
    - Do you wish to Add or Change Findings?

For some Reasons Not Billable such as Other, you must add an additional comment of at least 15 characters. If you remove the default date in the Earliest Auto Bill Date field, the autobiller will not create a claim for this event.

6.4. Third Party Joint Inquiry

This option is shared by all the financial modules within VistA and appears on numerous menus and options of the Claims Tracking, IB, and AR modules. You can use the Third Party Joint Inquiry (TPJI) option to look up a specific claim or all the claims, active and inactive, for a selected patient. You can add comments from within TPJI but the option is designed primarily as a source of information.

Note: For more detailed information on TPJI, refer to the IB V. 2.0 User Manual.

This option provides the following types of patient and claim information:

- Bill Charges
- Explanation of Benefits
- Bill Diagnoses
- Bill Procedures
- AR Account Profile

- Comment History
- Insurance Reviews
- Health Summary
- Insurance Company
- Insurance Policy
- Annual Benefits
- Patient Eligibility
- Expanded Benefit Information
- Electronic Claims Management Engine (ECME) - Prescription Claims
- EDI Status – electronic claim data

7. Claims Tracking Menu (Hospital Reviews) ...

This menu was intended for those RUR Nurses who did Hospital reviews. Refer to the Claims Tracking Menu (Combined Functions)… menu for details of the following options:

- Pending Reviews
- Claims Tracking Edit
- Hospital Reviews
- Inquire to Claims Tracking
- Reports Menu (Claims Tracking) ...
- Supervisors Menu (Claims Tracking) ...
- Single Patient Admission Sheet

Note: Hospital reviews are now done using the web-based National Utilization Management Integration (NUMI) system.

8. Claims Tracking Menu (Insurance Reviews)…

This menu was intended for those RUR Nurses who do Insurance reviews. Refer to the Claims Tracking Menu (Combined Functions)… menu for details of the following options:

- Pending Reviews
- Appeal/Denial Edit
- Claims Tracking Edit
- Inquire to Claims Tracking
- Insurance Review Edit
- Reports Menu (Claims Tracking) ...
- Supervisors Menu (Claims Tracking) ...
- Single Patient Admission Sheet
- Third Party Joint Inquiry

8.1. Health Care Services Review (HCSR) 278 Response

In addition to the above options, the Claims Tracking Menu (Insurance Reviews)… menu contains the Health Care Services Review (HCSR) 278 Response option. You can use this option

to view an X12N Health Care Services – Request for Review and Response (278) response from the UMO.

You can enter a patient's name and the system will display a list of events. You can then select the event response you wish to view.

When an X12N Health Care Services – Request for Review and Response (278) response with a final status is received by VistA, the patient's entry on the HCSR Worklist is removed. To view the response or to take further action such as submitting an Appeal, you may use the Health Care Services Review (HCSR) 278 Response option or the HCSR Response WL action from within the HCSR Worklist.

The following are final statuses:

- A1 – Certified in total
- A3 – Not Certified
- A6 – Modified
- C – Cancelled
- CT – Contact payer
- NA – No Action Required

Sample 278 Response Screens

```
HCSR Response View            Nov 13, 2014@10:09:54          Page:    1 of    7
IB,PATIENT 343                    XX-XX-XXXX     DOB: XXX X,XXXX    AGE: XX

                          Insurance Company Information
    Name: CIGNA                                 Reimburse?: WILL REIMBURSE
   Phone: 800/525-5803                       Billing Phone: 800/525-5803
                                             Precert Phone: 800/877-1209
 Address: PO BOX 9358, SHERMAN, TX  75091

                               Group/Plan Information
  Type Of Plan: COMPREHENSIVE MAJOR MEDICAL        Require UR: YES
       Group?: YES                                 Require Amb Cert:
    Group Name: CIGNA                              Require Pre-Cert: YES
  Group Number: WXXXXX                             Exclude Pre-Cond:
           BIN:                                 Benefits Assignable: YES
           PCN:

Plan Comments:

+         Enter ?? for more actions

SR  (Send 278 Request)    RP  Remove 'In Progress'
SP  Set 'In Progress'     VR  View Sent Request     EX  Exit
Select Action: Next Screen//
```

```
HCSR Response View            Nov 13, 2014@10:10:43          Page:    2 of    7
IB,PATIENT 343                    XX-XX-XXXX     DOB: XXX X,XXXX    AGE: XX
+
                          Policy/Subscriber Information
  Insured's Name: IB,PATIENT 343               Effective: 1/1/2014
   Subscriber Id: 123456789                       Expiration:
    Relationship: SELF                     Coord of Benefits: PRIMARY
   Insured's DOB: 1/1/1979
```

```
 Employer Sponsored Group Health Plan?:

                        User Added Comments for This Entry
  UMO Contact Information
  UMO Name:
  UMO Contact #:

  UMO Name:
  UMO Contact #:

                                PATIENT EVENT DETAIL

+         Enter ?? for more actions

SR  (Send 278 Request)    RP  Remove 'In Progress'
SP  Set 'In Progress'     VR  View Sent Request     EX  Exit
Select Action: Next Screen//
```

```
HCSR Response View            Nov 13, 2014@10:11:05          Page:    3 of    7
IB,PATIENT 343                    XX-XX-XXXX     DOB: XXX X,XXXX    AGE: XX
+
  Health Care Services Review
  Certification Action:  Certified in total
  Certification/Authorization Number:  XXXXXXXXXXXX
  Review Decision Reason:
  Second Surgical Opinion Ind:

  Admin Ref #:
  Previous Review Autho #:
  Proposed/Actual Event Date:
  Proposed/Actual Admission Date:  XXX XX,XXXX@09:00
  Proposed or Discharge Date:
  Cert. Effective Date:
  Cert. Issue Date:                         Cert. Expiration Date:XXX XX, XXXX

  Health Care Services Delivery
  Quantity Qualifier:  Visits               Service Unit Count:  1
  Unit/Basis for Measure Code:              Sample Selection Modulus:
  Time Period Qualifier:                      Period Count:
+         Enter ?? for more actions

SR  (Send 278 Request)    RP  Remove 'In Progress'
SP  Set 'In Progress'     VR  View Sent Request     EX  Exit
Select Action: Next Screen//
```

Note: Much of the data in the 278 Response is the same data that you include in your 278 Request.

The following important data is in the Health Care Services Review section of the response:

- Certification Action
- Certification/Authorization Number
- Review Decision Reason
- Certification Effective Date
- Certification Issue Date
- Certification Expiration Date

Note: The certification/authorization number that is received in the response will be automatically added to a third-party bill (billing screen 10) for the patient event when the billing clerk adds each payer to the claim (billing screen 3). The certification/authorization number(s) will then be transmitted in the X12N Health Care Claim (837) transaction to the payer(s).

```
HCSR Response View            Nov 13, 2014@10:11:31          Page:    4 of    7
IB,PATIENT 343                    XX-XX-XXXX     DOB: XXX X,XXXX    AGE: XX
+
  Delivery Frequency:
  Delivery Pattern:

  Patient Diagnosis Information
  No Diagnosis Information

  Institutional Claim Code
  Admission Type Code:                        Admission Source Code:
  Patient Status Code:  INPATIENT

  Ambulance Transport Information
  Ambulance Transport Code:                Unit/Basis for Measure Code:
  Transport Distance:

  Spinal Manipulation Service Information
  No Spinal Manipulation Service Information

+         Enter ?? for more actions

SR  (Send 278 Request)    RP  Remove 'In Progress'
SP  Set 'In Progress'     VR  View Sent Request     EX  Exit
Select Action: Next Screen//
```

```
HCSR Response View            Nov 13, 2014@10:12:22          Page:    5 of    7
IB,PATIENT 343                    XX-XX-XXXX     DOB: XXX X,XXXX    AGE: XX
+
  Home Oxygen Therapy Information
  No Home Oxygen Therapy Information

  Home Health Care Information
  Prognosis Code:                        Home Health Start Date:
  Home Health Certification Period:      Start:            End:
  Medicare Coverage Indicator:
  Certification Type Code:  Initial

  Additional Patient Information
  No Additional Patient Information

  Message Text:
XXXXXXX XX XXX XXXXXXX XXX XXXXXXXX XXX XXXXXX X XXXXXXXXXX XXXXXXXX XXXX.

  Additional Patient Information Contact Data
  No Additional Patient Information Contact Data
+         Enter ?? for more actions

SR  (Send 278 Request)    RP  Remove 'In Progress'
SP  Set 'In Progress'     VR  View Sent Request     EX  Exit
Select Action: Next Screen//
```

```
HCSR Response View            Nov 13, 2014@10:13:18          Page:    6 of    7
```

```
IB,PATIENT 343                    XX-XX-XXXX     DOB: XXX X,XXXX    AGE: XX
+

  Additional Patient Information Contact
  Response Contact Name:
  Response Contact #:

  Patient Event Provider Information
   Entity Provider Code:  24
   Provider ID:  XXXXXXXXXX               Provider Taxonomy:  Person
   Provider Name: IB,DOCTOR 32
   Provider Address: 123 TEST LN
                          CHEYENNE, WY  82002

  Patient Event Transport Information
   No Patient Event Transport Information

                                  SERVICE DETAIL
  No Service Detail Lines available
+         Enter ?? for more actions

SR  (Send 278 Request)    RP  Remove 'In Progress'
SP  Set 'In Progress'     VR  View Sent Request     EX  Exit
Select Action: Next Screen//
```

