Requirements Specification

Project MCCF_EDI_TAS (RM)

Prepared by Sharon Dees

October 25, 2018, 9:52:07 AM CDT

Table of Contents

Introduction

The purpose of this document is to define the requirements.

Add T for Transmitted to RCB Screen (Rally ID: US1908) <RALLY ID US1908>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	966169
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

Title: Add T for Transmitted to RCB Screen (Rally ID: US1908) <RALLY ID US1908>

Story

As a staff member at a VA Medical Center (VAMC) or Consolidated Patient Account Center (CPAC), I want to be able to see an explanation of the “T” that displays next to entries in the View/Resubmit Claims - Live or Test option when I elect to view previously printed claims.

Assumptions

n/a

Acceptance criteria

1. A user selects the option RCB - View/Resubmit Claims - Live or Test to generate a list of previously printed claims for a specified date range.

2. When the Listman screen is displayed, the following information displays on the screen: ** T = Test Claim

Sample Screen

PREVIOUSLY PRINTED CLAIMS May 11, 2017@12:31:44 Page: 1 of 1
** T = Test Claim
Claims Selected: 0 (marked with *)
Claim # Form Type Seq Status A/R Other Payer(s) Patient Na
CIGNA PO BOX 188061 CHATTANOOGA,TN
1 K506XXX T 1500 OUTPT P PRNT/TX N IB,PATIENT

Enter ?? for more actions >>>
Claim(s) Select/De select Print Report
Resubmit Claims Exit
View Claims Selected
Action:Quit//

Constraints

n/a

Risks

n/a

Comments

none

Transmitting SNF Claims with Appropriate Revenue Codes <RALLY US9>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	966162
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

User Story Name: Transmitting SNF Claims with Appropriate Revenue Codes <RALLY US9>

Product Backlog ID: 146

Backlog Priority: 9

Initial Sizing Estimate: 3

Rational ID: (to be added later)

Author: Julie Mann/M. Simons

Background

Skilled Nursing Facility (SNF) claims to the primary payer Medicare require Revenue code 0022 and the VA specific AAA00 RUG/Health Insurance Prospective Payment System Skilled Nursing Facility Rate Code (HIPPS) code. Until recently, the 0022 Revenue code was not available to billing clerks in VistA and VistA does not have the HIPPS code set. Because of these issues, the Financial Service Center (FSC) created a workaround that allows their system to create an additional 2400 loop for any claim to Medicare with a Bill Type of 21x, 22x or 23x.

Story

As a staff member at a VA Medical Center (VAMC) or Consolidated Patient Account Center (CPAC), I need to be able to transmit a Medicare Primary Skilled Nursing Facility (SNF) claim using the Medicare assigned Revenue and HIPPS codes. I want VistA to automatically create and transmit the necessary data required by Medicare for SNF claims.

Conversation

IB users can not currently send Revenue Code 0022 and VA specific AAA00 RUG/HIPPS codes for Medicare primary institutional Part A claims with the Bill Type equal to 21x, 22x or 23x. The logic in the IB software needs to replace the FSC workaround that currently makes it possible to send these claims to Medicare.

The VistA IB system should have the ability to perform the identical checks that are in place at FSC to ensure SNF claims are sent with the required data and the FSC workaround should be deactivated. VistA should automatically allow for this in the creation and transmission of the 837 flat file so that the biller does not have to enter the information. Currently, the FSC workaround does not create additional data entry for the end user and this should continue when this functionality is created as part of the IB software.

Existing FSC Logic

Business Rule:

For Medicare Primary Institutional (Part-A) claims with Bill Type = 21X or 22X or 23X

Add new 2400 Loop with following details:

Loop-Segment Name Value Comment

2400-LX01 Assigned Number Next line Number

2400-SV201 Revenue code 0022

2400-SV202-1 Product/Service Id Qualifier HP

2400-SV202-2 Procedure Code AAA00

2400-SV203 Line Item Charge Amount 0

If Value Code (2300-HI, HI01-1=BE and HI01-2=80) is present

then

2400-SV204 (Unit or Basis for Measurement Code)=DA

2400-SV205 (Quantity)=2300 HI01-3 (Copy covered days from Value code to line)

Else If Value Code is not present

Then

2400-SV204 (Unit or Basis for Measurement Code)=UN

2400-SV205 (Quantity)=0 Note that quantity (SV205) is integer field hence while copying the amount field from HI01-3; the data type need to be changed and last two digits will be removed from Value Amount (see example)

