Requirements Specification

eBilling IB*2*623 Build 7,8,9

Project MCCF_EDI_TAS (RM)

Prepared by Jan Wilson

August 16, 2019, 1:07:08 PM CDT

Table of Contents

Introduction

The purpose of this document is to define the requirements.

Transmitting SNF Claims with a new HIPPS code <RALLY US ID 8323>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	1092389
Status	In Draft
Who	Business Architect
Version	1
Testable	Yes

Artifact Content

User Story Name: Transmitting SNF Claims with a new HIPPS code <RALLY US ID 8323>

Sizing: 3

Epic Taxonomy 1 eBiz Compliance

0 Port

0 Update

0 Increase No Touch 0 TAS Apps

Story

As an eBilling user, I want to replace RUG/HIPPS code of AAA00 with ZZZZZ effective on 10/1/2019 for Medicare primary institutional Part A claims.

Detailed Listing of Acceptance Criteria

Requirement ID Description

US8323.1 For date of service on or after 10/01/2019, the IB software will use and send a VA specific ZZZZZ RUG/HIPPS code for Medicare primary institutional Part A claims with Bill Type equals to 21x, 22x or 23x with Revenue code 0022.

US8323.2 For date of service prior to 10/01/2019, the IB software will continue to use and send a VA specific AAA00 RUG/HIPPS code for Medicare primary institutional Part A claims with Bill Type equals to 21x, 22x or 23x with Revenue code 0022.

US8323.3 Prior to creation of the secondary claim, the VPE will continue to display the extra SNF specific INS record with a new ZZZZZ RUG/HIPPS code on or after 10/01/2019 and display an existing AAA00 RUG/HIPPS code prior to 10/01/2019.

Constraints

N/A

Risks

N/A

Assumptions

Patch IB*2*608 is national released prior to this user story.

Dependencies/Impacts

Patch IB*2*608 is national released prior to this user story.

Revision History

Date Version Description Author

03/10/19 1.0 Initial Version Team Leidos

Implement Release of Information <RALLY ID US 4995>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	1091009
Status	In Draft
Who	Business Architect
Version	1
Testable	Yes

Artifact Content

User Story Name: Implement Release of Information <RALLY ID US 4995>

Sizing: 3

Epic Taxonomy	eBiz Compliance	Port	Update	Increase No Touch	TAS Apps

Story

As an eBilling user, I need to implement the Release of Information changes so that we are compliant with the Mission Act Requirements.

Detailed Listing of Acceptance Criteria

Requirement ID	Description
US4995.1	For date of service on or after 01/28/2019, the software will not prompt the users the ROI form for sensitive record
US4995.2	For date of service on or after 01/28/2019, the system will not prevent the users from completing the claim for sensitive record
US4995.3	For date of service on or after 01/28/2019, the software will send an I (Informed consent to release Medical Information for Conditions or Diagnoses regulated by federal statutes) in CL1, piece 7 of the 837 messages to FSC

Constraints

Adhere to the VA Mission Act of 2018

Risks

Sites might need a short-term solution to meet compliance until this user story is nationally released.

Assumptions

N/A

Dependencies/Impacts

N/A

Revision History

Date	Version	Description	Author
10/9/18	1.0	Initial Version	Team Leidos
1/28/19	2.0	Updated the ROI date	Team Leidos

User Story ID: US141

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	1091003
Status	In Draft
Who	Business Architect
Version	1
Testable	Yes

Artifact Content

User Story ID: US141

User Story Name: CSA-Separate CHAMPVA/Tricare

Sizing: 5

Epic Taxonomy 0 eBiz Compliance 0 Port

1 Update

0Increase No Touch

0 TAS Apps

Story

As an end user I need to sort the CSA worklist to identify MCCF and Non-MCCF claims.

Acceptance Criteria

Requirement ID Description

US141.1 The software will provide users with the ability to specify the following additional search criteria when pulling up the CSA (Claims Status Awaiting Resolution) worklist:

• MCCF (Note: MCCF is the default)

• Non-MCCF

• Both

US141.2 When the patch is installed at a site, the Non-MCCF Rate Types list under section [12] Non-MCCF Pay-To Providers in the IB Site Parameters will be prepopulated, in addition to previously defined rate type(s), with the following rate types and will be used for the Non-MCCF Claims' search.

• CHAMPVA REIMB. INS.

• CHAMPVA

• TRICARE REIMB. INS.

• TRICARE

• INTERAGENCY

• INELIGIBLE

• INELIGIBLE REIMB. INS.

• SHARING AGREEMENT

Other current Rate Types that are not defined in the Non-MCCF Rate types list under section [12] Non-MCCF Pay-To Providers in the IB Site Parameters will be applied to the MCCF claims' search.