8.2. Health Care Services Review (HCSR) Worklist

The X12N Health Care Services Review – Request for Review and Response transaction is an Electronic Data Interchange (EDI) standard for the transmission of standardized data for the request of care authorizations or certifications and for the responses to those requests. The messages from VistA to the Financial Services Center (FSC) in Austin, TX are Health Level Seven (HL7) messages. The HL7 messages received by FSC are converted to a HIPAA compliant format and sent to a Health Care Clearing House (HCCH). The HCCH then sends the transaction to the payer or the payer's Utilization Management Organization. The UMO returns either a Pending notification to the VAMC or a response containing the authorization/certification number or denial of services or error condition. The 278 transactions from VistA are real-time transactions and are transmitted as soon as you trigger a request.

Refer to the eBilling_Build 2 ICD for details of the message structures.

8.2.1. The HCSR Worklist

You can select either only CHAMPVA/TRICARE if you are at a site and responsible for UR for these payers, only CPAC if you are not responsible for CHAMPVA and TRICARE and Both if you are responsible for all types of authorizations and certifications.

Sample HCSR Worklist Screens

```
Select Claims Tracking Menu (Insurance Reviews) <TEST ACCOUNT> Option: hw
Health Care Services Review (HCSR) Worklist


     Select one of the following:

          T         CHAMPVA/TRICARE
          C         CPAC
          B         Both
```

```
Show CHAMPVA/TRICARE entries, CPAC entries or Both: B//oth
```

You can select either Outpatient, Inpatient or Both types of events to be included on your worklist.

If you select Inpatient or Both, you are prompted for one or more wards.

Note: If you leave the ward prompt blank, you will get all wards.

If you select Outpatient or Both, you are prompted for one or more clinics.

Note: If you leave the Clinic prompt blank, you will get all clinics.

The screen then displays all of your choices.

You are then able to select how you want you worklist displayed (sorted).

```
Select one of the following:

          O         Outpatient
          I         Inpatient
          B         Both

Show Inpatient entries, Outpatient entries or Both: B//oth
Select Ward: C SURGERY
Select Another Ward:
Select Clinic: TEST
Select Another Clinic: TEST 1
Select Another Clinic: TEST 2
Select Another Clinic:

Show CHAMPVA/TRICARE entries, CPAC entries or Both: B
Show Inpatient entries, Outpatient entries or Both: B
Clinics to Display: TEST, TEST 1, TEST 2
Wards to Display:   C SURGERY

Enter RETURN to continue or '^' to exit:

     Select one of the following:

          1         Oldest Entries First
          2         Newest Entries First
          3         Outpatient Appointments First
          4         Inpatient Admissions First
          5         Insurance Company Name

Sort the list by: Oldest Entries First//
```

The worklist is displayed.

Sample HCSR Worklist

```
HCSR Worklist                 Oct 29, 2014@15:03:41          Page:    1 of    3
Filtered By: Both CPAC and Champ/TRICARE, Selected Outpt, Selected Inpt
Sorted By:   Oldest Entries First
      Patient Name           S Apt Date Ward/Clnc COB Insurance Comp U/P SC Re
1    *IB,PATIENT 2      XXXX O 08/29/14 TEST       P  AETNA US HEALT Y Y
2    ?IB,PATIENT 2      XXXX O 08/29/14 TEST       S  NEW YORK LIFE
3    *IB,PATIENT 37     XXXX O 09/02/14 TEST       P  CIGNA          Y Y
4    *IB,PATIENT 6      XXXX O 09/15/14 TEST       P  BCBS SERVICE B
5    ?IB,PATIENT 37     XXXX O 09/15/14 TEST       P  CIGNA HEALTHCA   Y
6    ?IB,PATIENT 37     XXXX O 09/15/14 TEST       S  CHAMPVA
```

```
7    ?IB,PATIENT 44     XXXX O 09/18/14 TEST 2     S  AETNA US HEALT Y Y
8    ?IB,PATIENT 44     XXXX O 10/07/14 TEST       P  AETNA          N   A
9     IB,PATIENT 2      XXXX O 10/09/14 TEST 1     S  NEW YORK LIFE
10   ?IB,PATIENT 777    XXXX O 10/09/14 TEST 2     P  BLUE CROSS/BS  N N
11   ?IB,PATIENT 2      XXXX O 10/14/14 TEST 1     P  AETNA US HEALT Y Y
12    IB,PATIENT 2      XXXX O 10/14/14 TEST 1     S  NEW YORK LIFE
13    IB,PATIENT 98     XXXX I 10/16/14 C SURGERY  P  CIGNA
14   #IB,PATIENT 37     XXXX I 10/17/14 C SURGERY  P  BLUE CROSS/BS  N N
+         ?Await #In-Prog -RespErr !Unable +Pend *NextRev
DE Remove Entry           AC Add Comment            SP Set 'In Progress' Mark
EE Expand Entry           ST Sort List              RP Remove 'In Progress' Mark
AE Add Entry              NR Next Review Date       PR HCSR Response WL
RL Refresh                EX Exit
Select Action: Next Screen//
```

The following actions are available from the HCSR Worklist:

- **Remove Entry** - This action allows you to remove an entry from the list.
- **Expand Entry** – This action allows you to select and expand an entry from the list.
- **Add Entry** – This actions allows you to add an entry to the list
- **Next Review Date** – This action allows you to delay a review until a specified future date or until an inpatient is discharged. Next Review Date is for inpatient entries only.
- **Add Comment** – This action allows you to enter a free text comment. The comments can be viewed in Expanded Entry. The user's name and the date and time are added to the comment automatically.
- **Sort List** – This action allows you to resort the worklist based on the following:
    - Oldest Entries First
    - Newest Entries First
    - Outpatient Appointments First
    - Inpatient Admissions First
    - Insurance Company Name
- **HCSR Response WL** – This action allows you to view a list of entries with final 278 Responses.

Note: When an X12N Health Care Services – Request for Review and Response (278) response with a final status is received by VistA, the patient's entry on the HCSR Worklist is removed. To view the response or to take further action such as submitting an Appeal, you may use the either the stand-alone Health Care Services Review (HCSR) 278 Response option or this HCSR Response WL action.

The following are final statuses:

- A1 – Certified in total
- A3 – Not Certified
- A6 – Modified
- C – Cancelled
- CT – Contact payer
- NA – No Action Required

- **Set 'In Progress' Mark** – This action allows you to mark an entry as being worked by you. The software places a pound sign (#) before the patient's name.

Note: If you start a 278 request and need to stop for some reason before you are done, the data you have entered will be saved and the entry will be automatically marked 'In Progress'.