Loop-Segment Name Value Comments

2400-REF01 Provider Control Number 6R

2400-REF02 Line Item Control Number LX01_KNumberfromBill Combination of line number and K number from the Bill Number

Example:

The Claim (603_K30CQ4F) from VistA has one line only and additional (second) line (loop 2400) is added as follows:

Input (VistA)

VC2 ^80^1200

INS ^2^0022^AAA00^1^0^^^0^^^^DA

LDAT^2^^^^^^^^^6R^2_K30CQ4F

Output (X12)

LX|2~

SV2|0022|HP:AAA00|0|DA|12~

REF|6R|2_K30CQ4F~

Rule in VistA Format

If (GEN-6= ENVOYH or PARTA)

and

If (CI2-2 =P and CI5-3= 12M61)

and if

{

(CL1-3 =2 and CL1-4=1)

Or

(CL1-3 =2 and CL1-4=2)

Or

(CL1-3 =2 and CL1-4=3)

}

Then

Add INS and LDAT with following specifications

INS-02=<next line number>

INS-03=0022

INS-04=AAA00

INS-5=<see logic-1 below>

INS-6=0

INS-9=0

INS-13=<see logic-1 below>

LDAT-02=INS-02 (same line number as new INS-02)

LDAT-11=6R

LDAT-12= INS-02_<K number from CL-01>

Logic-1:

If VCx-02=80 (Note VC can repeat up to 12 times, hence “x” above refers to digit from 1 through 12)

then

INS-13=DA

INS-5=VCx-03 (note that since VCx is amount field we need to ignore the last two digit while copying)

Else If no VCx-02 is equal to 80

Then

INS-13=UN

INS-5=0

Note: That INS can repeat multiple times in input; hence the above logic to add INS and LDAT should be executed as very last step

Note: There is no direct element for 2400-SV202-1, its defaulted to “HP” in the Gentran Map at FSC when INS-04=AAA00

Rule in X12 Format

If

Claim is 837- I (GS08= 005010X223A2) and

if 2000B-SBR03=P and

if 2010BB-NM109=12M61 and

if 2300-CLM05-01 is 21x or 22x or 23x

Then

1) 2400-LX01= <next line number>

2) 2400 SV2 with following spec

2400-SV201=0022

2400-SV202-1=HP

2400-SV202-2=AAA00

2400-SV203=0

If 2300-HI; HI01-1=BE and HI01-2=80 is present

then

2400-SV204 =DA

2400-SV205 =2300 HI01-3 (where HI01-1=BE and HI01-2=80)

Else 2300-HI; HI01-1=BE and HI01-2=80 is not present

Then

2400-SV204=UN

2400-SV205=0

3) 2400-REF-01=6R

2400-REF02=2400-LX01_<K number from CLM01>

The following table lists acceptance criteria for this user story:

ID Criteria

DM1-1-1 User is able to create and transmit a SNF institutional claim for Medicare as a primary payer.

DM1-1-2 The IB system automatically creates additional INS records and data elements to the outbound 837 mailman message to FSC based on the Bill Type. The user will not have to do anything to trigger this except enter the correct SNF Bill Type.

DM1-1-3 The INS record will have a piece in which to transmit a value of HP (HIPPS qualifier) for SV202 – 1. This value is currently set to HC (HCPCS qualifier) by FSC for all claims.

DM1-1-4 User is able to see the automatically created INS record using the View/Print EDI Bill Extract Data option.

DM1-1-5 Claim is able to pass the HIPAA validation at FSC without rejection for validator errors.

DM1-1-6 Claim is able to process at Medicare with the receipt of an eMRA back the originating VistA instances.

DM1-1-7 The VistA system is able to create a secondary claim to the next payer sequence with no extra INS record.

DM1-1-8 The VPE, prior to the creation of the secondary claim, will display the extra SNF specific INS record.

Constraints

n/a

Assumptions

• The Vista ICD will be updated as part of this effort.

• FSC will deactivate the code that currently creates the additional 2400 loop when they receive a claim with a Bill Type equal to 21x, 22x or 23x.

• The VPE display will display the newly created INS record with no corresponding coding changes. For Medicare claims, the VPE will only display the newly created INS record until the secondary claim is created.

Risks

n/a

Approval Signatures

Revision History

Date Version Description Author

09/14/2016 v0.01 Original J. Mann

10/5/2016 v0.02 Updated following elaboration session M. Simons

11/1/2016 v0.03 Updated following further elaboration M. Simons

11/4/2016 v1.0 Updated following Tech Writer review M. Simons

Comments

none

CMN Oxygen and EPN Nutrition (Rally ID: US3)

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	966160
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

Title: CMN Oxygen and EPN Nutrition (Rally ID: US3)

Story

As a biller, I need the ability to enter the required data for an Oxygen Certificate of Medical Necessity (CMN) (CMS-484.3) or an Enteral and Parenteral Nutrition CMN (CMS-10126) when completing a professional bill for Durable Medical Equipment (DME). I then need the ability to transmit the professional claim with the CMN data in the proprietary 837-P transaction to the Financial Services Center (FSC).

Assumptions

1.The data required by a biller to complete a professional bill for DME services that require a CMN will be available to the biller for manual entry into a claim.

Acceptance Criteria

3.1 Enter/Edit Billing Information - System prompts the user for the need for a CMN form for a procedure

3.2 Enter/Edit Billing Information – System prompts the user for the type of CMN form when a biller indicates a need for a CMN form (Only 484.3 and 10126 will be available at this time)

3.3 Enter/Edit Billing Information – System prompts the user for the data elements required to complete the type of CMN form selected

3.4 Transmit 837-P Transaction – System includes the CMN related data elements in the outbound professional 837 transaction

Constraints

The Financial Services Center (FSC) must make corresponding changes to the 837 mapping.

Candidates for IOC will need to have a source of information to complete the CMN fields or the new functionality will not be testable in IOC.

Risk

Electronically submitted claims for DME services that require an accompanying CMN form will be rejected by payer if this user story is not implemented correctly.

Comments

none

Remove Ability to Define Insurance Company as non-EDI (Rally ID: US1909)

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	966156
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

Title: Remove Ability to Define Insurance Company as non-EDI (Rally ID: US1909)

Story

As a staff member at a VA Medical Center (VAMC) or Consolidated Patient Account Center (CPAC), I no longer want the ability to define an Insurance Company as one that only accepts printed claims. I would also like to be able to receive a one-time report from each site showing me the value of the field that determines whether an Insurance Company is active for Electronic Data Interchange (EDI).

Assumptions

n/a

Acceptance criteria

1. A user selects the option EI - Insurance Company Entry/Edit to update the Billing/EDI Parameters

The available answers for the EDI - Transmit?: prompt are:

YES-LIVE

YES-TEST

(the choice NO is no longer available

2. The existing HELP text - This is the flag that says whether or not an insurance company is ready to be billed electronically via 837/EDI functions is now - This field determines whether an electronic claim to this insurance Company is sent as a test or a production claim.

3. When the patch is installed at a site, a report is generated and sent to the eBiz Rapid Response group (VHAeBillingRR@va.gov).

4. The report will contain the Site Name, Site ID, Date of Report, the Insurance Company Name, the Insurance Company Address, the current setting for the Transmit Electronically field (#3.01) in Insurance Company file (#36) for those payers that have the Transmit Electronically field set to NO

Sample Screen/Report

EDI - Transmit?: YES-LIVE// YES-LIVE// ??

This field determines whether an electronic claim to this insurance

Company is sent as a test or a production claim. Modified HELP text

Choose from:

0 NO <<<<<<Remove this option

YES-LIVE

2 YES-TEST

EDI - Transmit?: YES-LIVE//

Insurance Company EDI Parameter Report Page: 1

Site: XXXX VA Medical Center – Station 637 May 17, 2017@14:52:15

Insurance Company Address EDI-Transmit

==========

5STAR LIFE INSURANCE PO BOX 141159,CINCINNATI,OH NO

GROUP PLAN HEALTH INSURANCE 7169189 NO

8TH DIST ELECTRICAL BENEF PO BOX 30101 NO

AARP UNITEDHEALTHCARE AARP HEALTHCARE OPT ATLANTA,GA NO

ABA PO BOX 10787,SPOKANE,WA NO

ABERDEEN HEALTH CARE SERV PO BOX 4000,ABERDEEN,SD NO

ACORDIA PO BOX 2451,CHARLESTON,WV NO

ACORDIA NATIONAL PO BOX 3262,CHARLESTON,WV NO

Constraints

n/a

Risks

n/a

Comments

none

Remove Fatal Error - Rendering Provider CMS 1500 <RALLY ID US3214>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	961612
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