Note: Do not prepopulate the Non-MCCF Rate Types list with duplicate value if the value is already predefined.

Constraints

None identified to date

Risks

None identified to date

Assumptions

None identified to date

Dependencies/Impacts

None identified to date

Revision History

Date Version Description Author

11/13/18 1.0 Initial Version Team Leidos

11/20/18 2.0 Updated Story's description per eBusiness' feedback Team Leidos

12/11/18 3.0 Updated US141.2 for more clarity Team Leidos

Alternate Payer ID <RALLY ID US4100>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	1014167
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

User Story Name: Alternate Payer ID <RALLY ID US4100>

Sizing: 5

Epic Taxonomy 1 eBiz Compliance

0 Port

0 Update

0Increase No Touch

0 TAS Apps

Story

As a biller I need a secondary claim that contains an alternate payer ID to submit to the secondary using the alternate payer ID not the PAYER Primary Payer ID.

Acceptance Criteria

Requirement ID Description

US4100.1 When there is an Alternate Prof Payer ID on the professional primary claim, the Integrated Billing software will include this ID in the Other Insurance loop at the claim and line level for the primary sequence in the professional secondary claim after EOB/MRA is received on the primary claim

US4100.2 When there is an Alternate Prof Payer ID on the professional secondary claim, the Integrated Billing software will include this ID in the Other Insurance loop at the claim and line level for the secondary sequence in the professional tertiary claim after EOB/MRA is received on the secondary claim

US4100.3 When there is an Alternate Inst Payer ID on the institutional primary claim, the Integrated Billing software will include this ID in the Other Insurance loop at the claim and line level for the primary sequence in the institutional secondary claim after EOB/MRA is received on the primary claim

US4100.4 When there is an Alternate Inst Payer ID on the institutional secondary claim, the Integrated Billing software will include this ID in the Other Insurance loop at the claim and line level for the secondary sequence in the institutional tertiary claim after EOB/MRA is received on the secondary claim

Constraints

N/A

Risks

N/A

Assumptions

N/A

Dependencies/Impacts

1. Note: Patch IB*2.0*547 allowed users to define Alternate Prof Payer ID and Alternate Inst Payer ID along with the ID type. The IB Site Parameter is used to house the ID types for the alternate payers. The one-time alternate payer ID can be used for the current claim.

2. We will need to simulate EOB process through the ePayment Testing Tool and work with FSC on transmitting MRA to VistA for processing.

Revision History

Date Version Description Author

5/31/18 1.0 Initial Version Team Leidos

Dental Claims Mock-up <RALLY ID US 4055>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	1012623
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

User Story Name: Dental Claims Mock-up <RALLY ID US 4055>

Sizing: 5

Epic Taxonomy	eBiz Compliance	Port	Update	Increase No Touch	TAS Apps

Story

As a biller I would like to be able to type ?J430D (or something similar) at the end of my claim to see what information will be transmitted on a dental claim before completing and to see a warning message when I enter more than 4 diagnosis codes.

Acceptance Criteria

Requirement ID	Description
US4055.1	The Integrated Billing software will generate a mock-up of the claim with the following data for viewing only after the users finish capturing all the information through screen 10 and press Enter: • Claim provider(s) from screen 10 • Dental Claim Note • Diagnosis Codes (Display diagnosis codes 1 thru 4 only)

	• Date of Service • Place of Service • Oral Cavity Designation • Tooth Code • Tooth Surface • Procedure Code • Modifier • Associated Diagnosis • Quantity • Charge
US4055.2	The Integrated Billing software will provide users with the ability to correct the claim after the display of the mock-up.
US4055.3	The Integrated Billing software will provide users with the ability to create a help screen on J430D to bring up the dental mockup from any outpatient dental screens when they are viewing or editing those screens.
US4055.4	The Integrated Billing software will provide a warning message "Only 4 diagnosis codes are allowed on a dental transaction" at the end of the claim when users enter more than 4 diagnosis codes on screen 5.

Constraints

None

Risks

None

Assumptions

1. Note: When Patch IB*2*592 is national released, all dental claims will be electronic. Local printing to the J430D form will not be allowed.
2. Mock-up of the claim doesn't represent the order of the actual J430D form. It contains the information captured/system calculated in screen 5, 7 and 10.