- **Remove "In Progress' Mark** – This action allows you to remove the 'In Progress' indicator.
- **Refresh** – this action allows you to rebuild the worklist without leaving the option.

The HCSR Worklist provides an on screen legend which provides the following information:

```
?Await #In-Prog -RespErr !Unable +Pend *NextRev
```

- **?Await** – This indicator means that a 278 Request has been transmitted and a response has not yet been received.
- **#In-Prog** – This indicator means someone is working on this entry.
- **-RespErr** – This indicator means a 278 Request was sent and a 278 Response has been received which contains an error condition.
- **!Unable** – This indicator means VistA was unable to send a 278 Request for some reason (example: missing required data).
- **+Pend -** This indicator means a 278 Request was sent and a PENDING 278 Response has been received.
- ***NextRev -** This indicator means the entry on the worklist has been delayed either until a specific date or until the patient's discharge date.

Sample Next Review Date Screen

```
HCSR Worklist                  Oct 30, 2014@14:00:08          Page:    1 of    3
Filtered By: Both CPAC and CHAMPVA/TRICARE, Selected Outpt, Selected Inpt
Sorted By:   Oldest Entries First
      Patient Name           S Apt Date Ward/Clnc COB Insurance Comp U/P SC Re
1    *IB,PATIENT 2      XXXX O 08/29/14 TEST       P  AETNA US HEALT Y Y
2    ?IB,PATIENT 2      XXXX O 08/29/14 TEST       S  NEW YORK LIFE
3    *IB,PATIENT 37     XXXX O 09/02/14 TEST       P  CIGNA          Y Y
4    *IB,PATIENT 6      XXXX O 09/15/14 TEST       P  BCBS SERVICE B
5    ?IB,PATIENT 37     XXXX O 09/15/14 TEST       P  CIGNA HEALTHCA   Y
6    ?IB,PATIENT 37     XXXX O 09/15/14 TEST       S  CHAMPVA
7    ?IB,PATIENT 44     XXXX O 09/18/14 TEST 2     S  AETNA US HEALT Y Y
8    ?IB,PATIENT 44     XXXX O 10/07/14 TEST       P  AETNA          N   A
9     IB,PATIENT 2      XXXX O 10/09/14 TEST 1     S  NEW YORK LIFE
10   ?IB,PATIENT 777    XXXX O 10/09/14 TEST 2     P  BLUE CROSS/BS  N N
11   ?IB,PATIENT 2      XXXX O 10/14/14 TEST 1     P  AETNA US HEALT Y Y
12    IB,PATIENT 2      XXXX O 10/14/14 TEST 1     S  NEW YORK LIFE
13    IB,PATIENT 98     XXXX I 10/16/14 C SURGERY  P  CIGNA
14   #IB,PATIENT 37     XXXX I 10/17/14 C SURGERY  P  BLUE CROSS/BS  N N
+         ?Await #In-Prog -RespErr !Unable +Pend *NextRev
DE Remove Entry           AC Add Comment            SP Set 'In Progress' Mark
EE Expand Entry           ST Sort List              RP Remove 'In Progress' Mark
AE Add Entry              NR Next Review Date       PR HCSR Response WL
RL Refresh                EX Exit
Select Action: Next Screen// NR   Next Review Date
Select Event Entry(s):  (1-14): 2
Enter 'D' or Future Date for Entry 2: ??

Entry a future date or 'D' to delay until discharge.  A 'D' will remove the
selected entries from the worklist until the patients have been discharged.
Entering a Date will remove the selected entries from the worklist until the
selected date.

Enter 'D' or Future Date for Entry 2: D
```

Sample Add Comment Screen

```
HCSR Worklist                  Oct 30, 2014@14:04:13          Page:    1 of    3
Filtered By: Both CPAC and CHAMPVA/TRICARE, Selected Outpt, Selected Inpt
Sorted By:   Oldest Entries First
      Patient Name           S Apt Date Ward/Clnc COB Insurance Comp U/P SC Re
1    *IB,PATIENT 2      XXXX O 08/29/14 TEST       P  AETNA US HEALT Y Y
2    ?IB,PATIENT 2      XXXX O 08/29/14 TEST       S  NEW YORK LIFE
3    *IB,PATIENT 37     XXXX O 09/02/14 TEST       P  CIGNA          Y Y
4    *IB,PATIENT 6      XXXX O 09/15/14 TEST       P  BCBS SERVICE B
5    ?IB,PATIENT 37     XXXX O 09/15/14 TEST       P  CIGNA HEALTHCA   Y
6    ?IB,PATIENT 37     XXXX O 09/15/14 TEST       S  CHAMPVA
7    ?IB,PATIENT 44     XXXX O 09/18/14 TEST 2     S  AETNA US HEALT Y Y
8    ?IB,PATIENT 44     XXXX O 10/07/14 TEST       P  AETNA          N   A
9     IB,PATIENT 2      XXXX O 10/09/14 TEST 1     S  NEW YORK LIFE
10   ?IB,PATIENT 777    XXXX O 10/09/14 TEST 2     P  BLUE CROSS/BS  N N
11   ?IB,PATIENT 2      XXXX O 10/14/14 TEST 1     P  AETNA US HEALT Y Y
12    IB,PATIENT 2      XXXX O 10/14/14 TEST 1     S  NEW YORK LIFE
13    IB,PATIENT 98     XXXX I 10/16/14 C SURGERY  P  CIGNA
14   #IB,PATIENT 37     XXXX I 10/17/14 C SURGERY  P  BLUE CROSS/BS  N N
+         ?Await #In-Prog -RespErr !Unable +Pend *NextRev
DE Remove Entry           AC Add Comment            SP Set 'In Progress' Mark
EE Expand Entry           ST Sort List              RP Remove 'In Progress' Mark
AE Add Entry              NR Next Review Date       PR HCSR Response WL
RL Refresh                EX Exit
Select Action: Next Screen// AC   Add Comment
```

```
Select Event Entry(s):  (1-14): 1
COMMENT:
  No existing text
  Edit? NO// y  YES

==[ WRAP ]==[ INSERT ]===============< COMMENT >=============[ <PF1>H=Help ]====
This is a test comment for an entry on the HCSR WL.



<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======
```

Sample HCSR Response WL

```
HCSR Response Worklist        Nov 17, 2014@16:08:46          Page:    1 of    2
Filtered By: Both CPAC and CHAMPVA/TRICARE, All Outpt, All Inpt
Sorted By:   Oldest Entries First
     Patient Name            S Apt Date Ward/Clnc COB Insurance Comp CertAct
1    IB,PATIENT 2       XXXX I 08/27/14 C MEDICINE S  NEW YORK LIFE  A2
2    IB,PATIENT 56      XXXX I 09/15/14 O&E SURGIC P  CIGNA          A1
3    IB,PATIENT 203     XXXX O 09/15/14 TEST       P  CIGNA HEALTHCA A1
4    IB,PATIENT 66      XXXX O 09/22/14 C MEDICINE S  BLUE CROSS/BS  A1
5    IB,PATIENT 543     XXXX O 10/02/14 TESTIB     S  BLUE CROSS CA  A3
6    IB,PATIENT 11      XXXX O 10/09/14 TEST 1     S  NEW YORK LIFE  A3
7    IB,PATIENT 92      XXXX O 10/22/14 TEST       S  BLUE CROSS/BS  A1
8    IB,PATIENT 123     XXXX O 10/30/14 TEST       P  AETNA          C
9    IB,PATIENT 6       XXXX O 10/30/14 TEST 1     S  AETNA HEALTH P A3
10   IB,PATIENT 44      XXXX O 10/30/14 TEST 1     S  AETNA HEALTH P NA
11   IB,PATIENT 129     XXXX O 10/31/14 TEST       P  AETNA GROUP IN C
12   IB,PATIENT 377     XXXX I 11/01/14 O&E MEDICA P  CIGNA          A1
13   IB,PATIENT 10      XXXX O 11/03/14 TEST       P  AETNA          A1
14   IB,PATIENT 76      XXXX O 11/04/14 TEST 2     P  AETNA GROUP IN C
15   IB,PATIENT 3       XXXX O 11/10/14 TEST 1     P  AETNA US HEALT A1
+         Enter ?? for more actions
DE  Remove Entry          ST  Sort                 RP  Remove 'In Progress'
EE  Expand Entry          RL  Refresh              EX  Exit
NR  Next Review Date      SP  Set 'In Progress'
Select Action: Next Screen//
```