Name: Remove Fatal Error - Rendering Provider CMS 1500 <RALLY ID US3214>

Tags: eBilling VistA

Description:

Story

As a billing clerk at a VA Medical Center (VAMC) or Consolidated Patient Account Center (CPAC), I want to be able to authorize a professional Durable Medical Equipment (DME) claim without adding a Rendering Provider to the claim. I want to receive a non-fatal warning message reminding me that the Rendering Provider is normally required on a professional CMS 1500 claim.

Conversation

The existing fatal error that prevents a biller from submitting a claim with no Rendering Provider will be removed and replaced with a non-fatal warning message

Detailed Listing of Acceptance Criteria

Requirement ID Description

US3214.1 The Integrated Billing software will no longer require a Rendering Provider on professional claims

US3214.2 The Integrated Billing software will display a non-fatal warning message to the user when a professional claim does not contain a Rendering Provider

Constraints

n/a

Risks

n/a

Assumptions

n/a

Dependencies/Impacts Outside of VistA

n/a

TAS Architecture Considerations:

n/a

Attachments: TAS eBill US3214 OIT PM User Story Approval.docx

TAS eBill US3214 OIT User Story Approval.docx

TAS eBill SDD US3214 v1.00.docx

TAS eBill SDD US3214 Approval.pdf

TAS eBill US3214 eBiz User Story Approval.docx

Owner: Mary Simons

Project: eBilling

Hierarchy

Parent: US3340: US3214 (Parent) Remove Fatal Error - Rendering Provider CMS 1500 Feature:

Schedule

State: Defined Blocked: False

Ready: False Blocked Reason:

Release: eBilling Build 5&6

Iteration: eBilling B5 S3

Plan Est: 2.0 Points Task Est: 31.0 Hours

To Do: 31.0 Hours Expedite: False

Rank:

Custom

Approved System Design Document Date: 11/21/2017 12:00 AM EST eBiz Approved User Story Date: 11/09/2017

12:00 AM EST

eBusiness Priority:

OIT Approved User Story Date: 11/09/2017 12:00 AM EST

Old Product Backlog ID:

Patch:

Rational ID:

Story Backlog Step Code: 8 - Design Approved Taxonomy: eBusiness Compliance User Story Backlog Status: User Story

Notes

Notes:

Comments

none

RCB - Match COB Data to Payer Sequence <RALLY ID US2486>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	961611
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

Name: RCB - Match COB Data to Payer Sequence <RALLY ID US2486>

Story

As a staff member at a VA Medical Center (VAMC) or Consolidated Patient Account Center (CPAC), I want to be able to resubmit, to the Test queue, a claim using the option View/Resubmit Claims - Live or Test and have only the Coordination of Benefits (COB) data that is correct for the payer sequence be included in the transaction.

Assumptions

Users should not resubmit claims with EOB data to a payer's production queue as the payer will considered such a claim to be a duplicate claim.

Acceptance criteria

ID	Criteria
1	Users select RCB - View/Resubmit Claims - Live or Test
2	Users select one of more claim entries for resubmission to the Test queue
3	If users select a Primary claim to resubmit and the claim has received an EOB/MRA from the primary payer, VistA will not send the COB data from the EOB/MRA and the amount billed

	will not be offset by previous payments from the primary payer
4	If users select a Secondary claim to resubmit and the claim has received an EOB/MRA from the secondary payer, VistA will not send the COB data from the EOB/MRA and the amount billed will not be offset by previous payments from the secondary payer
5	If users select a Tertiary claim to resubmit and the claim has received an EOB/MRA from the tertiary payer, VistA will not send the COB data from the EOB/MRA and the amount billed will not be offset by previous payments from the tertiary payer
6	If users attempt to resubmit a claim(s) with EOB data in VistA to the Production queue, the system will filter out that claim(s) and not transmit it.

Constraints

n/a

Risks

n/a

Comments

none

Non-MCCF Unbilled Amounts Report <RALLY ID US142>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	961608
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

User Story ID: US142

User Story Name: non-MCCF Unbilled Amount Report

Sizing: 8

Epic Taxonomy	eBiz Compliance	Port	Update	Increase No Touch	TAS Apps

Story

As a Non-MCCF Billing Supervisor or clerk at a Veterans Affairs Medical Center (VAMC), I want to be able to sort the Outpatient portion of the Unbilled Amounts Report such that I only see the type of claims based on the following:

- Appointment Type
  - Employee
  - Sharing Agreement
- Eligibility of Encounter:
  - CHAMPVA
  - Tricare

  - Employee
  - Ineligible
  - Sharing Agreement
- Rate Type:
  - CHAMPVA REIMB. INS.
  - CHAMPVA
  - TRICARE REIMB. INS.
  - TRICARE
  - INTERAGENCY
  - INELIGIBLE
  - SHARING AGREEMENT

Conversation (if desired by developers)

The Re-generate Unbilled Amounts Report functionality currently behaves differently depending on whether or not the users elect to save the results.

Saved

Re-Generate Unbilled Amounts Report

Do you want to store Unbilled Amounts figures? NO// y YES

Re-compile Unbilled Amounts through MONTH/YEAR: SEP 2017// (SEP 2017)

NOTE: Just a reminder that by entering the above month/year this
report will re-calculate and update the Unbilled Amounts
data on file in your system.

NOTE: After this report is run, the Unbilled Amounts totals for
the month of SEP 2017 will be updated.

Print detail report with the Unbilled Amounts summary? NO// y YES

Do you want to include MRA claims?: NO//

This report takes a while to run, so you should queue it to run
after normal business hours.

You will need a 132 column printer for this report!

DEVICE: HOME//

Not Saved

Re-Generate Unbilled Amounts Report

Do you want to store Unbilled Amounts figures? NO//

Search by Division?? NO//

Start with DATE: 01/05/1915// t-30 (SEP 05, 2017)
Go to DATE: 10/05/2017// (OCT 05, 2017)

Choose report type(s) to print:

1 - INPATIENT UNBILLED
2 - OUTPATIENT UNBILLED
3 - PRESCRIPTION UNBILLED
4 - ALL OF THE ABOVE

```
Select: (1-4): 4//

You have selected

   4 - ALL OF THE ABOVE

Are you sure? NO// y YES

Print detail report with the Unbilled Amounts summary? NO// y YES

Do you want to include MRA claims?: NO// y YES

This report takes a while to run, so you should queue it to run
after normal business hours.

You will need a 132 column printer for this report!

DEVICE: HOME//
```

Detailed Listing of Acceptance Criteria

Requirement ID	Description
US142.1	The Integrated Billing software will provide the ability for users to specify the following *additional* search criteria when re-generating the Outpatient portion of the Unbilled Amounts Report and not saving the results: MCCF Claims Only Non-MCCF (Outpatient) Claims Both
US142.2	Non-MCCF's Rate Types include CHAMPVA, CHAMPVA Reimb. Ins, Tricare, Tricare Reimb. Ins, Interagency, Sharing Agreement and Ineligible
US142.3	Non-MCCF's Appointment Types include Employee and Sharing Agreement
US142.4	Non-MCCF's Eligibility of Encounters include CHAMPVA, Tricare, Employee, Ineligible and Sharing Agreement

Constraints

n/a

Risks

n/a

Assumptions

n/a

Dependencies/Impacts Outside of VistA

n/a

TAS Architecture Considerations:

n/a

Revision History

Date	Version	Description	Author
10/5/17	.01	Initial	Team Leidos
10/10/17	1.0	Updated following eBiz input	Team Leidos
2/13/18	2.0	Updated following meeting with Non-MCCF and eBiz staff	Team Leidos

Comments

none

Non-MCCF Pay-to Provider <RALLY ID US2599>

Attributes

Attribute	Value
Artifact Type	Business User Story
Identifier	961603
Status	In Draft
Who	Business Architect
Version	1
Testable	TBD

Artifact Content

Name: non-MCCF Pay-to Provider <RALLY ID US2599>

Tags: eBilling TRICARE VistA

Description: User Story ID: US2599

User Story Name: non-MCCF Pay-to Address_Rate Types

Sizing: 8

Epic Taxonomy eBiz Compliance Port Update Increase No Touch TAS Apps

Story

As an Insurance Clerk or Integrated Billing Supervisor at a Veterans Affairs Medical Center (VAMC), I want to be able to define one or more Rate Types for which the non-MCCF Pay-to Address (formerly the TRICARE Pay-to Address) will be used on claims with one of those Rate Types.

Conversation (if desired by developers)

n/a

Detailed Listing of Acceptance Criteria

Requirement ID Description

US2599.1 The Integrated Billing software will provide the ability for an authorized user with access to the IB Site Parameters and the TRICARE Pay-to security key, to add a Rate Type for which claims with that Rate Type will use

the non-MCCF Pay-to Address data

US2599.2 The Integrated Billing software will provide the ability for an authorized user with access to the IB Site Parameters and the TRICARE Pay-to security key, to delete a Rate Type for which claims with that Rate Type will use the non-MCCF Pay-to Address data

US2599.3 The Integrated Billing software will use the non-MCCF Pay-to Address data on claims with specified Rate Types only when the non-MCCF Pay-to Address is not exactly the same as the Billing Provider Name and Address

US2599.4 The Integrated Billing software will transmit the TRICARE Pay-to Address data on claims with specified Rate Types in the 837-I, 837-P or 837-D when the non-MCCF Pay-to Address is not exactly the same as the Billing Provider Name and Address

US2599.5 The Integrated Billing software will print the non-MCCF Pay-to Address data on institutional claims with specified Rate Types on the UB04 form (FL2) when the TRICARE Pay-to Address is not exactly the same as the Billing Provider Name and Address

US2599.6 The Integrated Billing software will print the non-MCCF Pay-to Address data on professional claims with specified Rate Types on the CMS 1500 form (Box 33) when the non-MCCF Pay-to Address is not exactly the same as the Billing Provider Name and Address

Constraints

n/a

Risks

n/a

Assumptions

1. VAMCs will have to be identified to participate in IOC as the claims that will potentially use the non-MCCF Pay-to Address data will be created by the VAMC billers, not the CPAC billers

Dependencies/Impacts Outside of VistA

n/a

TAS Architecture Considerations:

n/a

Revision History

Date Version Description Author

9/19/17 .01 Initial Team Leidos

9/27/17 1.0 Updated following USD&P Meeting Team Leidos

Attachments: TAS eBill US2599 eBiz User Story Approval.docx

TAS eBill US2599 OIT User Story Approval.docx

TAS eBill SDD US2599 v1.00.docx

TAS eBill SDD US2599 Approval.pdf

Owner: Lisa Duncan

Project: eBilling

Hierarchy

Parent: US3203: US2599 (Parent) TRICARE “Pay-To” Address RATE TYPES Feature:

Schedule

State: Defined Blocked: False

Ready: False Blocked Reason:

Release: eBilling Build 5&6

Iteration: eBilling B5 S3

Plan Est: 13.0 Points Task Est: 99.0 Hours

To Do: 99.0 Hours Expedite: False

Rank: 565.000

Custom

Approved System Design Document Date: 12/05/2017 12:00 AM EST eBiz Approved User Story Date: 10/02/2017 12:00 AM EDT

eBusiness Priority:

OIT Approved User Story Date:

Old Product Backlog ID:

Patch:

Rational ID:

Story Backlog Step Code: 8 - Design Approved Taxonomy: Update User Story Backlog Status: User Story

Notes

Notes: User Story Number:

User Story Name:

Priority: (High, Medium, Low) Medium

Rational ID:

Service Request Number:

Author: Allisha Robinson and Daryl Claggett

Background (If helpful, otherwise delete)

Story: I need the TRICARE “Pay-To” address functionality to include the RATE TYPES of CHAMPVA, INTER AGENCY, and SHARING AGREEMENT (and/or the ability to add RATE TYPES of claims that are Non-MCCF and the responsibility of the local medical centers)

Conversation: We need the ability to modify the TRICARE Pay to Address parameter in VistA to include additional

Rate Types of CHAMPVA, INTER AGENCY, and SHARING AGREEMENT so that the medical center’s address appears on institutional and professional claims.

Comments

none

Signature Page

Tammy L. Patchett 106127

Digitally signed by Tammy L. Patchett 106127
Date: 2018.11.05 13:28:58 -05'00'

eBusiness Solutions

Winston A. Noronha 993343

Digitally signed by Winston A. Noronha 993343
Date: 2018.11.05 11:26:20 -08'00'

Winston Noronha, OIT PM