Dependencies/Impacts

None

Revision History

Date	Version	Description	Author
5/24/18	1.0	Initial Version	Team Leidos

9/10/18	2.0	Added US4055.3 per eBiz's request	Team Leidos
9/11/18	3.0	Added US4055.4 and updated Story section	Team Leidos
9/13/18	4.0	Updated based on eBiz's feedback	Team Leidos

Transmit 837 Transactions Through New Platform <RALLY ID US3346>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	1012619
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

User Story Name: Transmit 837 Transactions Through New Platform <RALLY ID US3346>

Sizing:

Epic Taxonomy 0 eBiz Compliance

1 Port

0 Update

0 Increase No Touch

0 TAS Apps

Story

As a member of the eBusiness Solutions organization, I want to have the current, proprietary 837 transactions (Health Care Claim: Professional, Institutional, Dental) which are transmitted using VistA Mailman to the Financial Services Center (FSC), replaced with HL7 ® FHIR (Fast Healthcare Interoperability Resources) messages.

Conversation

eBilling currently transmits proprietary Mailman messages to FSC in batch mode. This method no longer meets the VHA's standards for secure message transmission. FSC processes these Mailman messages and converts them to ASC X12N/005010X222, ASC X12N/005010X223 or ASC X12N/005010X224 transactions. FSC then validates whether or not the X12N transaction is HIPAA compliant. If the transaction is not compliant, a rejection message is

returned to the originating site. If the transaction is compliant, it is handed off to the Health Care Clearing House (HCCH) for processing to the payer. Note, the HCCH is also capable of sending a rejection message to the originating site.

It is intended that current processes (translation and validation) will continue to be performed by the FSC.

Detailed Listing of Acceptance Criteria

Requirement ID Description

US3346.1 Propriety Health Care Claim: Professional, Institutional, Dental transactions will be created and transmitted to FSC at the times designated in the IB Site Parameters

US3346.2 Health Care Claim: Professional, Institutional, Dental transactions will be transmitted to FSC in batches that are created based on the rules designated in the IB Site Parameters

US3346.3 eBilling personnel will retain the existing ability to transmit one or more Health Care Claim: Professional, Institutional, Dental transactions outside the designated transmission time (On Demand)

US3346.4 Propriety Health Care Claim: Professional, Institutional, Dental transactions will be created using HL7 ® FHIR and transmitted to FSC

US3346.5 The HL7 ® FHIR transaction data will be made available to the Integrated Billing (IB) personnel via VistA

Constraints

n/a

Risks

n/a

Assumptions

1. The new HL7 ® FHIR transaction will contain the same claim data as the current Mailman messages

2. The FSC will continue to translate proprietary (data) messages into ASC X12N 5010 formats

3. The FSC will continue to validate that the ASC X12N 5010 formatted transactions are HIPAA compliant

4. The FSC will continue to send rejection messages and claim reports (277STAT) via Mailman.

Dependencies/Impacts Outside of VistA

1. FSC will need to make the changes necessary to receive and translate HL7 ® FHIR messages

2. TAS Core team will need to complete the new 837 ICD or potential ICDs and have it agreed to by FSC.

3. The TAS Core team will need to complete the FHIR resources which will be used by OIT to complete this user story.

TAS Architecture Considerations:

1. The TAS Architecture Team will be responsible for the investigation, design and prototyping of data retrieved from VistA needed to create the claim Transaction. Claim data includes both parameters associated with transmission times and batch creations. The prototype will provide for the creation, transmission and receipt of HL7 ® FHIR messages to and from the FSC.

Revision History

Date Version Description Author

10/18/17 .01 Initial Version Team Leidos

10/19/17 .02 Updated TAS Architecture Section Team Halfaker

Payer ID Report - Secondary Payer ID <RALLY ID US3995>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	1011844
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

User Story Name: Payer ID Report - Secondary Payer ID <RALLY ID US3995>

Sizing: 3

Epic Taxonomy	eBiz Compliance	Port	Update	Increase No Touch	TAS Apps

Story

As a biller and/or insurance clerk, I want to be able to run a report to include secondary payers for a specified period of time that identifies what Insurance Company payer identification numbers the system has either changed or attempted to change as a result of a 277STAT message received from the Health Care Clearing House (HCCH).

Acceptance Criteria

Requirement ID	Description
US3995.1	The Integrated Billing software will provide the users with access to the existing report, HCCH Payer ID Report for tracking updates of the following fields as a result of a 277STAT message: • 6.02 - EDI INST SECONDARY ID(1) • 6.06 - EDI PROF SECONDARY ID(1)

	• 6.04 - EDI INST SECONDARY ID(2) • 6.08 - EDI PROF SECONDARY ID(2)
US3995.2	A new data element will be added to the existing report, HCCH Payer ID Report, to track the Claim Office ID value with the new and the old value
US3995.3	The Integrated Billing software will only report one attempt per day per Insurance Company per ID unless subsequent attempts involve a different ID value

Constraints

None

Risks

None

Assumptions

1. FSC will maintain the same data conversion for piece 11 of 277STAT record. Currently, the value sent by Change Healthcare for this COBID is COBID=75300VACS, which is a combination of the Payer ID (75300) and the claim office ID (VACS). VistA receives it as 75300VACSCOBID=75300.