When you expand an entry from this list, a screen is displayed that looks the same as the stand-alone Health Care Services Review (HCSR) 278 Response option.

```
HCSR Response View            Nov 13, 2014@10:09:54          Page:    1 of    7
IB,PATIENT 343                    XX-XX-XXXX     DOB: XXX X,XXXX    AGE: XX

                          Insurance Company Information
    Name: CIGNA                                Reimburse?: WILL REIMBURSE
   Phone: 800/525-5803                       Billing Phone: 800/525-5803
                                             Precert Phone: 800/877-1209
 Address: PO BOX 9358, SHERMAN, TX  75091

                               Group/Plan Information
  Type Of Plan: COMPREHENSIVE MAJOR MEDICAL        Require UR: YES
       Group?: YES                              Require Amb Cert:
    Group Name: CIGNA                           Require Pre-Cert: YES
  Group Number: WXXXXX                          Exclude Pre-Cond:
           BIN:                               Benefits Assignable: YES
           PCN:

Plan Comments:

+         Enter ?? for more actions
SR  (Send 278 Request)    RP  Remove 'In Progress'
SP  Set 'In Progress'     VR  View Sent Request     EX  Exit
Select Action: Next Screen//
```

Sample Set 'In Progress' Mark Screen

```
HCSR Worklist                  Oct 30, 2014@14:21:51          Page:    2 of    3
Filtered By: Both CPAC and CHAMPVA/TRICARE, Selected Outpt, Selected Inpt
Sorted By:   Oldest Entries First
+     Patient Name           S Apt Date Ward/Clnc COB Insurance Comp U/P SC Re
1    *IB,PATIENT 2      XXXX O 08/29/14 TEST       P  AETNA US HEALT Y Y
2    ?IB,PATIENT 2      XXXX O 08/29/14 TEST       S  NEW YORK LIFE
3    *IB,PATIENT 37     XXXX O 09/02/14 TEST       P  CIGNA          Y Y
4    *IB,PATIENT 6      XXXX O 09/15/14 TEST       P  BCBS SERVICE B
5    ?IB,PATIENT 37     XXXX O 09/15/14 TEST       P  CIGNA HEALTHCA   Y
6    ?IB,PATIENT 37     XXXX O 09/15/14 TEST       S  CHAMPVA
7    ?IB,PATIENT 44     XXXX O 09/18/14 TEST 2     S  AETNA US HEALT Y Y
8    ?IB,PATIENT 44     XXXX O 10/07/14 TEST       P  AETNA          N   A
9     IB,PATIENT 2      XXXX O 10/09/14 TEST 1     S  NEW YORK LIFE
10   ?IB,PATIENT 777    XXXX O 10/09/14 TEST 2     P  BLUE CROSS/BS  N N
11   ?IB,PATIENT 2      XXXX O 10/14/14 TEST 1     P  AETNA US HEALT Y Y
12   #IB,PATIENT 2      XXXX O 10/14/14 TEST 1     S  NEW YORK LIFE
13    IB,PATIENT 98     XXXX I 10/16/14 C SURGERY  P  CIGNA
14   #IB,PATIENT 37     XXXX I 10/17/14 C SURGERY  P  BLUE CROSS/BS  N N
+         ?Await #In-Prog -RespErr !Unable +Pend *NextRev
DE Remove Entry           AC Add Comment            SP Set 'In Progress' Mark
EE Expand Entry           ST Sort List              RP Remove 'In Progress' Mark
AE Add Entry              NR Next Review Date       PR HCSR Response
RL Refresh                EX Exit
Select Action: Next Screen// sp   Set 'In Progress' Mark
Select Event Entry(s):  (15-28): 13
```

Sample Remove 'In Progress" Mark Screen

```
HCSR Worklist                 Oct 30, 2014@14:47:22          Page:    2 of    3
Filtered By: Both CPAC and CHAMPVA/TRICARE, Selected Outpt, Selected Inpt
Sorted By:   Newest Entries First
+     Patient Name           S Apt Date Ward/Clnc COB Insurance Comp U/P SC Re
1    *IB,PATIENT 2      XXXX O 08/29/14 TEST       P  AETNA US HEALT Y Y
2    ?IB,PATIENT 2      XXXX O 08/29/14 TEST       S  NEW YORK LIFE
3    *IB,PATIENT 37     XXXX O 09/02/14 TEST       P  CIGNA          Y Y
4    *IB,PATIENT 6      XXXX O 09/15/14 TEST       P  BCBS SERVICE B
5    ?IB,PATIENT 37     XXXX O 09/15/14 TEST       P  CIGNA HEALTHCA   Y
6    ?IB,PATIENT 37     XXXX O 09/15/14 TEST       S  CHAMPVA
7    ?IB,PATIENT 44     XXXX O 09/18/14 TEST 2     S  AETNA US HEALT Y Y
8    ?IB,PATIENT 44     XXXX O 10/07/14 TEST       P  AETNA          N   A
9     IB,PATIENT 2      XXXX O 10/09/14 TEST 1     S  NEW YORK LIFE
10   ?IB,PATIENT 777    XXXX O 10/09/14 TEST 2     P  BLUE CROSS/BS  N N
11   ?IB,PATIENT 2      XXXX O 10/14/14 TEST 1     P  AETNA US HEALT Y Y
12   #IB,PATIENT 2      XXXX O 10/14/14 TEST 1     S  NEW YORK LIFE
13    IB,PATIENT 98     XXXX I 10/16/14 C SURGERY  P  CIGNA
14   #IB,PATIENT 37     XXXX I 10/17/14 C SURGERY  P  BLUE CROSS/BS  N N
+         ?Await #In-Prog -RespErr !Unable +Pend *NextRev
DE Remove Entry           AC Add Comment            SP Set 'In Progress' Mark
EE Expand Entry           ST Sort List              RP Remove 'In Progress' Mark
AE Add Entry              NR Next Review Date       PR HCSR Response WL
RL Refresh                EX Exit
Select Action: Next Screen// rp   Remove 'In Progress' Mark
Select Event Entry(s):  (15-28): 12
```

8.2.2. HCSR Expanded Entry

This option provides you with the ability to view more information related to an entry and to create an initial X12N Health Care Services Review – Request for Review and Response (278 - 217) request to the UMO. It also provides you with the ability to force a follow-up X12N Health Care Services Review – Request for Review and Response (278 - 215) inquiry to the UMO. If a 278 request results in an error condition, you can fix the error and resubmit the request.

Note: An initial 278 transaction is referred to as a 278 - 217 transaction. A follow-on 278 inquiry sent in response to a Pending reply to an initial 217 is referred to as a 278 - 215 transaction.

Note: If a UMO responds to a X12N Health Care Services Review – Request for Review and Response (278 - 217) request with a Pending response, then the requester must respond with a follow-up X12N Health Care Services Review – Request for Review and Response (278 - 215) inquiry. VistA will automatically create and submit the 215 inquiry based on the number of days set in the following site parameters:

- Inquiry can be Triggered for Appointment: 2//
- Inquiry can be Triggered for Admission: 1//

Sample HCSR Expanded Entry Screens

```
HCSR Expanded Entry           Oct 30, 2014@14:59:32          Page:    1 of    3
IB,PATIENT M                        XX-XX-XXXX    DOB: XX-XX-XXXX     AGE: XX

                          Insurance Company Information
    Name: BLUE CROSS CA (65-WY)              Reimburse?: WILL REIMBURSE
   Phone:                                  Billing Phone: 877/737-7776
                                           Precert Phone:
 Address: PO BOX 60007, LOS ANGELES, CA  90060

                             Group/Plan Information
  Type Of Plan: PREFERRED PROVIDER ORGANIZATION (PPO)Require UR:
       Group?: YES                           Require Amb Cert:
    Group Name: GRP NAME 10                  Require Pre-Cert:
  Group Number: GRP NUM 10794                Exclude Pre-Cond:
           BIN:                            Benefits Assignable: YES
           PCN:

+         Enter ?? for more actions
SR (Send 278 Req Full)    DP View Pending Resp      SP Set 'In Progress'
SS Send 278 Req Brief     AC Add Comment            RP Remove 'In Progress'
CR (Copy 278 Request)     SI Send 278 Inquiry       VR View Sent Request
EX Exit
Select Action: Next Screen//
```

```
HCSR Expanded Entry           Oct 30, 2014@15:05:19          Page:    2 of    3
IB,PATIENT M                        XX-XX-XXXX    DOB: XX-XX-XXXX     AGE: XX

+
Plan Comments:
          THIS GROUP NAME "CALPERS" STANDS FOR CALIFORNIA PUBLIC EMPLOYEES'
          RETIREMENT SYSTEM.

                          Policy/Subscriber Information
  Insured's Name: IB,PATIENT M                    Effective: 3/2/2014
   Subscriber Id: RXXXXXXX                       Expiration:
    Relationship: SELF                    Coord of Benefits: SECONDARY
   Insured's DOB: X/X/XXXX
 Employer Sponsored Group Health Plan?:

                       User Added Comments for This Entry
User's Name: UR,NURSE 2             Date Comment Entered: 10/30/2014@15:03:38
 Comment:
 This is a Test comment.
+         Enter ?? for more actions

SR (Send 278 Req Full)    DP View Pending Resp      SP Set 'In Progress'
SS Send 278 Req Brief     AC Add Comment            RP Remove 'In Progress'
CR (Copy 278 Request)     SI Send 278 Inquiry       VR View Sent Request
EX Exit
Select Action: Next Screen//
```

```
HCSR Expanded Entry           Oct 30, 2014@15:07:25          Page:    3 of    3
IB,PATIENT M                       XX-XX-XXXX    DOB: XX-XX-XXXX     AGE: XX

+

User's Name: UR,NURSE 2             Date Comment Entered: 10/30/2014@15:04:17
 Comment:
 This is a follow-up Test comment.



          Enter ?? for more actions

SR (Send 278 Req Full)    DP View Pending Resp      SP Set 'In Progress'
SS Send 278 Req Brief     AC Add Comment            RP Remove 'In Progress'
CR (Copy 278 Request)     SI Send 278 Inquiry       VR View Sent Request
EX Exit
Select Action: Quit//
```

The following actions are available from the HCSR Expanded Entry screen:

- **Send 278 Request Full** – This action allows you to send an initial X12N Health Care Services Review – Request for Review and Response (278) request to the UMO.

  This action also allows you to edit a 278 request for resubmission when the original results in an error condition.

  Note: This action is currently disabled

- **Send 278 Request Brief –** This action allows you to send an initial X12N Health Care Services Review – Request for Review and Response (278) request to the UMO by selecting one of the following brief request formats:
  - Admission (Initial)
  - Appointment (Initial)

- **Copy 278 Request** – This action allows you to enter the data for a X12N Health Care Services Review – Request for Review and Response (278) request to a primary payer and then to copy that data to a new request for a secondary and/or tertiary payer.

  Note: This action is currently disabled

- **View Pending Response** – This actions allows you to view a Pending response from the UMO.
- **Add Comment** - This action allows you to enter a free text comment. The comments can be viewed in Expanded Entry. The user's name and the date and time are added to the comment automatically.
- **Send 278 Inquiry** – This action allows you to send a X12N Health Care Services Review – Inquiry and Response for a 278 request or inquiry with a Pending status. It also allows you to send a X12N Health Care Services Review – Inquiry and Response to cancel a 278 request or inquiry with a Pending status.
- **Set 'In Progress' Mark** – This action allows you to mark an entry as being worked by you. The software places a pound sign (#) before the patient's name.
- **Remove "In Progress' Mark** – This action allows you to remove the 'In Progress' indicator.

- **View Sent Request** – This action allows you to view the request or inquiry that was sent to payer in X12 format

Sample Send 278 Request Screens – Outpatient Brief

```
HCSR 278 Appointment - Brief          Nov 04, 2014@15:29:07       Page:    1 of    5
IB,PATIENT 543                      XX-XX-XXXX      DOB: XXX XX,XXXX    AGE: XX

 UM Organization                          Requester
  Name*: Aetna                            Name*: CHEYENNE VAMC
  National Payer ID*: XXXXXXXXXX         NPI*: XXXXXXXXXX
  HPID: XXXXXX                            Tax ID*: XXXXXXXXX
                                          Taxonomy Code: XXXXXXXXX
 Subscriber                               Address*: 1234 Test Blvd
  Name*: IB,SPOUSE                        City: CHEYENNE
  Primary ID*: WXXXXXXXXX                 State/ZIP*: WY 82005
  Address:123 TEST BLVD                   Contact Name*: UR,NURSE 34
  City/State/ZIP: FORT COLLINS WY 82007   Contact Phone/Ext.:
                                          Contact Fax:

+         Enter ?? for more actions
SR Send 278 Request       AD Add Data       EX Exit

Select Action: Next Screen//
```

```
HCSR 278 Appointment - Brief          Nov 04, 2014@15:29:07          Page: 2 of    5
IB,PATIENT 543                      XX-XX-XXXX      DOB: XXX XX,XXXX    AGE: XX

 Dependent                                Diagnosis
  Name: IB,PATIENT 543                    Diagnosis Qualifier:
                                          Diagnosis:

 Health Care Service Review               Provider Information
  Category*: Health Services Review       Provider Type:
  Certification Type*: Initial            Provider Name:
  Service Type*: Medical                   Provider NPI:
  Facility Type*: ON CAMPUS-OUTPATIENT HOSPITAL


+         Enter ?? for more actions
SR Send 278 Request       AD Add Data       EX Exit

Select Action: Next Screen//
```

```
HCSR 278 Appointment - Brief          Nov 04, 2014@15:29:07       Page:    3 of    5
IB,PATIENT 543                      XX-XX-XXXX      DOB: XXX XX,XXXX    AGE: XX

 Service Line                             Paperwork Attachments

 Service Line #:                          Report Type:
 Date of Service: Appointment Date        Transmission Method:
 Procedure Code*:                         Attachment Control Number:

 Request Comments
 Message:

+         Enter ?? for more actions
```

```
SR Send 278 Request       AD Add Data       EX Exit

Select Action: Next Screen//AD Add data



                              PATIENT EVENT DETAIL

Patient Event Service Type: Medical Care// 1       Medical Care
  Diagnosis Qualifier: ABF       ICD-10 Diagnosis
  Patient Event Diagnosis: M25.539

     Searching for a ICD-10 Diagnosis


 One match found

     M25.539   Pain in unspecified wrist

   OK?  Yes//   YES   M25.539   Pain in unspecified wrist


The following Diagnoses are currently on file.

#   Type   Diagnosis
--  -----  ---------
1   ABF    M25.539

Enter the # of a Diagnosis to edit, 'NEW' to add one or press Return to skip.
Selection #:
  Product or Service ID Qualifier: HC//   CPT/HCPCS Code
  Procedure: 73100

     Searching for a HCPCS (CPT) Procedure Codes
  73100    X-RAY EXAM OF WRIST
        ...OK? Yes//   (Yes)


The following Service Lines are currently on file.

#   Proc Code
--  --------------------
1   73100

Enter the # of a line to edit, 'NEW' to add one or press Return to skip.
Selection #:

Patient Event Provider Data
  Provider Type: DK       Ordering Physician
  Provider: IB,DOCTOR R

     Searching for a VA providers
  IB,DOCTOR R     VMS     111     PHYSICIAN
        ...OK? Yes//   (Yes)


The following Provider Data Information is currently on file.

#   Provider Type                     Provider
--  ------------------------------  ------------------------------
1   Ordering Physician              IB,DOCTOR R

Enter the # of an entry to edit, 'NEW' to add one or press Return to skip.
```

```
Selection #:

No Additional Patient Information is currently on file.

Add Additional Patient Information? NO// YES
  Report Type: RADIOLOGY REPORTS  RR     Radiology reports
  Report Transmission: AVAI  Available on request at provider site
  Attachment Control #:


The following Additional Patient Information is currently on file.

#   Report Type                  Delivery Method        Attachment Control #
--  ---------------------------  ---------------------  ----------------------
1   Radiology reports            Available on request

Enter the # of an entry to edit, 'NEW' to add one or press Return to skip.
Selection #:

Message Text:
  1>
Requester Contact Name: UR,STAFF 1//

Type of Requester Contact Number #1: TE//        Telephone
Requester Contact Number #1: 1112223333
Type of Requester Contact Number #2: FX       Facsimile
Requester Contact Number #2: 444555666
Type of Requester Contact Number #3:
```

```
HCSR 278 Appointment - Brief          Nov 04, 2014@15:29:07       Page:    4 of    5
IB,PATIENT 543                     XX-XX-XXXX      DOB: XXX XX,XXXX    AGE: XX

 Dependent                                          Diagnoses
  Name: IB,PATIENT 543                              Diagnosis Qualifier: ICD-10 Diag
                                                    Diagnosis: M25.539

 Health Care Service Review                         Provider Information
  Category*: Health Services Review                  Provider Type:Ordering Physician
  Certification Type*: Initial                      Provider Name: IB,DOCTOR R
  Service Type*: Diagnostic X-Ray                   NPI: XXXXXXXXXX
  Facility Type*: ON CAMPUS-OUTPATIENT HOSPITAL


+         Enter ?? for more actions
SR Send 278 Request       AD Add Data       EX Exit

Select Action: Next Screen//
```

```
HCSR 278 Appointment - Brief          Nov 04, 2014@15:29:07          Page:    5 of    5
IB,PATIENT 543                     XX-XX-XXXX      DOB: XXX XX,XXXX    AGE: XX

 Service Line                                       Paperwork Attachments
 Service Line #: 1                                  Report Type: Radiology Report
 Date of Service: Appointment Date                  Transmission Method: Available on Request
 Procedure Code*: 73100                             Attachment Control Number:



 Request Comments
```

```
 Message:



+         Enter ?? for more actions
SR Send 278 Request       AD Add Data       EX Exit

Select Action: Next Screen// Send 278 Request
```

9. MCCR Site Parameters

The MCCR Site Parameter Display/Edit option is an IB option that can be used to update IB, Claims Tracking, Automated Billing and Insurance Verification parameters. Refer to the IB V. 2.0 User Manual for a full description of all of the parameters.

Sample Screen

```
MCCR Site Parameters          Oct 28, 2014@12:39          Page:    1 of    1
Display/Edit MCCR Site Parameters.
Only authorized persons may edit this data.


 IB Site Parameters                          Claims Tracking Parameters
    Facility Definition                         General Parameters
    Mail Groups                                 Tracking Parameters
    Patient Billing                             Random Sampling
    Third Party Billing                         HCSR Parameters
    Provider Id
    EDI Transmission

 Third Party Auto Billing Parameters         Insurance Verification
    General Parameters                          General Parameters
    Inpatient Admission                         Batch Extracts Parameters
    Outpatient Visit                            Service Type Codes
    Prescription Refill

          Enter ?? for more actions
IB  Site Parameter        AB  Automated Billing     EX  Exit
CT  Claims Tracking       IV  Ins. Verification
Select Action: Quit//
```

The difference between the MCCR Site Parameter Display/Edit option and the Claims Tracking - Claims Tracking Parameter Edit option is that you can view all of the Claims Tracking parameters from MCCR Site Parameters Display/Edit option. The Claims Tracking Parameter Edit option only allows you to view/edit those parameters that are editable. Refer to the Claims Tracking Menu (Combined Functions)… → Supervisor Menu (Claims Tracking)… → Claims Tracking Parameter Edit.

9.1. The MCCR Site Parameter Display/Edit

The MCCR Site Parameter Display/Edit allows you to see all the following Claims Tracking parameter values:

- Tracking Parameters
  - Track Inpatient:
    - OFF
    - INSURED AND UR ONLY

        - ALL PATIENTS
    - Track Outpatient
        - OFF
        - INSURED ONLY
        - ALL PATIENTS
    - Track Rx
        - OFF
        - INSURED ONLY
        - ALL PATIENTS
    - Track Prosthetics
        - OFF
        - INSURED ONLY
        - ALL PATIENTS
- General Parameters
    - Extended Help
        - OFF
        - ON
    - Initialization Date
        - Date
    - Use Admission Sheet
        - NO
        - YES
    - Header Line 1
        - Free text
    - Header Line 2
        - Free text
    - Header Line 3
        - Free text
- Random Sample Parameters
    - Medicine Sample
        - Number
    - Medicine Admissions
        - Number
    - Surgery Sample
        - Number
    - Surgery Admissions
        - Number
    - Psych Sample
        - Number
    - Psych Admissions
        - Number

The sample number and the admissions number are used by the system to compute a random number.

- Health Care Services Review (HCSR) Parameters
  - CPAC Future Appointments Search: 30 days - Not editable
  - CPAC Future Admissions Search: 30 days – Not editable
  - CPAC Past Appointments Search: 14 days – Not editable
  - CPAC Past Admissions Search: 14 days – Not editable
  - TRICARE/CHAMPVA Future Appointments Search: 30 days – Not editable
  - TRICARE/CHAMPVA Future Admissions Search: 30 days – Not editable
  - TRICARE/CHAMPVA Past Appointments Search: 14 days – Not editable
  - TRICARE/CHAMPVA Past Admissions Search: 14 days – Not editable
  - Inquiry can be Triggered for Appointment
    - ❖ Number of days before an automatic 278 is triggered
  - Inquiry can be Triggered for Admission
    - ❖ Number of days before an automatic 278 is triggered
  - Days to wait to purge entry on HCSR Response
    - ❖ Number of days before a 278 response is removed from the worklist
  - Clinics Included In the Search – Defined in MCCR Site Parameters
  - Wards Included In the Search - Defined in MCCR Site Parameters
  - Insurance Companies Included In Appointments Search - Defined in MCCR Site Parameters
  - Insurance Companies Included In Admissions Search - Defined in MCCR Site Parameters

Sample Screens

```
Claims Tracking Parameters    Oct 28, 2014@13:09:50          Page:    1 of    2
Only authorized persons may edit this data.

           Tracking Parameters                    Random Sample Parameters
     Track Inpatient: INSURED AND UR ONLY       Medicine Sample: 5
    Track Outpatient: INSURED ONLY          Medicine Admissions: 5
            Track Rx: INSURED ONLY               Surgery Sample: 5
   Track Prosthetics: INSURED ONLY           Surgery Admissions: 5
  Reports Can Add CT: YES                           Psych Sample: 1
                                              Psych Admissions: 5

           General Parameters
 Initialization Date: 01/01/94
 Use Admission Sheet: NO
       Header Line 1: CHEYENNE VAMC
       Header Line 2: 2360 E. PERSHING BLVD
       Header Line 3: CHEYENNE, WY

+         Enter ?? for more actions
TP  Tracking              RS  Random Sample         GP  General
EA  Edit All              HS  HCSR                  EX  Exit
Select Action: Next Screen//
```

```
HCSR Parameters               Oct 28, 2014@14:20:48          Page:    1 of    1
Only authorized persons may edit this data.

                  Health Care Services Review (HCSR) Parameters
                         CPAC Future Appointments Search:   30 days
                           CPAC Future Admissions Search:   30 days
                           CPAC Past Appointments Search:   14 days
                             CPAC Past Admissions Search:   14 days
              TRICARE/CHAMPVA Future Appointments Search:   30 days
                TRICARE/CHAMPVA Future Admissions Search:   30 days
                TRICARE/CHAMPVA Past Appointments Search:   14 days
                  TRICARE/CHAMPVA Past Admissions Search:   14 days
                Inquiry can be Triggered for Appointment:    2 days
                  Inquiry can be Triggered for Admission:    1 days
            Days to wait to purge entry on HCSR Response:   20 days
                           Clinics Included In the Search:    3
                             Wards Included In the Search:    0
     Insurance Companies Included In Appointments Search:    6
       Insurance Companies Included In Admissions Search:    8
           Enter ?? for more actions
HC  Clinics                 HW  Wards                 OP  Other
HA  Adm Ins                 HI  Appt Ins              EX  Exit
Select Action: Quit//
```

9.1.1. Clinics Included In the Search

This parameter is defined in an option within the HCSR parameters. You can add an existing clinic for all payers or selected payers from the Hospital Location file to a list of clinics that will be included in the nightly search for appointment events. If a patient has an appointment in one of these clinics, his/her appointment event will be added to the HCSR Worklist.

If circumstances change, a clinic can be deleted from this inclusion list or a payer can be deleted from the clinic.

Note: If you remove a clinic from the list, it will affect future searches. Entries already on the list from earlier searches, will remain on the worklist.

```
HCSR Parameters               Oct 28, 2014@15:10:55          Page:    1 of    1
Only authorized persons may edit this data.


                  Health Care Services Review (HCSR) Parameters
                         CPAC Future Appointments Search:   14 days
                           CPAC Future Admissions Search:   14 days
                           CPAC Past Appointments Search:    7 days
                             CPAC Past Admissions Search:    7 days
              TRICARE/CHAMPVA Future Appointments Search:   14 days
                TRICARE/CHAMPVA Future Admissions Search:   14 days
                TRICARE/CHAMPVA Past Appointments Search:    7 days
                  TRICARE/CHAMPVA Past Admissions Search:    7 days
                Inquiry can be Triggered for Appointment:    0 days
                  Inquiry can be Triggered for Admission:    0 days
            Days to wait to purge entry on HCSR Response:   20 days
                         Clinics Included In the Search:    3
                           Wards Included In the Search:    0
     Insurance Companies Included In Appointments Search:    6
       Insurance Companies Included In Admissions Search:    9
           Enter ?? for more actions
HC  Clinics                 HW  Wards                 OP  Other
HA  Adm Ins                 HI  Appt Ins              EX  Exit
```

```
Select Action: Quit// HC
```

```
HCSR Clinic Inclusions        Nov 19, 2014@10:51:39          Page:    1 of    1
Only authorized persons may edit this data.
Clinics Included in the Search:

 1    CHY CARDIOLOGY             -for all payers
 2    TEST                       -for 2 payers
 3    TEST 1                     -for all payers
 4    TEST 2                     -for all payers
 5    TESTIB                     -for all payers


          Enter ?? for more actions
AC  Add Clinic            AP  Add Payer to Clinic   EX  Exit
DL  Delete Clinic         DP  Delete Payer from Clinic
Select Action: Quit// ac   Add Clinic

**Warning**
Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health
Care Services Review Worklist.

Select a Clinic to be added: FTC DIABETIC      IB,DOCTOR L
Clinic is currently included in the list for no payers


INCLUDE FOR ALL PAYERS?: NO// y  YES
Select a Clinic to be added:


Select Action: Quit// ap   Add Payer to Clinic

Select HCSR Clinic(s):  (1-5): 2

Clinic is currently included in the list for the following 2 payers:

AETNA
CIGNA

INCLUDE FOR ALL PAYERS?: NO//
Select Payer: BCBS KANSAS CITY
Payer added to the list.
Select Payer:
```

9.1.2. Wards Included in the Search

This parameter is defined in an option within the HCSR parameters. You can add an existing ward for all payers or selected payers from the Hospital Location file to a list of wards that will be included in the nightly search for admission events. If a patient has an admission to one of these wards, his/her admission event will not be added to the HCSR Worklist if the wards are not specified in the inclusion list.

Note: If circumstances change, a ward can be deleted from this inclusion list or a payer can be deleted from the ward.

Note: If you remove a ward from the list, it will affect future searches. Entries already on the list from earlier searches, will remain on the worklist.

Sample Screens

```
HCSR Parameters              Oct 28, 2014@15:10:55          Page:    1 of    1
Only authorized persons may edit this data.


                 Health Care Services Review (HCSR) Parameters
                        CPAC Future Appointments Search:   14 days
                          CPAC Future Admissions Search:   14 days
                          CPAC Past Appointments Search:    7 days
                            CPAC Past Admissions Search:    7 days
              TRICARE/CHAMPVA Future Appointments Search:   14 days
                TRICARE/CHAMPVA Future Admissions Search:   14 days
                TRICARE/CHAMPVA Past Appointments Search:    7 days
                  TRICARE/CHAMPVA Past Admissions Search:    7 days
                Inquiry can be Triggered for Appointment:    0 days
                  Inquiry can be Triggered for Admission:    0 days
            Days to wait to purge entry on HCSR Response:   20 days
                           Clinics Included In the Search:    3
                             Wards Included In the Search:    0
    Insurance Companies Included In Appointments Search:    6
      Insurance Companies Included In Admissions Search:    9
          Enter ?? for more actions
HC  Clinics                HW  Wards                 OP  Other
HA  Adm Ins                HI  Appt Ins              EX  Exit
```

```
HCSR Ward Inclusions         Nov 19, 2014@10:56:13          Page:    1 of    0
Only authorized persons may edit this data.
Wards Included In the Search:

1    O&E MEDICAL                    - for 2 payers
2    TRANSITIONAL                   - for all payers









          Enter ?? for more actions
AW  Add Ward               AP  Add Payer to Ward     EX  Exit
DW  Delete Ward            DP  Delete Payer from Ward
Select Action: Quit// AW   Add Ward

**Warning**
Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health
Care Services Review Worklist.


Select a Ward to be added: C MEDICINE
INCLUDE FOR ALL PAYERS?: NO// Y
Select a Ward to be added:


Select Action: Quit// AP   Add Payer to Ward
Select HCSR Ward(s):  (1-2): 1

Ward is currently included in the list for the following 2 payers:
```

```
CIGNA NATIONAL
CIGNA

INCLUDE FOR ALL PAYERS?: NO//
Select Payer: bcbs of Kansas
Payer added to the list.
Select Payer:
```

9.1.3. Insurance Companies Included In Appointment Search

This parameter is defined in an option within the HCSR parameters. You can add an existing insurance company from the Insurance Company file to a list of companies that will be included in the nightly search for appointment events. If a patient has insurance with one of these insurance companies, his/her appointment event will be added to the HCSR Worklist.

Note: If circumstances change, an insurance company can be deleted from this inclusion list.

Note: If you remove an insurance company from the list, it will affect future searches. Entries already on the list from earlier searches, will remain on the worklist.

Sample Screens

```
HCSR Parameters               Oct 28, 2014@14:20:48          Page:    1 of    1
Only authorized persons may edit this data.

                 Health Care Services Review (HCSR) Parameters
                        CPAC Future Appointments Search:   14 days
                          CPAC Future Admissions Search:   14 days
                          CPAC Past Appointments Search:    7 days
                            CPAC Past Admissions Search:    7 days
             TRICARE/CHAMPVA Future Appointments Search:   14 days
               TRICARE/CHAMPVA Future Admissions Search:   14 days
               TRICARE/CHAMPVA Past Appointments Search:    7 days
                 TRICARE/CHAMPVA Past Admissions Search:    7 days
               Inquiry can be Triggered for Appointment:    0 days
                 Inquiry can be Triggered for Admission:    0 days
           Days to wait to purge entry on HCSR Response:   20 days
                           Clinics Included In the Search:    3
                           Wards Included From the Search:    0
  Insurance Companies Included From Appointments Search:    6
    Insurance Companies Included From Admissions Search:    8
          Enter ?? for more actions
HC  Clinics               HW  Wards                 OP  Other
HA  Adm Ins               HI  Appt Ins              EX  Exit
Select Action: Quit// HI   Appt Ins
```

```
HCSR Insurance Inclusions     Nov 19, 2014@11:03:09          Page:    1 of    1
Only authorized persons may edit this data.
Insurance Companies Included In the Appointment Search:
      Insurance Company Name              Address Line 1                       ST
 1    AETNA                               PO BOX 2600                          CA
 2    CIGNA                               PO BOX 9999                          KY



AI  Add Ins               DI  Delete Ins            EX  Exit
Select Action: Quit// AI   Add Ins

**Warning**
Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health
```

```
Care Services Review Worklist.

Select an Insurance Company to be added: AETNA US HEALTHCARE     PO BOX 2559
FT WAYNE     INDIANA       Y
Include all payers with the same electronic Payer ID?? NO// y  YES
Select an Insurance Company to be added:
```

9.1.4. Insurance Companies Included In Admissions Search

This parameter is defined in an option within the HCSR parameters. You can add an existing insurance company from the Insurance Company file to a list of companies that will be included in the nightly search for admission events. If a patient has insurance with one of these insurance companies, his/her admission event will be added to the HCSR Worklist.

Note: If circumstances change, an insurance company can be deleted from this inclusion list.

Note: If you remove an insurance company from the list, it will affect future searches. Entries already on the list from earlier searches, will remain on the worklist.

Sample Screens

```
HCSR Parameters               Oct 28, 2014@14:20:48          Page:    1 of    1
Only authorized persons may edit this data.

                 Health Care Services Review (HCSR) Parameters
                        CPAC Future Appointments Search:   14 days
                          CPAC Future Admissions Search:   14 days
                          CPAC Past Appointments Search:    7 days
                            CPAC Past Admissions Search:    7 days
             TRICARE/CHAMPVA Future Appointments Search:   14 days
               TRICARE/CHAMPVA Future Admissions Search:   14 days
               TRICARE/CHAMPVA Past Appointments Search:    7 days
                 TRICARE/CHAMPVA Past Admissions Search:    7 days
               Inquiry can be Triggered for Appointment:    0 days
                 Inquiry can be Triggered for Admission:    0 days
           Days to wait to purge entry on HCSR Response:   20 days
                          Clinics Included In the Search:    3
                            Wards Included In the Search:    0
    Insurance Companies Included In Appointments Search:    6
      Insurance Companies Included In Admissions Search:    8
          Enter ?? for more actions
HC  Clinics               HW  Wards                 OP  Other
HA  Adm Ins               HI  Appt Ins              EX  Exit
Select Action: Quit//
```

```
HCSR Insurance Inclusions     Nov 19, 2014@11:07:56          Page:    1 of    1
Only authorized persons may edit this data.
Insurance Companies Included In the Admissions Search:
      Insurance Company Name            Address Line 1                        ST
 1    AETNA                             PO BOX 2344                           CA
 2    CIGNA                             PO BOX 99999                          KY



AI  Add Ins               DI  Delete Ins            EX  Exit
Select Action: Quit// AI   Add Ins
```

```
**Warning**
Changing the value in CPAC/TRICARE/CHAMPVA parameters will affect the Health
Care Services Review Worklist.

Select an Insurance Company to be added: UNITED HEALTHCARE     PO BOX 30555
SALT LAKE CITY     UTAH       Y
Include all payers with the same electronic Payer ID?? NO// y  YES
Select an Insurance Company to be added:
```

10. Appendix A – Follow-up Actions Codes

The following is a list of the AAA error segments and follow-up codes that may be returned to the requester when there is a problem with an X12N Health Care Services Review – Request for Review and Response (278):

Loop	Valid Request	Segment Name	Reject Reason Codes	Follow-up Action Codes
2000A	Yes or No	AAA – Request Validation	Authorization Quantity Exceeded Authorization/Access Restrictions Unable to Respond at Current Time Invalid Participant Identification	Please Correct and Resubmit Resubmission Not Allowed Please Resubmit Original Transaction Do Not Resubmit; We Will Hold Your Request and Respond Shortly
2010A	Always No	AAA – UMO Request Validation	Unable to Respond at Current Time Invalid Participant Identification No Response received – Transaction Terminated Payer Name or Identifier Missing	Resubmission Not Allowed Please Resubmit Original Transaction Do Not Resubmit; We Will Hold Your Request and Respond Shortly
2010B	Always No	AAA – Requester Request Validation	Required application data missing Out of Network Authorization/Access Restrictions Invalid/Missing Provider Identification Invalid/Missing Provider Name Invalid/Missing Provider Specialty Invalid/Missing Provider Phone Number Invalid/Missing Provider State Provider is Not Primary Care Physician Provider Not on File Invalid Participant Identification Invalid or Missing Provider Address	Please Correct and Resubmit Resubmission Not Allowed Resubmission Allowed
2010C	Always No	AAA – Subscriber Request Validation	Invalid/Missing Date-of-Birth Invalid/Missing Patient ID Invalid/Missing Patient Name	Please Correct and Resubmit Resubmission Not Allowed

			Invalid/Missing Patient Gender Code Patient Not Found Duplicate Patient ID Number Patient Birth Date Does Not Match That for the Patient on the Database Invalid/Missing Subscriber/Insured ID Invalid/Missing Subscriber/Insured Name Invalid/Missing Subscriber/Insured Gender Code Subscriber/Insured Not Found Duplicate Subscriber/Insured ID Number Subscriber Found/Patient Not Found Invalid Participant Identification Patient Not Eligible	
2010D	Always No	AAA – Dependent Request Validation	Required application data missing Input Errors Invalid/Missing Date-of-Birth Invalid/Missing Patient ID Invalid/Missing Patient Name Invalid/Missing Patient Gender Code Patient Not Found Duplicate Patient ID Number Patient Birth Date Does Not Match That for the Patient on the Database Subscriber Found/Patient Not Found Patient Not Eligible	Please Correct and Resubmit Resubmission Not Allowed
2000E	Always No	AAA – Patient Event Request Validation	Required application data missing Input Errors Service Date Not Within Provider Plan Enrollment Inappropriate Date Invalid/Missing Date(s) of Service Date of Birth Follows Date(s) of Service Date of Death Precedes Date(s) of Service	Please Correct and Resubmit Resubmission Not Allowed

			Date of Service Not Within Allowable Inquiry Period Authorization Number Not Found Invalid/Missing Diagnosis Code(s) Invalid/Missing Onset of Current Condition or Illness Date Invalid/Missing Accident Date Invalid/Missing Last menstrual Period Date Invalid/Missing Expected dat4e of Birth Invalid/Missing Admission Date Invalid/Missing Discharge Date Certification Information Missing	
2010EA	Always No	AAA – Patient Event Provider Request Validation	Required application data missing Input Errors Out of Network Authorization/Access Restrictions Invalid/Missing Provider Identification Invalid/Missing Provider Name Invalid/Missing Provider Specialty Invalid/Missing Provider Phone Number Invalid/Missing Provider State Provider is Not Primary Care Physician Provider Not on File Service Dates Not Within Provider Plan Enrollment Invalid Participant Identification Invalid or Missing Provider Address Inappropriate Provider Role	Please Correct and Resubmit Resubmission Not Allowed
2010EC	Always No	AAA – Patient Event Transport Location Request Validation	Required application data missing Input Errors Invalid/Missing Provider State Invalid or Missing Provider Address	Please Correct and Resubmit Resubmission Not Allowed

2000F	Always No	AAA – Service Request Validation	Required application data missing Input Errors Service Dates Not Within Provider Plan Enrollment Invalid/Missing Date(s) of Service Date of Birth Follows Date(s) of Service Date of Death Procedes Date(s) of Service Date of Service Not Within Allowable Inquiry Period Authorization Number Not Found Invalid/Missing Procedure Code(s) Certification Information Missing	Please Correct and Resubmit Resubmission Not Allowed
2010FA	Always No	AAA – Service Provider Request Validation	Required application data missing Input Errors Out of Network Authorization/Access Restrictions Invalid/Missing Provider Identification Invalid/Missing Provider Name Invalid/Missing Provider Specialty Invalid/Missing Provider Phone Number Invalid/Missing Provider State Provider is Not Primary Care Physician Provider Not on File Service Dates Not Within Provider Plan Enrollment Invalid Participant Identification Invalid or Missing Provider Address Inappropriate Provider Role	Please Correct and Resubmit Resubmission Not Allowed