Dependencies/Impacts

1. US3994
2. FSC will need to provide resources to support integration testing.

Revision History

Date	Version	Description	Author
5/7/18	1.0	Initial Version	Team Leidos
5/10/18	2.0	Updated based on eBiz's feedback	Team Leidos
6/6/18	3.0	Updated based on developers' feedback and fixed the revision year	Team Leidos

Secondary Payer IDs <RALLY ID US3994>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	1011843
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

User Story Name: Secondary Payer IDs <RALLY ID US3994>

Sizing: 5

Epic Taxonomy	eBiz Compliance	Port	Update	Increase No Touch	TAS Apps

Story

As a biller I expect existing Insurance Company entries in the Insurance Company file to have a defined Institutional and Professional Secondary Payer Identification Number, Claim Office ID Qualifier and Claim Office ID number in VistA. When there is no Secondary Professional or Institutional Payer ID defined in VistA and I transmit a claim(s) to the payer(s) and the Health Care Clearing House (HCCH) has an electronic agreement with the payer(s), I expect the HCCH to do a lookup of the Payer IDs and return them to VistA in a 277STAT transaction. I expect the VistA software to use the Secondary Payer IDs (COBID=_in the 277STAT message to update the Payer ID and the Claim Office ID #s, including the Claim Office ID Qualifier and Payer IDs for the corresponding companies in the Insurance Company file (#36) when those fields are blank.

Acceptance Criteria

Requirement ID	Description
US3994.1	The Integrated Billing (IB) software will accept inbound 277STAT message from Financial Services Center (FSC)

US3994.2	The Integrated Billing software will process 277STAT message and evaluate piece 11 of the 277STAT record when there is a value in COBID= • Check position 6-9 of piece 11. If there is a value other than 0000, that is a Claim Office ID.
US3994.3	The Integrated Billing software will update the following fields of the insurance company file (#36) based on the claim type with a value in piece 11, position 6-9 sent by FSC ***only*** if the one of following field(s) is blank and doesn't contain the Claim Office ID. IB software will display the value for user to see in the EDI Parameters section. • 6.02 - EDI INST SECONDARY ID(1) • 6.06 - EDI PROF SECONDARY ID(1) • 6.04 - EDI INST SECONDARY ID(2) • 6.08 - EDI PROF SECONDARY ID(2)
US3994.4	The Integrated Billing software will set the following fields of the insurance company file (#36) as Claim Office # (FY) qualifier accordingly based on US3994.3 above and display the value for user to see in the EDI Parameters section. • 6.01 - EDI INST SECONDARY ID QUAL(1) • 6.05 - EDI PROF SECONDARY ID QUAL(1) • 6.03 - EDI INST SECONDARY ID QUAL(2) • 6.07 - EDI PROF SECONDARY ID QUAL(2)

Constraints

None

Risks

None

Assumptions

1. FSC will maintain the same data conversion for piece 11 of 277STAT record. Currently, the value sent by Change Healthcare for this COBID is COBID=75300VACS, which is a combination of the Payer ID (75300) and the claim office ID (VACS). VistA receives it as 75300VACSCOBID=75300.

Dependencies/Impacts

1. FSC will need to provide resources to support integration testing.
2. Test sites will need to identify and submit a claim transaction without Institutional and Professional Secondary Payer Identification Number, Claim Office ID Qualifier and Claim Office ID number in VistA's Insurance Company File.

Revision History

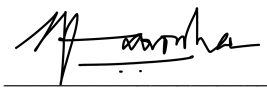
Date	Version	Description	Author

5/2/18	1.0	Initial Version	Team Leidos
5/10/18	2.0	Updated based on eBiz's feedback	Team Leidos
6/6/18	3.0	Updated based on developers' feedback and fixed the revision year	Team Leidos

Approval Signatures

This section is used to record the approvals during the Formal Review. Conduct the review face-to-face where signatures can be obtained 'live' during the review. If unable to conduct a face-to-face meeting, conduct the review via a teleconferencing medium and capture concurrence during the meeting. The Scribe should add names by each position cited.

The following members governing the document are required to sign. Please annotate signature blocks accordingly.



8/28/2019

Signed: Winston Noronha, Project Manager Date:

Lisa Keeling  8/21/19

Signed: Lisa Keeling, eBusiness Date: