

Electronic Data Interchange (EDI) Billing User Guide

VA



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1. Introduction

In 1996, Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act directs the federal government to adopt national electronic standards for automated transfer of certain healthcare data between healthcare payers, plans, and providers. Now that these standards are in place, the Veterans Health Administration (VHA) will submit claims containing the required standard data content to all payers accepting electronic data interchange (EDI).

1.1. Revenue Process

The overall patient billing revenue process for the VHA is summarized in the table below:

Intake	Utilization Review	Billing	Collection	Utilization Review
Patient Registration Insurance Identification Insurance Verification	Pre-certification & Certification Continued Stay	Documentation EDI Bill Generation MRA Claim status messages	Establish Receivables A/R Follow-up Lockbox Collection Correspondence	Appeals

During the Intake phase, the patient is registered. Insurance information is identified and/or verified.

In the Utilization Review phase, the patient is pre-certified and certified, and continued stay reviews are performed.

In the Billing phase, the patient encounter is documented and coded. An electronic data interchange (EDI) bill and/or Medicare Remittance Advice (MRA) request is generated and sent to the payer. Claim status messages include information that appears on the Claims Status Awaiting Resolution (CSA) report.

During the Collections phase, establishment of receivables, accounts receivables follow-up, lockbox, and any collection correspondence take place.

Another Utilization Review can take place if there are any appeals.

EDI Billing provides the VHA with the capability to submit Institutional and Professional claims electronically as 837 Health Care Claim transmissions, rather than printing and mailing claims from each facility.

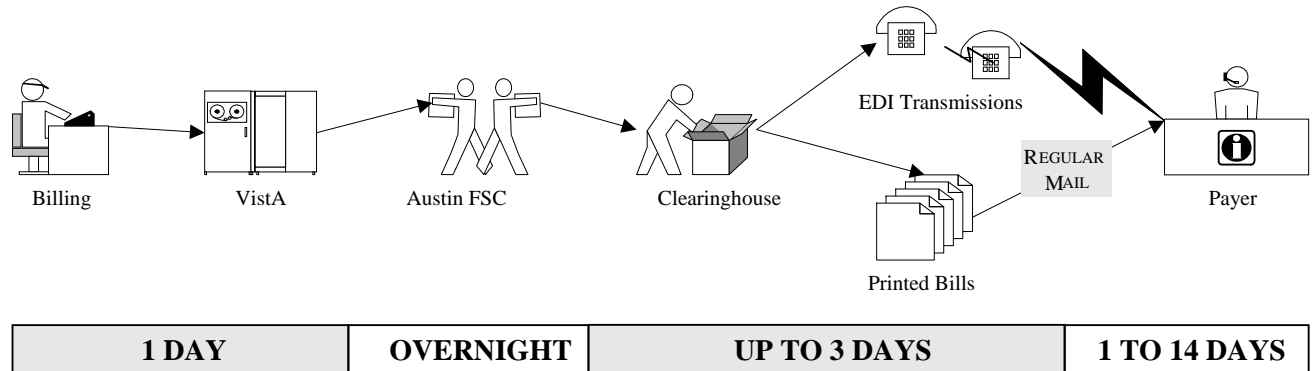
1.2. Critical EDI Process Terms

Also see APPENDIX B – GLOSSARY.

- **835 Health Care Claim Payment/Advice** – The HIPAA adopted standard for electronic remittance advice to report the processing of all claim types (including retail pharmacy). The term “835” represents the data set that is sent from health plans to healthcare providers and contains detailed information about the processing of the claim. This includes payment information and reduction or rejection reasons. All health plans are required to use the same explanation of benefit codes (adjustment reason codes) and adhere to very specific reporting requirements. The term “835” is used interchangeably with Electronic Remittance Advice (ERA) and Medicare Remittance Advice (MRA).
- **837 Health Care Claim** – The HIPAA adopted standard for electronic submission of hospital, outpatient and dental claims. The term “837” represents the data set that is sent from healthcare providers to insurance companies (payers). The 837 standard includes the data required for coordination of benefits and is used for primary and secondary payer claims submission. The term “837” is used interchangeably with electronic claim.
- **277 Claim Status Messages** – Electronic messages returned to the VAMC providing status information on a claim from the Financial Service Center (FSC) in Austin, Texas. These messages can originate at FSC, at the payer or at the clearinghouse.
- **Clearinghouse** – A company that provides batch and real-time transaction processing services and connectivity to payers or providers. Transactions include insurance eligibility verification, claims submission processing, electronic remittance processing and payment posting for electronic claims.
- **eClaim** – A claim that is transmitted electronically to FSC from the VHA.
- **EDI – Electronic Data Interchange (EDI)** is the process of transacting business by exchanging data electronically. It includes submitting claims electronically (paperless claims processing), as well as electronic funds transfer (EFT) and electronic inquiry for claim status and patient eligibility.
- **EOB – An Explanation of Benefits (EOB)** reports the disposition of an individual claim. Many EOBs may be contained within a single 835 ERA file.
- **ePayer** – Payer that accepts electronic claims from the clearinghouse.
- **Fiscal Intermediary** – A fiscal intermediary performs services on behalf of health-care payers. These services include claim adjudication, reimbursement and collections. Trailblazer Health Enterprises is an example of a fiscal intermediary that acts on behalf of Medicare. Trailblazer receives claims from the VA in the form of an 837 file and then adjudicates the claims to create a MRA 835 file.
- **FSC** – The FSC receives 837 Health Care Claim transmissions from VistA and transmits this data to the clearinghouse. FSC also receives error/informational messages and 835 Health Care Claim Payment/Advice transmissions from the clearinghouse and transmits this data to VistA.
- **HIPAA** – In 1996, Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain healthcare data between health-care payers, plans, and providers. This enables the entire healthcare industry to communicate electronic data using a single set of standards, thus eliminating all non-standard formats currently in use. Once these standards are in place, a healthcare provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will “simplify” many clinical, billing, and other financial applications, and reduces costs.

- ASC X12 (also known as ANSI ASC X12) – This is the official designation of the U.S. national standards body for the development and maintenance of Electronic Data Interchange (EDI) standards. The HIPAA transactions are based upon these standards.

1.3. EDI Process Flow



The above flowchart (EDI Process Flow) represents the path that electronic claims follow. The objective of electronic billing is to submit completely correct claims. Claims sent electronically reach the payer faster, are processed faster, and are paid faster than claims submitted to the payer on paper via the mail.

From the user's desktop, the claim goes to the FSC as a VistA Mailman message. The FSC translates the claim into the HIPAA 837 Health Care Claim format and forwards it to the clearinghouse.

From the clearinghouse, the arrow pointing upwards represents the path claims travel if they can be submitted electronically to the payer. If the clearinghouse does not have an electronic connection with a payer, or if specific claims must be submitted on paper, the claim is printed at Express Bill and mailed to the payers.

Electronic claims status messages from ePayers return to the VAMCs along the same path. Payers receiving printed claims do not return electronic messages. However, the clearinghouse returns a message indicating that the claim was printed and mailed.

Different electronic edits are in place at each transmission point that may initiate the sending of a claims status message. Claim status messages returned by the clearinghouse and/or payer will provide information on a specific claim. There is no standard content for messages. The information contained within a claim status message varies from payer to payer.

2. Insurance Company Set-up




The most common cause of claims rejection is the improper setup of the insurance company and/or provider IDs within VistA. With EDI Billing, there are fields in an 837 claim transmission that are auto-populated with the data defined in VistA. This information must be accurate to generate a clean electronic claim.

2.1. Insurance Company Setup

2.1.1 Activate New Payer to Transmit eClaims

The typical business process for setting up new payers is:

1. The Insurance Verification Office initially enters a new payer into VistA.
2. Lists of new payers are printed and provided to the medical center's billing office on a regular basis (daily/weekly). Some individuals become members of the IB New Insurance mail group so they receive e-mail bulletins whenever a new insurance policy is added to VistA.
3. Billing staff uses the Insurance Company Editor to define Provider IDs: Type of Coverage; Electronic Insurance Type and Electronic Transmit? by Insurance Company. The Profession/Institutional Payer Primary and Secondary IDs are also defined using the Insurance Company Editor.
4. Billing staff use The Insurance Company Editor to specify the correct Electronic Plan Type for each Insurance Plan.

	Note: Selecting the correct electronic plan type is important. This field may determine which provider IDs are transmitted and/or printed. Choosing the wrong electronic plan type for an Insurance Plan could result in claims being rejected by the clearinghouse <i>or by the payer</i> .
	Note: When Patch IB*2*477 is installed and a claim is authorized with more than one payer, a warning is displayed unless all the Payer IDs are on the claim.
	Note: When Patch IB*2*576 is installed and a claim is sent without a Payer ID and the clearing house returns a Payer ID in the 277Stat messages that deliver clearing house claims reports, the system will update the Payer ID in the Insurance Company file if the field is BLANK. Refer to the new HCCH Payer ID Report for further detail.

2.1.1.1 Define EDI settings for a Blue Cross/Blue (BC/BS) Shield Insurance Company

Step	Procedure
1	At the Billing Parameters screen in the Insurance Company Editor, enter BP – Billing/EDI Param.

Insurance Company Editor		Oct 01, 2007@10:15:14	Page: 1 of 9
Insurance Company Information for: BLUE CROSS			
Type of Company: HEALTH INSURANCE		Currently Active	

Billing Parameters			
Signature Required?: NO	Filing Time Frame:		
Reimburse?: WILL REIMBURSE	Type Of Coverage: HEALTH INSURAN		
Mult. Bedsections:	Billing Phone: 800/933-9146		
Diff. Rev. Codes:	Verification Phone: 800/933-9146		
One Opt. Visit: NO	Precert Comp. Name:		
Amb. Sur. Rev. Code:	Precert Phone: 800/274-7767		
Rx Refill Rev. Code:			

EDI Parameters			
Transmit?: YES-LIVE		Insurance Type:	
+ Enter ?? for more actions >>>			
BP Billing/EDI Param	IO Inquiry Office	EA Edit All	
MM Main Mailing Address	AC Associate Companies	AI (In)Activate Company	
IC Inpt Claims Office	ID Prov IDs/ID Param	CC Change Insurance Co.	
OC Opt Claims Office	PA Payer	DC Delete Company	
PC Prescr Claims Of	RE Remarks	VP View Plans	
AO Appeals Office	SY Synonyms	EX Exit	
Select Action: Next Screen//BP Billing/EDI Param			








*Note: When Patch IB*2*488 is installed and users create a new Insurance Company, the system will set the value of the EDI – Transmit? field in the Insurance Company Entry/Edit option, equal to YES-LIVE.*

The following prompts will display.

```

SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS:
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY:
AMBULATORY SURG. REV. CODE:
PRESCRIPTION REFILL REV. CODE:
FILING TIME FRAME:
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 800/933-9146//
VERIFICATION PHONE NUMBER: 800/933-9146//
Are Precerts Processed by Another Insurance Co.?:
PRECERTIFICATION PHONE NUMBER: 800/274-7767//
EDI - Transmit?:YES-LIVE// YES-LIVE
EDI - Inst Payer Primary ID: 12B30
EDI - Alt Inst Payer Primary ID Type:
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID: SB960
EDI - Alt Prof Payer Primary ID Type:
EDI - 1ST Prof Payer Sec. ID Qualifier:
EDI - Insurance Type: GROUP POLICY //
EDI - Print Sec/Tert Auto Claims?:
EDI - Print Medicare Sec Claims w/o MRA?:YES//
EDI - Bin Number: .....




```

Step	Procedure
	Patch IB*2.0*320 added a new security key, IB EDI INSURANCE EDIT . A user must hold this key to edit the EDI-Transmit, EDI Prof Payer ID; EDI Inst Payer ID and EDI-Insurance Type fields.
2	At the EDI - Inst Payer Primary ID : prompt, enter the Payer Primary ID provided by the clearinghouse.
	Patch IB*2.0*488 will make changes that prevent a user from entering any value containing PRNT/prnt as a Primary Payer ID.
	When editing the Payer Primary ID fields for a commercial payer, (not BC/BS) these fields may be left blank. The clearinghouse will try to match the VistA payer name and address to an entry in its Payer Lookup Table and auto-populate these fields. Payer ID numbers are available at https://access.emdeon.com/PayerLists/ .
3	At the EDI - 1ST Inst Payer Sec. ID Qualifier : prompt, press the <Enter> key to leave field blank.
	Patch IB*2*371 added the ability to define Payer Secondary IDs. They are unusual and should only be populated if the clearing house or eBusiness Solutions Office provides you with a secondary ID number.
4	At the EDI - Prof Payer Primary ID : prompt, enter the Payer Primary ID provided by the clearinghouse.
5	At the EDI - 1ST Prof Payer Sec. ID Qualifier : prompt, press the <Enter> key to leave field blank.
6	At the EDI - Insurance Type : prompt, enter ?? to see the choices available. For this example, select Group Policy . This will result in a checkmark in the GROUP insurance box of the CMS-1500/BOX 1.
7	Press the <Enter> key until the Billing Parameters screen reappears.
	When Patch IB*2*371 is loaded, the patch will automatically define a Professional Payer Secondary for Medicare WNR that will have a Qualifier = Payer ID Number and an ID = VA plus the site's ID.

```

EDI - Transmit?: YES-LIVE//
EDI - Inst Payer Primary ID: 12M61//
EDI - Alt Inst Payer Primary ID Type:
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID: SMTX1//
EDI - Alt Prof Payer Primary ID Type:
EDI - 1ST Prof Payer Sec. ID Qualifier: PAYER ID #//
EDI - 1ST Prof Payer Sec. ID: VA442//

```

	Patch IB*2*432 added the ability to define whether or not the payer will accept MRA secondary claims electronically when the primary claim was never sent to Medicare and no MRA was ever received. When the patch is loaded, this field will be set to '0' which means that the claims will be transmitted electronically unless this field is changed by the site. This only pertains to claims that cannot be submitted thru MRA due to the service being on the Payer Excluded Service list.
	Patch IB*2*432 added the ability to define whether or not the payer will accept MRA secondary claims electronically when the primary claim was never sent to Medicare and no MRA was ever received. When the patch is loaded, this field will be set to '0' which means that the claims will be transmitted electronically unless this field is changed by the site.
	Note: Once Patch IB*2*516 is installed, a new field, HPID/OEID, will display in the EDI Parameters section. The field will not be editable. The HPID or OEID number will come

from the National Insurance File.

EDI - Insurance Type: GROUP POLICY //
EDI - Bin Number:
EDI - UMO (278) ID:
EDI - Print Sec/Tert Auto Claims?:
EDI - Print Medicare Sec Claims w/o MRA?:

2.1.1.2 Define EDI settings for a Blue Cross/Blue Shield Group Insurance Plan

Step	Procedure
1	At the Billing Parameters Screen in the Insurance Company Editor, enter VP -View Plans and press the <Enter> key.


```
Insurance Company Editor      Oct 01, 2007@10:15:14      Page:      1 of      9
Insurance Company Information for: BLUE CROSS
Type of Company: HEALTH INSURANCE                        Currently Active

                               Billing Parameters
Signature Required?: NO          Filing Time Frame:
Reimburse?: WILL REIMBURSE      Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:              Billing Phone: 800/933-9146
Diff. Rev. Codes:               Verification Phone: 800/933-9146
One Opt. Visit: NO              Precert Comp. Name:
Amb. Sur. Rev. Code:            Precert Phone: 800/274-7767
Rx Refill Rev. Code:

                               EDI Parameters
Transmit?: YES-LIVE              Insurance Type: GROUP POLICY
+ Enter ?? for more actions      >>>
BP Billing/EDI Param      IO Inquiry Office      EA Edit All
MM Main Mailing Address  AC Associate Companies  AI (In)Activate Company
IC Inpt Claims Office    ID Prov IDs/ID Param    CC Change Insurance Co.
OC Opt Claims Office     PA Payer                DC Delete Company
PC Prescr Claims Of      RE Remarks              VP View Plans
AO Appeals Office        SY Synonyms             EX Exit
Select Action: Next Screen//VP View Plans
```

Step	Procedure
2	The Insurance Plan List appears. Select the appropriate plan from the list. In this example, Plan 1 is selected by typing VP=1 and pressing the Enter key.

Insurance Plan List			Mar 31, 2004@16:12:52		Page:		1 of 1		
All Plans for: BLUE CROSS BLUE SHIELD DEMO Insurance Company									
#	+ => Indiv. Plan		* => Inactive Plan			Pre-	Pre-	Ben	
	Group Name		Group Number		Type of Plan	UR?	Ct?	ExC?	As?
1	DEMO FOR TRAINING		87654		COMPREHENSIVE	NO	YES	YES	YES
Enter ?? for more actions									
VP View/Edit Plan					IP (In)Activate Plan				
AB Annual Benefits					EX Exit				
Select Action: Quit// VP=1									

Step	Procedure
3	The View/Edit Plan screen displays. To edit plan information, type PI and press the <Enter> key.
	<i>Note: The IB GROUP PLAN EDIT security key is required to use PI.</i>

```

View/Edit Plan           Mar 31, 2004@16:19:51           Page:      1 of      3
Plan Information for: BLUE CROSS Insurance Company
                        ** Plan Currently Active **

Plan Information                               Utilization Review Info
  Is Group Plan: YES                               Require UR: NO
    Group Name: DEMO FOR TRAINING                 Require Amb Cert: YES
    Group Number: 87654                           Require Pre-Cert: YES
    Type of Plan: COMPREHENSIVE MAJOR MED          Exclude Pre-Cond: YES
    Plan Filing TF:                               Benefits Assignable: YES

Plan Coverage Limitations



Coverage      Effective Date    Covered?      Limit Comments
-----
INPATIENT     02/10/04          YES
OUTPATIENT    02/10/04          YES
PHARMACY      02/10/04          NO


+           Enter ?? for more actions

PI Change Plan Info          IP  (In)Activate Plan
UI  UR Info                 AB  Annual Benefits
CV  Add/Edit Coverage       CP  Change Plan
PC  Plan Comments           EX  Exit

Select Action: Next Screen// PI  Change Plan Info

```

Step	Procedure
4	For this scenario NO is typed in for the Do you wish to change this plan to an Individual Plan? field.
5	Continue to press the <Enter> key until Electronic Plan Type field is displayed.
6	Type in the appropriate code and press the <Enter> key. The chosen plan will be displayed. In this example BL has been selected.
	<i>Selecting the correct electronic plan type is critical. The electronic plan type for BC/BS payers should usually be set to BL - not commercial. Choosing the wrong electronic plan type for a Group Insurance Plan could result in claims being rejected by the clearinghouse or by the payer.</i>
	<i>Note: Patch IB*2*432 added the ability to define two additional types of Electronic Plan Type: 17 – Dental and FI – Federal Employee Plan.</i>

Step	Procedure
	<i>Note: Patch IB*2*436 added the ability to define an additional plan type for MediGap F and G plans. MEDIGAP (SUPPL - COINS, DED, PART B EXC)</i>

```

This plan is currently defined as a Group Plan.
Do you wish to change this plan to an Individual Plan? NO
No change was made.

GROUP PLAN NAME: DEMO GROUP//
GROUP PLAN NUMBER: 7878787878//
TYPE OF PLAN: COMPREHENSIVE MAJOR MED
ELECTRONIC PLAN TYPE: ?
Enter the appropriate type of plan to be used for electronic billing.
Choose from:
    16      HMO MEDICARE
    MX      MEDICARE A or B
    TV      TITLE V
    MC      MEDICAID
    BL      BC/BS
    CH      TRICARE
    15      INDEMNITY
    CI      COMMERCIAL
    HM      HMO
    DS      DISABILITY
    12      PPO
    13      POS
    ZZ      OTHER
    FI      FEP - Do not use for BC/BS
    17      DENTAL
ELECTRONIC PLAN TYPE: BL BCBS

```

The following screen will display.

```

View/Edit Plan           Mar 31, 2004@16:19:51           Page:    1 of    3
Plan Information for: BLUE CROSS Insurance Company
                        ** Plan Currently Active **

Plan Information                     Utilization Review Info
Is Group Plan: YES                   Require UR: NO
Group Name: DEMO FOR TRAINING        Require Amb Cert: YES
Group Number: 87654                 Require Pre-Cert: YES
Type of Plan: COMPREHENSIVE MAJOR MED Exclude Pre-Cond: YES
Electronic Type: BC/BS              Benefits Assignable: YES

+          Enter ?? for more actions

Select Action: Next Screen//

```






2.1.2 Activate Existing Commercial Payer to Transmit eClaims

To activate an existing payer to receive electronic claims, use the Billing Parameters screen in the Insurance Company Editor. The **EDI - Transmit?** field on this screen must be set to **YES-LIVE**. In the Live mode, bills are automatically sent electronically and cannot be printed until the confirmation of a receipt message has been received from the FSC.

Follow these steps to change the **EDI - Transmit?** Field:

Step	Procedure
1	On the Billing Parameters screen in the Insurance Company Editor, type BP and press the <Enter> key.

Insurance Company Editor	Oct 01, 2007@10:40:16	Page:	1 of 8
Insurance Company Information for: AETNA			
Type of Company: HEALTH INSURANCE	Currently Inactive		
Billing Parameters			
Signature Required?: NO	Filing Time Frame: 12 MOS		
Reimburse?: WILL REIMBURSE	Type Of Coverage: HEALTH INSURAN		
Mult. Bedsections:	Billing Phone:		
Diff. Rev. Codes:	Verification Phone:		
One Opt. Visit: NO	Precert Comp. Name:		
Amb. Sur. Rev. Code:	Precert Phone:		
Rx Refill Rev. Code:			
EDI Parameters			
Transmit?: NO	Insurance Type:		
+ Enter ?? for more actions		>>>	
BP Billing/EDI Param	IO Inquiry Office	EA Edit All	
MM Main Mailing Address	AC Associate Companies	AI (In)Activate Company	
IC Inpt Claims Office	ID Prov IDs/ID Param	CC Change Insurance Co.	
OC Opt Claims Office	PA Payer	DC Delete Company	
PC Prescr Claims Of	RE Remarks	VP View Plans	
AO Appeals Office	SY Synonyms	EX Exit	
Select Action: Next Screen//BP Billing/EDI Param			

Step	Procedure
	<i>Patch IB*2.0*320 added a new security key, IB EDI INSURANCE EDIT. A user must hold this key to edit the EDI-Transmit, EDI Prof Payer ID; EDI Inst Payer ID and EDI-Insurance Type fields.</i>
2	At the EDI - Transmit? field, make sure the field is defined as YES-LIVE .
3	At the EDI - Insurance Type field, enter the correct response for the Insurance Company being edited. For this example, the correct Electronic Insurance Type is Group .
	<i>Except for the testing of Primary BC/BS and some secondary end to end claims, it is no longer necessary to change the EDI - Transmit? field to YES-TEST. Instead, use the new option, RCB – View/Resubmit Claims-Live or Test. Refer to Section 4.</i>
	<i>Note: Once Patch IB*2*516 is installed, a new field, HPID/OEID, will display in the EDI Parameters section. The field will not be editable. The HPID or OEID number will come from the National Insurance File.</i>
	<i>Note: Patch IB*2*547 will add a field, UMO (278)ID, to the EDI Parameters section which will allow users to define a primary payer identification number which will be transmitted in ASC X12N 5010 Health Care Services Review – Request for Review and Response (278) transactions.</i>
	<i>Note: Patch IB*2*547 will add the fields, EDI - Alt Inst Payer Primary ID Type, EDI - Alt Inst Payer Primary ID, EDI - Alt Prof Payer Primary ID Type and EDI - Alt Prof Payer Primary ID, to the EDI Parameters section which will allow users to define one or more primary payer identification numbers which will be transmitted in ASC X12N 5010 Health Care Claims (837) transactions which need to be routed to contractors who adjudicate specific claim types such as claims for durable medical equipment (DME).</i>

```

SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS: YES//
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY: NO//
AMBULATORY SURG. REV. CODE:
PRESCRIPTION REFILL REV. CODE: 253//
FILING TIME FRAME: ONE YEAR//
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 800-555-5298//
VERIFICATION PHONE NUMBER: 800-555-5298//
Are Precerts Processed by Another Insurance Co.?: NO
//
PRECERTIFICATION PHONE NUMBER: XXX-XXX-XXXX//
EDI - Transmit?: ??
    This is the flag that says whether or not an insurance company is ready
    to be billed electronically via 837/EDI functions.

    Choose from:
    0          NO
    1          YES-LIVE
    2          YES-TEST
EDI - Transmit?: 1 YES-LIVE
EDI - Inst Payer Primary ID:
EDI - Inst Payer Primary ID: Available from Emdeon
EDI - Alt Inst Payer Primary ID Type: LTC//
    EDI - Alt Inst Payer Primary ID Type: LTC//
    EDI - Alt Inst Payer Primary ID: LTC1234//
Select EDI - Alt Inst Payer Primary ID Type:
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID:
EDI - Prof Payer Primary ID: Available from Emdeon
EDI - Alt Prof Payer Primary ID Type: LTC//
    EDI - Alt Prof Payer Primary ID Type: LTC//
    EDI - Alt Prof Payer Primary ID: LTC1234P//
Select EDI - Alt Prof Payer Primary ID Type:
EDI - 1ST Prof Payer Sec. ID Qualifier:
EDI - Insurance Type: ??
    Choose from:
    1          HMO
    2          COMMERCIAL
    3          MEDICARE
    4          MEDICAID
    5          GROUP POLICY
    9          OTHER
EDI - Insurance Type: 5 GROUP POLICY
EDI - Bin Number:
EDI - UMO (278) ID:
EDI - Print Sec/Tert Auto Claims?:
EDI - Print Medicare Sec Claims w/o MRA?:

```

The following steps show you how to enter the Electronic Plan Type for a **Commercial Group Insurance Plan**:

Step	Procedure
1	At the Billing Parameters Screen in the Insurance Company Editor type in VP (View Plans) and press the <Enter> key.

```

Insurance Company Editor      Oct 01, 2007@10:40:16      Page:      1 of      8
Insurance Company Information for: AETNA
Type of Company: HEALTH INSURANCE                      Currently Inactive

                        Billing Parameters
Signature Required?: NO                      Filing Time Frame: 12 MOS
Reimburse?: WILL REIMBURSE                  Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:                          Billing Phone:
Diff. Rev. Codes:                          Verification Phone:
One Opt. Visit: NO                        Precert Comp. Name:
Amb. Sur. Rev. Code:                      Precert Phone:
Rx Refill Rev. Code:

                        EDI Parameters
Transmit?: YES-LIVE                      Insurance Type: GROUP POLICY
+      Enter ?? for more actions                      >>>
BP Billing/EDI Param      IO Inquiry Office      EA Edit All
MM Main Mailing Address  AC Associate Companies  AI (In)Activate Company
IC Inpt Claims Office    ID Prov IDs/ID Param  CC Change Insurance Co.
OC Opt Claims Office     PA Payer      DC Delete Company
PC Prescr Claims Of      RE Remarks      VP View Plans
AO Appeals Office        SY Synonyms      EX Exit
Select Action: Next Screen//VP View Plans

```

Step	Procedure
2	The Insurance Plan List appears. In this example, Plan 1 is selected by typing VP=1 and pressing the <Enter> key.


```

Insurance Plan List      Apr 14, 2004@09:21:12      Page:      1 of      1
All Plans for: AETNA Insurance Company

#  + => Indiv. Plan      * => Inactive Plan
   Group Name            Group Number      Type of Plan  UR?  Ct?  Pre-  Pre-  Ben
1  MANAGED CHOICE        55555-111-00001  COMPREHENSIVE YES  YES  UNK  ExC?  As?
                                     YES  YES  UNK  YES

      Enter ?? for more actions
VP View/Edit Plan      IP (In)Activate Plan
AB Annual Benefits      EX Exit
Select Action: Quit// VP=1

```

Step	Procedure
3	The View/Edit Plan screen appears. To edit plan information, type PI and press the <Enter> key.
	<i>Note: The IB GROUP PLAN EDIT security key is required to use PI.</i>

View/Edit Plan Apr 14, 2004@09:22:11 Page: 1 of 3
 Plan Information for: AETNA Insurance Company

 ** Plan Currently Active **

Plan Information	Utilization Review Info
Is Group Plan: YES	Require UR: YES
Group Name: MANAGED CHOICE	Require Amb Cert:
Group Number: 55555-111-00001	Require Pre-Cert: YES
Type of Plan: COMPREHENSIVE MAJOR MED	Exclude Pre-Cond:
Plan Filing TF:	Benefits Assignable: YES


Plan Coverage Limitations

Coverage	Effective Date	Covered?	Limit Comments
-----	-----	-----	-----
INPATIENT	02/01/04	YES	
OUTPATIENT	02/01/04	YES	
PHARMACY	02/01/04	NO	

+ Enter ?? for more actions

PI Change Plan Info	IP (In)Activate Plan
UI UR Info	AB Annual Benefits
CV Add/Edit Coverage	CP Change Plan
PC Plan Comments	EX Exit

Select Action: Next Screen// **PI Change Plan Info**

Step	Procedure
4	For this scenario, NO is entered for the Do you wish to change this plan to an Individual Plan? field.
5	Continue to press the <Enter> key until Electronic Plan Type field is activated.
6	Type in the appropriate code and press the <Enter> key. The chosen plan will be displayed. In this example CI has been selected.
	<i>Selecting the correct electronic plan type is important. Choosing the wrong electronic plan type for a Group Insurance Plan could result in claims being rejected by the clearinghouse or by the payer.</i>

```

This plan is currently defined as a Group Plan.
Do you wish to change this plan to an Individual Plan? NO
No change was made.

GROUP PLAN NAME: MANAGED CHOICE//
GROUP PLAN NUMBER: 55555-111-00001//
TYPE OF PLAN: COMPREHENSIVE MAJOR MEDICAL//
ELECTRONIC PLAN TYPE: ?
Enter the appropriate type of plan to be used for electronic billing.
  Choose from:
    16      HMO MEDICARE
    MX      MEDICARE A or B
    TV      TITLE V
    MC      MEDICAID
    BL      BC/BS
    CH      TRICARE
    15      INDEMNITY
    CI      COMMERCIAL
    HM      HMO
    DS      DISABILITY
    12      PPO
    13      POS
    ZZ      OTHER
    17      Dental
    FI      FEP - Do not use for BC/BS
ELECTRONIC PLAN TYPE: CI COMMERCIAL
PLAN FILING TIME FRAME: .....

```

The following screen will display.

```

View/Edit Plan          Apr 14, 2004@09:24:02          Page:    1 of    3
Plan Information for: AETNA DEMO INSURANCE Insurance Company
                        ** Plan Currently Active **

Plan Information          Utilization Review Info
Is Group Plan: YES          Require UR: YES
  Group Name: MANAGED CHOICE  Require Amb Cert:
  Group Number: 55555-111-00001  Require Pre-Cert: YES
  Type of Plan: COMPREHENSIVE MAJOR MED  Exclude Pre-Cond:
  Electronic Type: COMMERCIAL  Benefits Assignable: YES

+      Enter ?? for more actions

Select Action: Next Screen//

```

2.1.3 Activate Existing Payer to Test Primary Blue Cross/Blue Shield eClaims

Blue Cross and Blue Shield payers require the submission of test claims before accepting live claims. A member of the eBilling Team contacts someone at the facility to coordinate this testing.




When testing the electronic submission of secondary claims using the RCB – View/Resubmit Claims-Live or Test, it is not necessary to change Electronic Transmit? to YES-TEST nor is it necessary to print and mail claims sent using RCB.

If an eBilling Team member, request claims submitted electronically as a Live test enables the BC/BS payer to receive primary claims electronically but in a testing mode, use the Billing Parameters screen in the Insurance Company Editor. The **EDI -Transmit?** field on this screen must be set to **YES-TEST**. In testing mode, bills are automatically sent electronically and cannot be printed until the confirmation of receipt message has been received from the FSC.

The following steps show you how to change the **Electronic Transmit?** field:

Step	Procedure
1	On the Billing Parameters screen in the Insurance Company Editor, type BP and press the <Enter> key.

Insurance Company Editor	Oct 01, 2007@10:15:14	Page: 1 of 9
Insurance Company Information for: BLUE CROSS		
Type of Company: HEALTH INSURANCE	Currently Active	
Billing Parameters		
Signature Required?: NO	Filing Time Frame:	
Reimburse?: WILL REIMBURSE	Type Of Coverage: HEALTH INSURAN	
Mult. Bedsections:	Billing Phone: 800/933-9146	
Diff. Rev. Codes:	Verification Phone: 800/933-9146	
One Opt. Visit: NO	Precert Comp. Name:	
Amb. Sur. Rev. Code:	Precert Phone: 800/274-7767	
Rx Refill Rev. Code:		
EDI Parameters		
Transmit?: NO	Insurance Type:	
+ Enter ?? for more actions >>>		
BP Billing/EDI Param	IO Inquiry Office	EA Edit All
MM Main Mailing Address	AC Associate Companies	AI (In)Activate Company
IC Inpt Claims Office	ID Prov IDs/ID Param	CC Change Insurance Co.
OC Opt Claims Office	PA Payer	DC Delete Company
PC Prescr Claims Of	RE Remarks	VP View Plans
AO Appeals Office	SY Synonyms	EX Exit
Select Action: Next Screen// BP Billing/EDI Param		

Step	Procedure
2	At the EDI - Transmit? field, type 2 to change the field to YES-TEST . Continue to press the <Enter> key until the Billing Parameters screen reappears.
	<i>When using the TEST mode setting for BC/BS claims for which payment is expected, it is important to note the carrier will not process bills sent in test mode. These bills must be printed locally and mailed in order to receive payment.</i>

```

SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS: YES//
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY: NO//
AMBULATORY SURG. REV. CODE: 490//
PRESCRIPTION REFILL REV. CODE: 250//
FILING TIME FRAME: ONE YEAR FROM DATE OF SERVICE
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 205-988-2213//
VERIFICATION PHONE NUMBER: ITS:800-253-9307//
Are Precerts Processed by Another Insurance Co.?: NO
//
PRECERTIFICATION PHONE NUMBER: 800-248-2342//
EDI - Transmit?: NO// ??
    This is the flag that says whether or not an insurance company is
    ready to be billed electronically via 837/EDI functions.

    Choose from:
    0          NO
    1          YES-LIVE
    2          YES-TEST
EDI - Transmit?: 1 YES-LIVE
EDI - Inst Payer Primary ID: Available from Emdeon
Select EDI - Alt Inst Payer Primary ID Type:
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID: Available from Emdeon
Select EDI - Alt Prof Payer Primary ID Type:
EDI - 1ST Prof Payer Sec. ID Qualifier:
EDI - Insurance Type: 5 GROUP POLICY
EDI - Bin Number:
EDI - UMO (278) ID:
EDI - Print Sec/Tert Auto Claims?:
EDI - Print Medicare Sec Claims w/o MRA?:

```


3. Pay-to Provider(s) Set-up

Each VA database can have one or more Pay-to Providers. Each VA database must have at least one Pay-to Provider. A Pay-to Provider is the entity which is seeking payment for a claim (who will receive the payment). The Pay-to Provider does not need to have a physical location. It can have a street address or a Post Office Box number.

With Patch IB*2*516, sites will gain the ability to define a second set of Pay-to Providers to be used on claims with the Rate Type of TRICARE REIMB. or TRICARE. To define the TRICARE Pay-to Providers, the steps are the same as the following steps for regular Pay-to Providers. A new section has been added to the IB Site Parameters.

```
IB Site Parameters          Jun 16, 2014@11:34:09          Page:    3 of    5
Only authorized persons may edit this data.
+

[10]Pay-To Providers      : 1 defined, default - CHEYENNE VAMC

[11]TRICARE Pay-To Providers: 0 defined






[12]Inpt Health Summary: INPATIENT HEALTH SUMMARY
    Opt Health Summary : OUTPATIENT HEALTH SUMMARY

[13]HIPPA NCPDP Active Flag          : Active

[14]Inpatient TP Active : YES
    Outpatient TP Active: YES
    Pharmacy TP Active  : YES
    Prosthetic TP Active: YES

[15] EDI/MRA Activated          : BOTH EDI AND MRA
    EDI Contact Phone           : (307)778-7581
+      Enter ?? for more actions
EP  Edit Set                      EX  Exit
Select Action: Next Screen//
```

3.1. Define Default Pay-to Provider

Step	Procedure
	<i>Note: With Patch IB*2*516, two new Security Keys have been added: IB EDIT PAY-TO and IB EDIT PAY-TO TC. Users must be assigned these keys before adding or editing a Pay-to Provider.</i>
1	Access the option SITE→MCCR Site Parameter Display/Edit .
2	From the MCCR Site Parameters screen, enter the action: IB Site Parameters .
3	Press the <Enter> key for Next Screen until Page 2 is displayed.
4	From the IB Site Parameters screen, enter the action: EP Edit Set .
5	Enter the number 10 .
6	From the Pay-to Providers screen, enter the action: AP Add Provider .
7	From the Enter Pay-to Provider: prompt, enter CHEYENNE VAMC for this example.
	<i>Note: A Pay-to Provider should be a VAMC level facility with a valid NPI. The Pay-to Provider can be an institution outside your own database. Example: VAMC A could process payments for services provided by VAMC B.</i>
8	At the Are you adding 'CHEYENNE VAMC' as a new PAY-TO PROVIDERS (the 1ST for this IB SITE PARAMETERS)? No// prompt, enter YES for this example.
9	At the Pay-to Provider Name prompt, press the <Enter> key to accept the default name from the Institution file.
10	At the Pay-to Provider Address Line 1 prompt; press the <Enter> key to accept the default address from the Institution file.
11	At the Pay-to Provider Address Line 2 prompt; press the <Enter> key to accept the default address from the Institution file.
12	At the Pay-to Provider City prompt; press the <Enter> key to accept the default City from the Institution file.
13	At the Pay-to Provider State prompt; press the <Enter> key to accept the default State from the Institution file.
14	At the Pay-to Provider Zip Code prompt; press the <Enter> key to accept the default ZIP from the Institution file.
15	At the Pay-to Provider Phone Number prompt; enter the Phone Number that a payer should use to contact the site.
16	At the Pay-to Provider Federal Tax ID Number prompt; press the <Enter> key to accept the default Tax ID.
	<i>Note: There will be a default Tax ID only when the institution selected as the Pay-to Provider is the same as the main division in the site's database. This is taken from the IB Site Parameters.</i>
	<i>Do not add your site's Tax ID if the Pay-to Provider is another VAMC. Make sure to obtain and enter the other site's Tax ID.</i>
	<i>Note: A Pay-to Provider does not have to have an actual street address. You can enter a P.O. Box as an address.</i>

Pay-To Providers	Dec 22, 2008@13:58:13	Page: 1 of 1
------------------	-----------------------	--------------

No Pay-To Providers defined.

* = Default Pay-to provider

AP Add Provider	DP Delete Provider	EX Exit
EP Edit Provider	AS Associate Divisions	

Select Item(s): Quit// **AP Add Provider**

Enter Pay-to Provider: CHEYENNE VAMC WY M&ROC 442

Are you adding 'CHEYENNE VAMC' as a new PAY-TO PROVIDERS (the 1ST for this IB SITE PARAMETERS)? No// **y (Yes)**

Pay-to Provider Name: CHEYENNE VAMC//

Pay-to Provider Address Line 1: 2360 E PERSHING BLVD

Replace

Pay-to Provider Address Line 2: **Mail Stop 10234**

Pay-to Provider City: CHEYENNE//

Pay-to Provider State: WYOMING//

Pay-to Provider Zip Code: 82001-5356//

Pay-to Provider Phone Number: **555-555-5555**

Pay-to Provider Federal Tax ID Number: 83-0168494//

The following screen will display.

Pay-To Providers	Dec 22, 2008@14:38:21	Page: 1 of 1
------------------	-----------------------	--------------

1.	*Name : CHEYENNE VAMC	State : WY
	Address 1: 2360 E PERSHING BLVD	Zip Code: 82001-5356
	Address 2:	Phone :
	City : CHEYENNE	Tax ID : 83-0168494

*** = Default Pay-to provider**

AP Add Provider	DP Delete Provider	EX Exit
EP Edit Provider	AS Associate Divisions	

Select Item(s): Quit//

When the first Pay-to Provider is entered, it becomes the default Pay-to Provider and all the divisions in the database are assigned automatically to the default provider.

Step	Procedure
17	From the Pay-to Providers screen, enter the action AS Associate Divisions .

The following screen will display.


```

Pay-To Provider Associations Dec 22, 2008@14:42:27      Page: 1 of 1
CHEYENNE VAMC (Default)
  1      442GA      CASPER
  2      442GC      FORT COLLINS
  3      442GD      GREELEY
  4      442        CHEYENNE VAMROC
  5      442GB      SIDNEY
  6      442GE      TEST MORC

      Enter ?? for more actions
AS Associate Division      EX Exit
Select Item(s): Quit//
  
```

3.2. Associate Divisions with non-Default Pay-to Provider

When adding a second Pay-to Provider, users will be prompted to make it the default Pay-to Provider, Is this the default Pay-To Provider? NO//. If users make the new Pay-to Provider the default provider, all divisions will be associated with the new default. If users do not make the new provider the default, then they will have to associate select divisions with the new Pay-to Provider.

Step	Procedure
	<i>Note: When there is more than one Pay-to Provider, users must associated divisions with the non-default Pay-to Provider(s).</i>
1	From the Pay-to Providers screen, enter the action AS Associate Divisions .

```

Pay-To Providers Dec 22, 2008@14:55:32      Page: 1 of 1
1.  *Name      : CHEYENNE VAMC      State   : WY
    Address 1: 2360 E PERSHING BLVD      Zip Code: 82001-5356
    Address 2:                          Phone   :
    City      : CHEYENNE      Tax ID   : 83-0168494

2.  Name       : MONTANA HEALTH CARE SYSTEM - FT. H State   : MT
    Address 1: VA Medical Center      Zip Code: 59636
    Address 2:                          Phone   : 666-666-6666
    City      : FORT HARRISON      Tax ID   : 11-1111111



      * = Default Pay-to provider
AP Add Provider      DP Delete Provider      EX Exit
EP Edit Provider      AS Associate Divisions
Select Item(s): Quit// AS Associate Divisions
  
```

The following screen will display.

```

Pay-To Provider Associations Dec 22, 2008@15:32:45      Page: 1 of 1
CHEYENNE VAMC (Default)
  1      442GA      CASPER
  2      442GC      FORT COLLINS
  3      442GD      GREELEY
  4      442        CHEYENNE VAMROC
  5      442GB      SIDNEY
  
```

6	442GE	TEST MORC
MONTANA HEALTH CARE SYSTEM - FT. HARRISON DIVISION		
No Divisions found.		
Enter ?? for more actions		
AS	Associate Division	EX Exit
Select Item(s): Quit// AS Associate Division		
Select Division (1-6): 5		
Select Pay-To Provider: Montana		

Step	Procedure
2	At the Select Item(s): prompt, enter the action AS Associate Divisions .
3	At the Division (1-6): prompt, enter 5 for this example.
4	At the Pay-to Provider: prompt, enter Montana for this example.
	<i>Note: Users can not associate a division that is defined as a Pay-to Provider, to another Pay-to Provider. Users will get the following error if they try: A division used as a Pay-to Provider can not be associated with another Pay-to Provider.</i>
5	Repeat steps 2 - 4 if necessary.
	<i>Note: Once a division has been explicitly associated with a particular Pay-to Provider, changing the default Pay-to Provider will not automatically change the division's associated Pay-to Provider.</i>

The following screen will display.

Pay-To Provider Associations Dec 22, 2008@15:34:39		Page: 1 of 1
CHEYENNE VAMC (Default)		
1	442GA	CASPER
2	442GC	FORT COLLINS
3	442GD	GREELEY
4	442	CHEYENNE VAMROC
5	442GE	TEST MORC
MONTANA HEALTH CARE SYSTEM - FT. HARRISON DIVISION		
6	442GB	SIDNEY
Enter ?? for more actions		
AS	Associate Division	EX Exit
Select Item(s): Quit//		

4. Provider ID Set-up

Payers require the use of a variety of provider identifiers on claims submitted for adjudication. Printed claim forms have boxes where these IDs can be printed.

The general term, Provider ID, can refer to an ID that belongs to a human being such as an Attending physician or it can refer to an ID that belongs to an organization that provides healthcare services to a veteran such as a VAMC or an outside laboratory. Both VA and non-VA people and organizations have IDs.

IDs have qualifiers that identify what type of ID is being transmitted. An Attending physician's primary ID is his/her Social Security Number (SSN). This SSN is transmitted with a qualifier (34) which indicates that this number is an SSN. A Blue Cross ID is transmitted with a qualifier (1A) which indicates that this number is a Blue Cross number. Appendix C has a list of qualifiers and which ones can be transmitted in which 837 records.

The NPI (National Provider Identifier) is a HIPAA requirement with a usage requirement date beginning May 23, 2007. It is transmitted on 837 records along with treating specialty taxonomies from the National Uniform Claims Committee (NUCC) published code list.

Patch IB*2.0*343 added the ability to define the NPI and Taxonomy Codes for the VAMC, Non-VA facilities and both VA and Non-VA human providers.

Patches IB*2.0*348 and 349 added the ability to print the NPI on the new UB-04 and CMS-1500 claim forms.

After Patch IB*2.0*436, old claims can be reprinted locally for legal purposes and sent to Regional Counsel even though the original claim was created prior to the requirement for providers to have an assigned NPI. A legal claim is defined as having a Billing Rate Type of "NO FAULT INS", "WORKERS' COMP", or "TORT FEASOR".

When Patch IB*2.0*432 is loaded, the Social Security Number (SSN) will no longer be transmitted in the 837 records as a human providers Primary ID. The NPI will be transmitted in the 837 Health Care Claim transmission as the Primary ID for both human providers and organizational providers such as the Billing Provider.

The HIPAA 837 transaction set includes a number of segments in which to transmit multiple IDs and qualifiers for a single claim. The list below indicates the VistA record name, the type of information being transmitted, the maximum number of IDs that can go in that record for one claim and if the IDs will print on a paper claim (P), transmit electronically (T), or do both (B).

Segment	Type of ID	Max # of IDs	(P)rint (T)ransmit (B)oth
PRV:9	Billing Provider Primary ID	1	B
PRV1:6	Pay-to Provider Primary ID	1	T
CI1A:2-17	Billing Provider Secondary IDs	8	B
OPR1	Attending, Other Operating or Operating Physician Primary ID	1/Physician	B
OPR1	Referring Provider Primary ID	1/Provider	B

Segment	Type of ID	Max # of IDs	(P)rint (T)ransmit (B)oth
OPR7	Supervising Provider's Primary ID	1/Provider	B
OPR9	Rendering Provider Primary ID	1	B
OPR2	Attending Physician Secondary IDs	5	B
OPRA	Rendering Provider Secondary ID	4	B
OPR3	Operating Physician Secondary IDs	5	B
OPR4	Other Physician Secondary IDs	5	B
OPR5	Referring Provider Secondary IDs	5	B
OPR8	Supervising Provider Secondary IDs	1	B
SUB2	Laboratory or Facility Primary ID	1	B
SUB2	Laboratory or Facility Secondary IDs	5	T

4.1. Table of IDs

The following table shows where IDs are defined in VistA; where they are stored in VistA; where they appear on billing forms; and where they appear in the VistA option View/Print EDI Bill Extract Data (VPE) and the EDI 837 transaction record location.

Pay-to Provider NPI	
VistA Option	The Institution file is not available to Billing personnel
VistA File	Institution (#4)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	PRV1, Piece 6
Pay-to Provider Primary ID (Federal Tax Number of the VAMC) - Legacy	
VistA Option	MCCR Site Parameter Display/Edit
VistA File	IB SITE PARAMETERS (#350.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	N/A
Billing Provider NPI	
VistA Option	The Institution file is not available to Billing personnel
VistA File	Institution (#4)
UB-04	FL 56
CMS-1500	Box 33a
VPE (837 Record)	PRV, Piece 9
Billing Provider Taxonomy Code	
VistA Option	The Institution file is not available to Billing personnel
VistA File	Institution (#4)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	PRV, Piece 14
Billing Provider Secondary ID (Federal Tax Number of the VAMC)	
VistA Option	MCCR Site Parameter Display/Edit

VistA File	IB SITE PARAMETERS (#350.9)
UB-04	FL 5
CMS-1500	Box 25
VPE (837 Record)	CI1A, Piece 5
Billing Provider Secondary IDs - Legacy	
Note: If none are defined, the default is the Federal Tax ID.	
VistA Option	Insurance Company Entry/Edit→ID Prov IDs/ID Param
VistA File	FACILITY BILLING ID (#355.92)
UB-04	FL 57
CMS-1500	Box 33b
VPE (837 Record)	CI1A, Pieces 6-17
VA - Attending, Other Operating or Operating Physician NPI	
VistA Option	Provider Self Entry (Not available to Billing personnel) Add/Edit NPI values for Providers
VistA File	NEW PERSON (#200)
UB-04	FL 76-79
CMS-1500	N/A
VPE (837 Record)	OPR1, Piece 3, 6, or 9
VA – Attending Provider Taxonomy Code	
VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User Person Class Edit
VistA File	PERSON CLASS (#8932.1)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR, Piece 17
VA - Referring Provider NPI	
VistA Option	Provider Self Entry (Not available to Billing personnel) Add/Edit NPI values for Providers
VistA File	NEW PERSON (#200)
UB-04	FL 78 or 79
CMS-1500	Box 17b
VPE (837 Record)	OPR1, Piece 12
VA – Rendering Provider NPI	
VistA Option	Provider Self Entry (Not available to Billing personnel) Add/Edit NPI values for Providers
VistA File	NEW PERSON (#200)
UB-04	FL 78 or 79
CMS-1500	24J (Rendering)
VPE (837 Record)	OPR9, Piece 9
VA - Rendering Taxonomy Code	
VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User Person Class Edit

VistA File	PERSON CLASS (#8932.1)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR9, Piece 11
VA - Supervising Provider NPI	
VistA Option	Provider Self Entry (Not available to Billing personnel) Add/Edit NPI values for Providers
VistA File	NEW PERSON file #200
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR7, Piece 7
Non-VA - Attending, Other Operating or Operating Physician NPI	
VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA File	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	FL 76-79
CMS-1500	N/A
VPE (837 Record)	OPR1, Piece 3,6, or 9
Non-VA – Attending Provider Taxonomy Code	
VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA File	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	FL 76-79
CMS-1500	N/A
VPE (837 Record)	OPR, Piece 17
Non-VA – Rendering Provider NPI	
VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	FL 78-79
CMS-1500	24J
VPE (837 Record)	OPR9, Piece 9
Non-VA – Referring Provider NPI	
VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	FL 78-79
CMS-1500	17b
VPE (837 Record)	OPR1, Piece 12
Non-VA – Rendering Provider Taxonomy Code	
VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB NON/OTHER VA BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR9, Piece 11
Non-VA – Supervising Provider NPI	

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR7, Piece 7
VA - Attending, Other Operating or Operating Physician Secondary IDs - Legacy	
VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	FL 76-79
CMS-1500	N/A
VPE (837 Record)	OPR2, OPR3, OPR4 Pieces 3, 5, 7, 9 or 11
VA – Rendering Provider Secondary IDs - Legacy	
VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	FL 78-79
CMS-1500	Box 24J
VPE (837 Record)	OPRA, Pieces 2-9
VA – Referring Provider Secondary IDs - Legacy	
VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	FL 78-79
CMS-1500	Box 17a
VPE (837 Record)	OPR5, Pieces 2-10
VA – Supervising Provider Secondary IDs - Legacy	
VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR 8, Pieces 2-11
Non - VA - Attending, Other Operating or Operating Physician Secondary IDs - Legacy	
VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	FL 76-79
CMS-1500	N/A

VPE (837 Record)	OPR2, OPR3, OPR4 Pieces 2-11
Non - VA – Rendering Provider Secondary IDs - Legacy	
VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	FL 78-79
CMS-1500	Box 24J
VPE (837 Record)	OPRA, Pieces 2-9
Non-VA - Referring Provider Secondary IDs - Legacy	
VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	FL 78-79
CMS-1500	Box 17a
VPE (837 Record)	OPR5, Pieces 2-10
Non - VA – Supervising Provider Secondary IDs - Legacy	
VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR8, Pieces 2-11
VA - Service Facility – Laboratory or Facility NPI	
After Patch IB*2*400, only VA facility types that do <i>not</i> have NPIs (e.g., MORC) are used as VA Service Facilities. Most often the Service Facility is blank.	
VA - Service Facility – Laboratory or Facility Federal Tax ID	
VistA Option	MCCR Site Parameter Display/Edit Insurance Company Entry/Edit
VistA File	IB SITE PARAMETERS (#350.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	SUB, Piece 9
VA - Service Facility – Laboratory or Facility Secondary IDs - Legacy	
VistA Option	Insurance Company Entry/Edit → ID Prov IDs/ID Param → VA-Lab/Facility IDs
VistA File	FACILITY BILLING ID (#355.92)
UB-04	N/A
CMS-1500	Box 32b
VPE (837 Record)	SUB2, Pieces 7-16

Non-VA - Service Facility – Laboratory or Facility NPI	
VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Facility Info
VistA File	IB NON VA/OTHER BILLING PROVIDER file #355.93
UB-04	N/A
CMS-1500	Box 32a
VPE (837 Record)	SUB2, Piece 6
Non-VA - Service Facility – Laboratory or Facility Secondary IDs - Legacy	
VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Secondary ID Maint
VistA File	IB BILLING PRACTITIONER ID (#355.9)
UB-04	Not Printed
CMS-1500	32b
VPE (837 Record)	SUB2, Pieces 7-16

4.2. Pay-to Provider IDs

4.2.1 Define the Pay-to Provider Primary ID/NPI

The Pay-to Provider NPI is not entered or maintained by Billing personnel. The Pay-to Provider NPI is retrieved from the Institution file (#4).

Beginning with Patch IB*2*432, the Pay-to Provider Primary ID is the NPI number of the site defined as the Pay-to Provider. The Federal Tax Number is defined when the Pay-to Provider is defined, but will no longer be used as the Primary ID. Refer to **Section 3.1**.

4.2.2 Define the Pay-to Provider Secondary IDs

With Patch IB*2*400, the CI1B segment was added to the outbound 837 claim transmission map to transmit Pay-to Provider Secondary IDs if the need should arise in the future. The CI1B segment was removed with Patch IB*2*432.

4.3. Billing Provider IDs

The Billing Provider Primary ID and the Billing Provider Secondary IDs are IDs that identify the facility at which the patient service was provided. This is a facility with a physical location (street address). The Billing Provider on a claim must be one of the following Facility Types that have been assigned NPI numbers:

- CBOC – Community Based Outpatient Clinic
- HCS – Health Care System
- M&ROC – Medical and Regional Office Center
- OC – Outpatient Clinic (Independent)
- OPC – Out Patient Clinic
- PHARM – Pharmacy
- VAMC – VA Medical Center
- RO-OC – Regional Office – Outpatient Clinic

When care is provided at any other facility type (i.e. a mobile unit), the Billing Provider becomes the Parent facility as defined in the Institution file (#4) and the mobile unit becomes the Service Facility.

With Patch IB*2*432, the name for the Billing Provider on a claim is extracted from the new Billing Facility Name field (#200) of the Institution file (#4). If this field is not populated, the IB software continues to extract the name from the .01 field of the Institution file.

4.3.1 Define the Billing Provider Primary ID/NPI

For all claims generated by the VA, the Billing Provider Secondary ID is the Federal Tax Number of the site. Once defined, the IB software will automatically assign this ID to a claim.

The Billing Provider NPI is the Billing Provider Primary ID. The Billing Provider NPI is defined in the Institution file. Once defined, the IB software automatically assigns this ID to a claim.

The VA Billing Provider NPI and Taxonomy Code will not be entered or maintained by Billing personnel. Users may change the default Billing Provider taxonomy code for a claim but users cannot change the Billing Provider NPI.

Step	Procedure
1	Access the option SITE→MCCR Site Parameter Display/Edit.
2	From the MCCR Site Parameters screen, enter the action: IB Site Parameters.
3	Press the <Enter> key for Next Screen until Page 2 is displayed.
4	From the IB Site Parameters screen , enter the action: EP Edit Set.
5	Enter the number 9.
6	At the Federal Tax Number prompt, enter the site's Federal Tax Number.

```

IB Site Parameters          Oct 20, 2005@16:23:16          Page:    2 of    6
Only authorized persons may edit this data.
+
[5] Medical Center        : LOMA LINDA VAMC          Default Division   : JERRY L PETTI
    MAS Service           : PATIENT ELIGIBILITY      Billing Supervisor  : KYDFES,SHUUN

[6] Initiator Authorize: YES                        Xfer Proc to Sched : NO
    Ask HINQ in MCCR      : YES                      Use Non-PTF Codes  : YES
    Multiple Form Types: YES                        Use OP CPT screen  : YES

[7] UB-04 Print IDs       : YES                      UB-04 Address Col  :
    CMS-1500 Print IDs    : YES                      CMS-1500 Addr Col  : 28

[8] Default RX DX Cd      : 780.99                  Default ASC Rev Cd : 490
    Default RX CPT Cd     :                          Default RX Rev Cd  : 251

[9] Bill Signer Name      : <No longer used>         Federal Tax #       :
    Bill Signer Title     : <No longer used>
    Remark on Each Bill: BILL # MUST BE ON ALL REMITTANCE

+          Enter ?? for more actions
EP  Edit Set                                EX  Exit Action
Select Action: Next Screen//  ep  Edit Set
Select Parameter Set(s): (5-9): 9
NAME OF CLAIM FORM SIGNER: BUSINESS OFFICE//
TITLE OF CLAIM FORM SIGNER:
FEDERAL TAX NUMBER: XXX123456
  
```



4.3.2 Define the Billing Provider Secondary IDs

The Billing Provider Secondary IDs are IDs and Qualifiers that are provided to a site by the insurance company. There can be a total of eight Billing Provider Secondary IDs per claim. The first ID is calculated by the system and used by the clearinghouse to sort claims. The second ID is always the site's Federal Tax ID, and the remaining six IDs must be defined by the IB staff if required.

Users can define one Billing Provider Secondary ID for a CMS-1500 and another for a UB-04 for the main division. If no other Billing Provider Secondary IDs are defined, these two IDs become the default IDs for all claims.

Billing Provider Secondary IDs can be defined by Division, Form Type, and Care Unit.

4.3.2.1 Define Default Billing Provider Secondary IDs by Form Type

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU → Insurance Company Entry/Edit .
2	At the Select Insurance Company Name : prompt, enter Blue Cross of California for this example.
3	From the Insurance Company Editor screen, enter the action: ID Prov IDs/ID Param .
4	From the Billing Provider IDs screen, enter the action Add an ID .
5	At the Define Billing Provider Secondary IDs by Care Units? No// prompt, press the <Enter> key to accept the default of No .
6	At the Division prompt, accept the default for the main Division.
7	At the ID Qualifier: Electronic Plan Type// prompt, enter Blue Shield to override the default value for this example.
	<i>Note: The default value for the Billing Provider Secondary ID Qualifier is still based upon the Electronic Plan Type of the patient's insurance plan. Users now have the ability to override this default.</i>
8	At the Form Type prompt, enter CMS-1500 for this example.
9	At the Billing Provider Secondary ID prompt, enter the ID XXXXXXXX1B for this example.
10	Repeat these steps for the Form Type = UB-04 , Qualifier = Blue Cross and ID = XXXXXX1A .
	<i>Note: Beginning with Patch IB*2*432, if no Billing Provider Secondary IDs are defined, the Federal Tax ID will no longer be used as a default value.</i>

Billing Provider IDs (Parent)	May 27, 2005@12:48:29	Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA	Billing Provider Secondary IDs	
ID Qualifier	ID #	Form Type

No Billing Provider IDs found

Enter ?? for more actions

Add an ID	Additional IDs	Exit
Edit an ID	ID Parameters	
Delete an ID	VA-Lab/Facility IDs	

Select Action: Quit// **a Add ID**

Define Billing Provider Secondary IDs by Care Units? No//??

Enter No to define a Billing Provider Secondary ID for the Division.
Enter Yes to define a Billing Provider Secondary ID for a specific Care Unit.
If no Care Unit is entered on Billing Screen 3, the Billing Provider Secondary ID defined for the Division will be transmitted in the claim.

0 No
1 Yes

Define Billing Provider Secondary IDs by Care Units? No//**No**

Division: Main Division// **Main Division**

ID Qualifier: Electronic Plan Type//**Blue Shield**

Enter Form Type for ID: **CMS-1500**

Billing Provider Secondary ID: **XXXXXX1B**

The following screen will display. These two IDs will be the default IDs for all claims and will appear on Billing Screen 3.

Billing Provider IDs (Parent)	May 27, 2005@12:48:29	Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA	Billing Provider Secondary IDs	
ID Qualifier	ID #	Form Type

Division: Name of Main Division/Default for All Divisions

1	Blue Cross	XXXXXX1A	UB04
2	Blue Shield	XXXXXX1B	1500


Enter ?? for more actions

Add an ID	Additional IDs	Exit
Edit an ID	ID Parameters	
Delete an ID	VA-Lab/Facility IDs	

Select Action: Quit//


4.3.2.2 Define Billing Provider Secondary IDs by Division and Form Type

If an insurance company requires different Billing Provider Secondary IDs for each division, then users must define more than just the default IDs.

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Insurance Company Entry/Edit.
2	At the Select Insurance Company Name: prompt, enter Blue Cross of California for this example.
3	From the Insurance Company Editor screen, enter the action ID Prov IDs/ID Param.
4	From the Billing Provider IDs screen, enter the action Add an ID.
5	At the Define Billing Provider Secondary IDs by Care Units? No// prompt, press the <Enter> key to accept the default of No.
6	At the Division prompt, override the default for the main division by entering the name of another division, Remote Clinic for this example.
7	At the ID Qualifier: Electronic Plan Type// prompt, enter Blue Shield to override the default value for this example.
8	At the Form Type prompt, enter CMS-1500 for this example.
9	At the Billing Provider Secondary ID prompt, enter the ID 1XXXXX1B for this example.
10	Repeat these steps for the Form Type = UB-04 , Qualifier = Blue Cross and ID = 1XXXXX1A .
	<i>Note: Users may repeat these steps to define different Billing Provider Secondary IDs for each division if required by the insurance company.</i>

Billing Provider IDs (Parent)		May 27, 2005@12:48:29	Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA		Billing Provider Secondary IDs	
ID Qualifier	ID #	Form Type	
Division: Name of Main Division/Default for All Divisions			
1	Blue Cross	XXXXXX1A	UB04
2	Blue Shield	XXXXXX1B	1500
Enter ?? for more actions			
Add an ID	Additional IDs	Exit	
Edit an ID	ID Parameters		
Delete an ID	VA-Lab/Facility IDs		
Select Action: Quit// a Add ID			
Define Billing Provider Secondary IDs by Care Units? No//No			
Division: Main Division// Remote Clinic			
ID Qualifier: Electronic Plan Type//Blue Shield			
Enter Form Type for ID: CMS-1500			
Billing Provider Secondary ID: 1XXXXX1B			


The following screen will display.

	<i>Note: The two IDs for the Remote Clinic division are available to the clerk on Billing Screen 3 for claims for services provided by this division.</i>
---	---

Billing Provider IDs		May 27, 2005@12:48:29	Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA		Billing Provider Secondary IDs	
ID Qualifier	ID #	Form Type	
Division: Name of Main Division/Default for All Divisions			
1	Blue Cross	XXXXXX1A	UB04
2	Blue Shield	XXXXXX1B	HCFA
Division: Remote Clinic			
3	Blue Cross	1XXXXX1A	UB04
4	Blue Shield	1XXXXX1B	1500
<p>Enter ?? for more actions</p> <p>Add an ID Additional IDs Exit</p> <p>Edit an ID ID Parameters</p> <p>Delete an ID VA-Lab/Facility IDs</p> <p>Select Action: Quit//</p>			

4.3.2.3 Define Billing Provider Secondary IDs by Division, Form Type and Care Unit

If an insurance company requires different Billing Provider Secondary IDs for services provided by particular Care Units, users can define them by Division, Form Type, and Care Unit.

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU → Insurance Company Entry/Edit .
2	At the Select Insurance Company Name: prompt, enter Blue Cross of California for this example.
3	From the Insurance Company Editor screen, enter the action ID Prov IDs/ID Parameters .
4	From the Billing Provider IDs screen, enter the action Add an ID .
5	At the Define Billing Provider Secondary IDs by Care Units? No// prompt, enter YES to override the default.
6	At the Division prompt, press the <Enter> key to accept the default for the Main Division .
7	At the Care Unit: prompt, enter ?? to see a pick list of available Care Units.
	<i>Refer to Section 3.4.2 to learn how to create this list of available Care Units.</i>
8	At the Care Unit: prompt, enter Anesthesia for this example.
9	At the ID Qualifier: Electronic Plan Type// prompt, enter Blue Shield to override the default value for this example.
10	At the Form Type prompt, enter CMS-1500 for this example.
11	At the Billing Provider Secondary ID prompt, enter the ID 11XXXX1B for this example.
12	Repeat these steps for the Form Type = UB-04 , Qualifier = Blue Cross and ID = 11XXXX1A .
13	Repeat these steps for Care Units Reference Lab and Home Health .

Insurance Co: BLUE CROSS OF CALIFORNIA Billing Provider Secondary IDs

ID Qualifier ID # Form Type

Division: Name of Main Division/Default for All Divisions

1	Blue Cross	XXXXXX1A	UB04
2	Blue Shield	XXXXXX1B	1500

Division: Remote Clinic

3	Blue Cross	1XXXXX1A	UB04
4	Blue Shield	1XXXXX1B	1500

Enter ?? for more actions

Add an ID	Additional IDs	Exit
Edit an ID	ID Parameters	
Delete an ID	VA-Lab/Facility IDs	

Select Action: Quit// a Add ID

Define Billing Provider Secondary IDs by Care Units? No//??

Enter No to define a Billing Provider Secondary ID for the Division.

Enter Yes to define a Billing Provider Secondary ID for a specific Care Unit.

If no Care Unit is entered on Billing Screen 3, the Billing Provider Secondary ID defined for the Division will be transmitted in the claim.

0 No
1 Yes

Define Billing Provider Secondary IDs by Care Units? No//1 Yes

Division: Main Division// Main Division

Care Unit:??

Select a Care Unit from the list:

1 Anesthesia
2 Reference Lab
3 Home Health

Care Unit: 1 Anesthesia

ID Qualifier: Electronic Plan Type//Blue Shield

Enter Form Type for ID: CMS-1500

Billing Provider Secondary ID: 11XXXX1B

The following screen will display.

Billing Provider IDs		May 27, 2005@12:48:29	Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA		Billing Provider Secondary IDs	
ID Qualifier	ID #	Form Type	
Division: Name of Main Division/Default for All Divisions			
1 Blue Cross	XXXXXX1A	UB04	
2 Blue Shield	XXXXXX1B	1500	
Care Unit: Anesthesia			
3 Blue Cross	11XXXX1A	UB04	
4 Blue Shield	11XXXX1B	1500	
Care Unit: Reference Lab			
5 Blue Cross	12XXXX1A	UB04	
6 Blue Shield	12XXXX1B	1500	
Care Unit: Home Health			
7 Blue Cross	13XXXX1A	UB04	
8 Blue Shield	13XXXX1B	1500	
+			
Enter ?? for more actions			
Add an ID	Additional IDs	Exit	
Edit an ID	ID Parameters		
Delete an ID	VA-Lab/Facility IDs		
Select Action: Quit//			




If users want a default Billing Provider Secondary ID to populate Billing Screen 3, define a default ID for the division and define IDs for the division and specific care units. Users can then accept the default ID or override it with one of the Care Unit IDs during the creation of a claim.


4.3.2.4 Define Additional Billing Provider Secondary IDs by Division and Form Type

In addition to the Billing Provider Secondary ID that appears on Billing Screen 3 for each insurance company on the bill, there can be five additional Billing Provider Secondary IDs that will be transmitted with claims for an insurance company.

Prior to Patch IB*2.0*320, the IDs defined in IB Site Parameters, Section 14 and Provider ID Maintenance, Number 3, were transmitted with all claims to all payers. These options for defining IDs were removed with Patch IB*2.0*320.

If an insurance company requires additional Billing Provider Secondary IDs, users can define them in Insurance Company Entry/Edit.

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU → Insurance Company Entry/Edit .
2	At the Select Insurance Company Name: prompt, enter Blue Cross of California for this example.
3	From the Insurance Company Editor screen, enter the action: ID Prov IDs/ID Param .
4	From the Billing Provider IDs screen, enter the action Additional IDs .
5	From the Billing Provider IDs – Additional Billing Provider Sec. IDs screen, enter the action Add an ID .
6	At the ID Qualifier: prompt, enter Medicare for this example.
	<i>Note: There cannot be two Billing Provider Secondary IDs on a claim with the same Qualifier. If you enter an ID with the same Qualifier here as one defined under Billing Provider Secondary IDs for the Division on a claim, the Additional Billing Provider Secondary ID with</i>

	<i>the same Qualifier will not be transmitted on the claim.</i>
7	At the Form Type prompt, enter CMS-1500 for this example.
9	At the Billing Provider Secondary ID prompt, enter the ID 14XXXX1C for this example.
10	Repeat these steps for the Form Type = UB-04 , Qualifier = Medicare , ID = 14XXXX1C .
	<i>Note: Users can repeat these steps to define multiple additional Billing Provider Secondary IDs if required by the insurance company.</i>

```

Billing Provider IDs (Parent) May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA  Additional Billing Provider Sec. IDs
      ID Qualifier              ID #              Form Type

No Additional Billing Provider IDs found

      Enter ?? for more actions
Add an ID              Delete an ID              Exit
Edit an ID              Copy IDs

Select Action: Quit//  Add an ID
Type of ID: Medicare
Form Type: 1500
Billing Provider Secondary ID: 14XXXX1C

```

The following screen will display.

```

Billing Provider IDs (Parent) May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA  Additional Billing Provider Sec. IDs
      ID Qualifier              ID #              Form Type
Division: Name of Main Division/Default for All Divisions
1   Medicare                  14XXXX1C      UB04
2   Medicare                  14XXXX1C      1500

      Enter ?? for more actions
Add an ID              Delete an ID              Exit
Edit an ID              Copy IDs

Select Action: Quit// Add an ID
Type of ID: Medicare
Form Type: UB-04
Billing Provider Secondary ID: XXXXXXXX11

```

4.4. Service Facility IDs (Laboratory or Facility IDs)

The 837 claims transmission records contain Service Facility data like the name and address of a facility and primary and secondary IDs for that facility. Often this is an outside, non-VA facility. These IDs are called the Laboratory or Facility Primary ID and the Laboratory or Facility Secondary IDs.

If there is a non-VA facility on a claim because a veteran received care at an outside laboratory or a private hospital or clinic, an insurance company can require the claim to contain primary and secondary Laboratory or Facility IDs for the organization that provided the care.

If there is not an outside facility on a claim, but the care was provided by the VA at a facility such as a Mobile clinic, an insurance company can require the claim to contain primary and secondary Laboratory or Facility IDs for the clinic.

Patch IB*2.0*320 provided enhancements to allow users to more easily define Laboratory or Facility IDs for the VA or non-VA.

Beginning with Patches IB*2.0*348 and 349, the Service Facility NPI will be printed on locally printed CMS-1500 claims.




Beginning with Patch IB*2.0*400, the Service Facility loop will not be populated if the care was provided at a VA location that has an NPI such as a CBOC, VAMC or Pharmacy.




The non-VA Service Facility NPI and Taxonomy Code will be entered and maintained by Billing personnel.

4.4.1 Define Non-VA Laboratory or Facility Primary IDs/NPI

For outside, non-VA facilities such as an independent laboratory, the Laboratory or Facility Primary ID should be the entity's NPI.

In addition to the Federal Tax ID, an NPI and one or more Taxonomy Codes can be defined for outside, non-VA facilities.

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU → Provider ID Maintenance .
2	At the Select Provider ID Maintenance Option: prompt, enter NF for Non-VA Facility.
3	At the Select a NON/Other VA Provider: prompt, enter IB Outside Facility for this example.
4	From the Non-VA Lab or Facility Info screen , enter the action FI for Lab/Facility Info.
5	At the Street Address: prompt, enter 123 Westbend Street for this example.
	Effective with Patch IB*2*488, only a physical street address may be entered (no post office box). Any entry that begins with "P.O." or "PO" or "Box" is prohibited.
6	At the Street Address Line 2: prompt, press the <Enter> key to leave blank.
7	At the City prompt, enter Long Beach for this example.
8	At the State: prompt, enter California for this example.
9	At the Zip Code prompt, enter 920601234 for this example.
	Effective with Patch IB*2*488, only a 9- or 10-digit ZIP code may be entered: 999999999/99999-9999.
	With 5010, claims must be submitted with a street address and a full nine-digit zip code when reporting a non-VA service facility locations
10	At the Contact Name: prompt, enter IB,CONTACT O for this example.

Step	Procedure
11	At the Contact Phone Number: prompt, enter 703-333-3333 for this example.
12	At the Contact Phone Extension: prompt, enter 123478 .
13	At the ID Qualifier: prompt, press the <Enter> key to accept the default.
14	At the Lab or Facility Primary ID: prompt, enter 11111112 .
15	At the X12 Type of Facility: prompt, enter FA - Facility for this example.
	<i>With Patch IB*2*371, FA will be sent as the Type of Facility on all institutional claims regardless of what is defined. HIPAA only allows FA on institutional claims.</i>
16	At the Mammography Certification Number: prompt, press the <Enter> key to leave it blank. If you know the Mammography number you can enter it here.
17	At the NPI: prompt, enter XXXXXXXXXX for this example.
	<i>Note: With Patch IB*2*516, users will have the ability to define a Non-VA Facility as a sole-proprietorship and link it to a human provider. If a facility is linked to a human provider, then the human's NPI may be used for both the human and the facility. The individual provider must be defined in VistA before he/she can be linked to the facility.</i>
18	At the Select Taxonomy Code: prompt, enter 954 for this example.
19	At the OK? Prompt, press the <Enter> key to accept the default.
20	At the Are you adding 'General Acute Care Hospital' as a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No// prompt, enter Yes .
21	At the Primary Code: prompt, enter Yes for this example.
22	At the Status: prompt, enter Active .
23	At the Select Taxonomy Code: prompt, press the <Enter> key.
	<i>Note: With Patch IB*2*432, the ability to define the name of a contact person at the outside facility and the telephone number for that person will be available to users.</i>
24	At the Allow future updates by FEE BASIS automatic interface? YES // prompt, press the <Enter> key to accept the default. (Note: This question does not impact current functionality as this is part of Future Development)

```

STREET ADDRESS: 123 Test Street
STREET ADDRESS LINE 2:
CITY: CHEYENNE// Long Beach
STATE: CALIFORNIA
ZIP CODE: 920601234//
CONTACT NAME: IB,CONTACT O//
CONTACT PHONE NUMBER: 703-333-3333//
CONTACT PHONE EXTENSION: 123478//
ID Qualifier: 24 - EMPLOYER'S IDENTIFICATION #
Lab or Facility Primary ID: 11111112//
X12 TYPE OF FACILITY: FACILITY//
MAMMOGRAPHY CERTIFICATION #:
SOLE PROPRIETORSHIP?: NO
NPI: XXXXXXXXXX
Select TAXONOMY CODE: 954 General Acute Care Hospital      282N000
00X
    ...OK? Yes//      (Yes)

Are you adding 'General Acute Care Hospital' as
a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No/
/ y (Yes)
PRIMARY CODE: y YES
STATUS: a ACTIVE
Select TAXONOMY CODE:

```

The following screen will display.

Non-VA Lab or Facility Info		Jul 05, 2012@16:04:07	Page: 1 of 1
-----------------------------	--	-----------------------	--------------

Name: IB OUTSIDE FACILITY
 Address: 123 Test Street
 Long Beach, CALIFORNIA 92060
 Contact Name: IB,CONTACT O
 Contact Phone: 703-333-3333 123478

Type of Facility: FACILITY
 Primary ID: 11111112
 ID Qualifier: 24 - EMPLOYER'S IDENTIFICATION #
 Mammography Certification #:
 NPI: XXXXXXXXXX
 Taxonomy Code: 261QV0200X (Primary)

Allow future updates by FEE BASIS automatic interface? : YES

Enter ?? for more actions


FI Lab/Facility Info	LI Lab/Facility Ins ID
LO Lab/Facility Own ID	EX Exit

Select Action: Quit//

4.4.2 Define Non-VA Laboratory or Facility Secondary IDs

For outside, non-VA facilities, users can define multiple Laboratory or Facility Secondary IDs. These IDs can be either the facility's own IDs, such as a Clinical Laboratory Improvement Amendment (CLIA) number, or IDs assigned to the facility by an insurance company.

4.4.2.1 Define a non-VA Facility's Own Laboratory or Facility Secondary IDs

Step	Procedure
1	Access the option MCCR System Definition Menu → Provider ID Maintenance .
2	At the Select Provider ID Maintenance Option: prompt, enter NF for Non-VA Facility.
3	From the Non-VA Lab or Facility Info screen , enter the action LO for Lab/Facility Own ID.
4	From the Secondary Provider ID screen, enter the action AI for Add an ID.
5	At the Enter Provider ID Qualifier prompt, enter X5 CLIA Number for this example.
6	At the Form Type Applied to: prompt, enter CMS-1500 FORMS ONLY for this example.
7	At the Care Type: prompt, enter OUTPATIENT ONLY for this example.
8	At the Enter Lab or Facility Secondary ID prompt, enter DXXXXX for this example.
	<i>Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs.</i>

Secondary Provider ID		May 11, 2005@11:17:20	Page: 1 of 1
-----------------------	--	-----------------------	--------------

** Lab or Facility's Own IDs (No Specific Insurance Co) **

Provider: IB Outside Facility (Non-VA Lab or Facility)

ID Qualifier	Form	Care Type	ID#
No ID's found for provider			

Enter ?? for more actions

AI Add an ID	DI Delete an ID
EI Edit an ID	EX Exit

Select Action: Quit// AI Add an ID

Select Provider ID Qualifier: **X5 CLIA Number**
 FORM TYPE APPLIED TO: **CMS-1500 FORMS ONLY**
 BILL CARE TYPE: **OUTPATIENT ONLY**

THE FOLLOWING WAS CHOSEN:
 INSURANCE: ALL INSURANCE
 PROV TYPE: CLIA #
 FORM TYPE: CMS-1500 FORM ONLY
 CARE TYPE: OUTPATIENT ONLY

Provider ID: **DXXXXX**

The following screen will display.

Secondary Provider ID May 11, 2005@11:17:20 Page: 1 of 1
 ** Lab or Facility's Own IDs (No Specific Insurance Co) **

Provider: IB Outside Facility (Non-VA Lab or Facility)


	ID Qualifier	Form	Care Type	ID#
1	CLIA #	1500	OUTPT	DXXXXX

Enter ?? for more actions

AI	Add an ID	DI	Delete an ID
EI	Edit an ID	EX	Exit

Select Action: Quit//

4.4.2.2 Define a non-VA Facility's Laboratory or Facility Secondary IDs Assigned by an Insurance Company

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU → Provider ID Maintenance .
2	At the Select Provider ID Maintenance Option: prompt, enter NF for Non-VA Facility.
3	From the Non-VA Lab or Facility Info screen, enter the action LI for Lab/Facility Ins ID.
4	From the Secondary Provider ID screen, enter the action AI for Add an ID.
5	At the Enter Provider ID Qualifier prompt, enter Blue Shield for this example.
6	At the Form Type Applied to: prompt, enter CMS-1500 FORMS ONLY for this example.
7	At the Care Type: prompt, enter BOTH for this example.
8	At the Enter Lab or Facility Secondary ID prompt, enter 111XXX1B for this example.
	<i>Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs. A maximum of 5 Laboratory or Facility Secondary IDs can be defined per insurance company. A maximum of 5 Laboratory or Facility Secondary IDs can be transmitted in a claim.</i>

Secondary Provider ID May 11, 2005@11:17:20 Page: 1 of 1
 ** Lab or Facility Secondary IDs from Insurance Co **

Provider: IB Outside Facility (Non-VA Lab or Facility)
 Insurance Co: BLUE CROSS OF CALIFORNIA

ID Qualifier	Form	Care Type	ID#
--------------	------	-----------	-----

No ID's found for provider and selected insurance co


```

Enter ?? for more actions
AI   Add an ID           DI   Delete an ID
EI   Edit an ID          EX   Exit
Select Action: Quit// AI   Add an ID
Select Provider ID Qualifier: BLUE SHIELD ID
FORM TYPE APPLIED TO: 1500 FORMS ONLY
BILL CARE TYPE: b BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
INSURANCE: BLUE CROSS OF CALIFORNIA
PROV TYPE: BLUE SHIELD ID
FORM TYPE: 1500 FORM ONLY
CARE TYPE: BOTH INPATIENT AND OUTPATIENT

Provider ID: 111XXX1B

```

The following screen will display.

```

Secondary Provider ID      May 11, 2005@11:17:20      Page: 1 of 1
** Lab or Facility Secondary IDs from Insurance Co **

Provider: IB Outside Facility (Non-VA Lab or Facility)
Insurance Co: BLUE CROSS OF CALIFORNIA

ID Qualifier      Form   Care Type      ID#
1  BLUE SHIELD ID  1500  INPT/OUTPT     111XXX1B

Enter ?? for more actions
AI   Add an ID           DI   Delete an ID
EI   Edit an ID          EX   Exit
Select Action: Quit//

```


4.4.3 Define VA Laboratory or Facility Primary IDs/NPI

The VA Service Facility NPI and Taxonomy Code will not be entered or maintained by Billing personnel. Beginning with Patch IB*2.0*400, only those VA locations for which no NPI numbers were obtained, (i.e. MORC, CMOP) will populate the Service Facility. Because of this, there will usually be no VA Laboratory or Facility NPI in the 837 claim transmission.

4.4.4 Define VA Laboratory or Facility Secondary IDs

For each insurance company, users can define multiple Laboratory or Facility Secondary IDs for the VA by division and form type.

Step	Procedure
1	Access the option Patient Insurance Menu ... → Insurance Company Entry/Edit.
2	At the Select Insurance Company Name: prompt, enter Blue Cross of California for this example.
3	From the Insurance Company Editor screen, enter the action ID Prov IDs/ID Parameters.
4	From the Billing Provider IDs screen, enter the action VA-Lab/Facility IDs.
5	From the VA-Lab/Facility IDs screen, enter the action Add an ID.
6	At the Division prompt, accept the default for the main Division.
7	At the ID Qualifier: prompt, enter Blue Shield for this example.

Step	Procedure
8	At the Form Type prompt, enter CMS-1500 for this example.
9	At the VA Lab or Facility Secondary ID prompt, enter the ID 1212XX1B for this example.
10	Repeat these steps for the Form Type = UB-04 , Qualifier = Blue Cross and ID = 1212XX1A .
11	Repeat these steps for the Form Type = UB-04 , Qualifier = Commercial and ID = 1313XXG2 .
	<i>Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs. A maximum of 5 Laboratory or Facility Secondary IDs can be defined per division, form and insurance company.</i>

VA-Lab/Facility IDs	May 27, 2005@12:48:29	Page: 1 of 1
Insurance Co.: BLUE CROSS OF CALIFORNIA		
VA-Lab/Facility Primary ID: XX123456		
VA-Lab/Facility Secondary IDs		
ID Qualifier	ID #	Form Type
No Laboratory or Facility IDs found		
Enter ?? for more actions		
Add an ID	Delete an ID	
Edit an ID	Exit	
Select Action: Add an ID		

The following screen will display.

VA-Lab/Facility IDs	May 27, 2005@12:48:29	Page: 1 of 1
Insurance Co.: BLUE CROSS OF CALIFORNIA		
VA-Lab/Facility Primary ID: Federal Tax ID		
VA-Lab/Facility Secondary IDs		
ID Qualifier	ID#	Form Type
Division: Name of Main Division/Default for All Divisions		
1	Blue Cross	1212XX1A UB04
2	Blue Shield	1212XX1B 1500
Division: CBOC		
3	Commercial	1313XXG2 UB04
Enter ?? for more actions		
Add an ID	Delete an ID	
Edit an ID	Exit	
Select Action: Edit//		

4.5. Attending, Operating and Other Physicians and Rendering, Referring and Supervising Providers

A physician can appear on a UB-04 claim form as an Attending, Operating or Other Operating Physician. Beginning with Patch IB*2*432, Rendering and Referring Providers can also be added to an Institutional

claim. A healthcare provider (physician, nurse, physical therapist, etc.) can appear on a 1500 claim form as a Rendering, Referring or Supervising Provider.

All of these healthcare providers have a primary ID. Their primary ID is their NPI. These physicians/providers can also have multiple secondary IDs that are either their own IDs, or IDs provided by an insurance company.


The VA Physician's or Provider's NPI is stored in the New Person file. This file is not maintained by Billing personnel. The Non-VA Physician's or Provider's NPI is defined in Provider ID Maintenance.

A human provider's NPI is transmitted in the 837 Health Care Claim transmission, and since Patches IB*2.0*348 and 349 it is printed on locally printed claim forms.

All of these types of healthcare providers can be either VA or non-VA employees.

4.5.1 Define a VA Physician/Provider's Primary ID/NPI

The VA Physician's or Provider's SSN and NPI are stored in the New Person file (#200). These IDs should be entered when the user is originally added to the system. The provider's Taxonomy code is entered along with the Person Class.

	<p><i>Note: Beginning with Patch IB*2*432, SSNs will continue to be defined in the New Person file for VA Providers and users may continue to define SSNs as secondary IDs for non-VA providers but VistA will no longer transmit SSNs as human providers' Primary IDs. There will no longer be a edit check in Enter/Edit Billing Information to insure that a provider's SSN is available.</i></p>
---	--



4.5.2 Define a VA Physician/Provider's Secondary IDs

Physicians and Providers can have both their own ID, such as a state medical license, and an ID provided by an insurance company.

4.5.2.1 Define a VA Physician/Provider's Own Secondary IDs

Physicians and other healthcare providers are assigned IDs that identify them. These IDs include an NPI which serves as their primary ID. In addition to their NPI, they may also have one or more of the following types of secondary IDs:

- OB – State License Number
- EI – EIN
- SY – SSN (VA SSNs are defined in the New Person file)
- X5 – State Industrial Accident Provider Number
- 1G – UPIN Number

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance.
2	At the Select Provider ID Maintenance Option: prompt, enter PO for Provider Own IDs.
3	At the (V)A or (N)on-VA provider: V//: prompt, press the <Enter> key to accept the default.
4	At the Select V.A. PROVIDER NAME: prompt, enter IB,DOCTOR 1.
	<i>This screen can be accessed through the MCCR System Definition Menu. Users must hold the IB PROVIDER EDIT security key to access this option.</i>
	<i>Note: With Patch IB*2*447, IB will prevent the user from authorizing a claim in which a human provider has an EIN or SSN consisting of anything other than nine digits.</i>

Provider ID Maintenance Main Menu

Enter a code from the list.

Provider IDs
PO Provider Own IDs
PI Provider Insurance IDs

Insurance IDs
BI Batch ID Entry
II Insurance Co IDs

Care Units
CP Care Units for Providers
CB Care Units for Billing Provider

Non-VA Items
NP Non-VA Provider
NF Non-VA Facility

Select Provider ID Maintenance Option: **PO Provider Own IDs**

(V)A or (N)on-VA provider: **V// A PROVIDER**

Select V.A. PROVIDER NAME: **IB,DOCTOR 1**

Step	Procedure
6	At the Select Action: prompt, enter AI for Add an ID.
7	At the Select ID Qualifier: prompt, enter State License for this example.
8	At the Select LICENSING STATE: prompt, enter California for this example.
9	When asked if you are entering California as the 1 st state for this provider, enter Yes .
10	At the LICENSING STATE: prompt, press the <Enter> key to accept the default.
11	At the LICENSING NUMBER: prompt, enter XXXXSTATE for this example.

Physician/Provider ID Nov 02, 2005@10:24:46 Page: 1 of 1
** Physician/Provider's Own IDs (No Specific Insurance Co) **
Provider : IB,DOCTORB (VA PROVIDER)

ID Qualifier	Form	Care Type	Care Unit	ID#
--------------	------	-----------	-----------	-----

No ID's found for provider

Enter ?? for more actions

AI	Add an ID	DI	Delete an ID
EI	Edit an ID	EX	Exit

Select Action: Quit// **AI Add an ID**
Select ID Qualifier: **??**

Choose from:

EIN	EI
SOCIAL SECURITY NUMBER	SY
STATE INDUSTRIAL ACCIDENT PROV	X5
STATE LICENSE	0B
UPIN	1G

Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: **0B State License**
Select LICENSING STATE: **CALIFORNIA**
Are you adding 'CALIFORNIA' as a new LICENSING STATE (the 1ST for this NEW PERSON)? No// **y (Yes)**

LICENSING STATE: CALIFORNIA//
 LICENSE NUMBER: XXXXSTATE

The following screen will display.

```

Physician/Provider ID      Nov 02, 2005@10:24:46      Page:      1 of      1
      ** Physician/Provider's Own IDs (No Specific Insurance Co) **
Provider      : IB,DOCTORB (VA PROVIDER)

      ID Qualifier      Form      Care Type      Care Unit      ID#
1  CA STATE LICENSE #      XXXXSTATE

      Enter ?? for more actions
AI      Add an ID      DI      Delete an ID
EI      Edit an ID      EX      Exit
Select Action: Quit//
  
```

4.5.2.2 Define a VA Physician/Provider's Insurance Company Secondary IDs

Physicians and other healthcare providers can be assigned secondary IDs by insurance companies. Some insurance companies assign one ID to be used by every physician/provider at a site. Other insurance companies assign each physician/provider his or her own ID. In addition to their NPI, they may also have one or more of the following types of secondary IDs:

- 1A - Blue Cross
- 1B - Blue Shield
- 1C - Medicare
- 1H - CHAMPUS
- G2 - Commercial
- LU - Location #
- N5 - Provider Plan Network
- 1G - UPIN

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance.
2	At the Select Provider ID Maintenance Option: prompt, enter PI for Provider Insurance IDs.
3	At the (V)A or (N)on-VA provider: V//: prompt, press the <Enter> key to accept the default.
4	At the Select V.A. PROVIDER NAME: prompt, enter IB,DOCTOR 1.
5	At the Select Insurance Co.: prompt, enter Blue Cross of California for this example.

Provider ID Maintenance Main Menu

Enter a code from the list.

Provider IDs

PO Provider Own IDs
PI Provider Insurance IDs

Insurance IDs

BI Batch ID Entry
II Insurance Co IDs

Care Units

CP Care Units for Providers
CB Care Units for Billing Provider

Non-VA Items




NP Non-VA Provider
NF Non-VA Facility

Select Provider ID Maintenance Option: **PI Provider Insurance IDs**

(V)A or (N)on-VA provider: **V// A PROVIDER**

Select V.A. PROVIDER NAME: **IB,DOCTOR 1**

Select INSURANCE CO: **BLUE CROSS OF CALIFORNIA**

Step	Procedure
6	At the Select Action: prompt, enter AI for Add an ID.
7	At the Select ID Qualifier: prompt, enter 1B – Blue Shield for this example.
8	At the FORM TYPE APPLIED TO: prompt, enter CMS-1500 Only for this example.
9	At the BILL CARE TYPE: prompt, enter 0 for this example.
10	At the CARE UNIT: prompt, enter Surgery for this example.
11	At the PROVIDER ID: prompt, enter XXXXBSHIELD for this example.
	<i>Defining an insurance company provided ID for a particular Care Unit is only necessary when the insurance company assigns physician/provider IDs by care unit.</i>
	<i>Users can repeat these steps for this Physician/Provider adding more IDs from this insurance company or change insurance company or change physician/provider. Refer to Section 3.7 to learn about copying IDs to multiple insurance companies.</i>
	<i>Note: If you do not define a Network ID for TRICARE claims, the system will automatically include the provider's SSN as the Network ID.</i>

```

Physician/Provider ID          Nov 02, 2005@10:24:46          Page:    1 of    1
      ** Physician/Provider's IDs from Insurance Co **
Provider      : IB,DOCTORB (VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

      ID Qualifier      Form      Care Type      Care Unit      ID#
      No ID's found for provider

      Enter ?? for more actions
AI   Add an ID              DI   Delete an ID
EI   Edit an ID             EX   Exit
Select Action: Quit// AI Add an ID
Select ID Qualifier: ??
  
```

Choose from:

BLUE CROSS	1A
BLUE SHIELD	1B
CHAMPUS	1H
COMMERCIAL	G2
LOCATION NUMBER	LU
MEDICARE PART A	1C
MEDICARE PART B	1C
PROVIDER PLAN NETWORK	N5
UPIN	1G

Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: **Blue Shield**
 FORM TYPE APPLIED TO: **CMS-1500 FORMS ONLY**
 BILL CARE TYPE: 0 **BOTH INPATIENT AND OUTPATIENT**
 Select IB PROVIDER ID CARE UNIT: **Surgery**

THE FOLLOWING WAS CHOSEN:

INSURANCE: BLUE CROSS OF CALIFORNIA
 PROV TYPE: BLUE SHIELD ID
 FORM TYPE: CMS-1500 FORM ONLY
 CARE TYPE: BOTH INPATIENT AND OUTPATIENT
 CARE UNIT: Surgery

PROVIDER ID: **XXXXBSHIELD**

The following screen will display.

Physician/Provider ID Nov 02, 2005@10:24:46 Page: 1 of 1
 ** Physician/Provider's IDs from Insurance Co **
 Provider : IB,DOCTORB (VA PROVIDER)
 INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

ID Qualifier	Form	Care Type	Care Unit	ID#
1 BLUE SHIELD ID	1500	INPT/OUTPT		XXXXBSHIELD

Enter ?? for more actions

AI Add an ID	DI Delete an ID
EI Edit an ID	EX Exit

Select Action: Quit//

4.5.2.3 Define non-VA Physician and Provider Primary IDs/NPI




Non-VA physicians and other healthcare providers are not VistA users, so they are not normally in the New Person file unless they are also current/previous VA employees. Even if a physician/provider functions in both a VA and non-VA role, the SSN, NPI and Taxonomy Code of a non-VA Physician/Provider must be entered by Billing personnel using Provider ID Maintenance. Non-VA physician/provider primary and secondary legacy IDs are both defined the same way and the system uses the SSN as the primary ID. Refer to **Section 3.4.4.1**.



*Note: Non-VA Physician/Provider IDs can be defined through Provider ID Maintenance through **PO > Provider Own IDS** or through **NP > Non- VA PROVIDER**.*

4.5.2.4 Define a non-VA Physician/Provider's NPI

The NPI and Taxonomy Code for a non-VA Physician or Provider can be entered by Billing personnel using Provider ID Maintenance.

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance .
2	At the Select Provider ID Maintenance Option: prompt, enter NP for Non-VA Provider.
3	At the Select a Non-VA Provider: prompt, enter IB,OUTSIDEPROV for this example.
	<i>When accessing an existing entry, press ENTER to continue or, if necessary, the spelling of the provider's name can be corrected at the NAME prompt. Names should be entered in the following format: LAST NAME,FIRST NAME MIDDLE INITIAL.</i>
	<i>Note: Beginning with Patch IB*2*436, it will be possible to enter a provider into the VA New Person file as a VA provider and then enter that same provider in Provider Maintenance as a non-VA provider using the same name. It will no longer be necessary to manipulate the name by adding a middle initial (for example).</i>
	<i>Users must hold the IB PROVIDER EDIT security key to access this option.</i>

Provider ID Maintenance Main Menu

Enter a code from the list.

Provider IDs

PO Provider Own IDs
PI Provider Insurance IDs

Insurance IDs

BI Batch ID Entry
II Insurance Co IDs

Care Units

CP Care Units for Providers
CB Care Units for Billing Provider

Non-VA Items

NP Non-VA Provider
NF Non-VA Facility

Select Provider ID Maintenance Option: **NP Non-VA Provider**
Select a NON-VA PROVIDER: **IB,OUTSIDEPROV INDIVIDUAL**
For individual type entries: The name should be entered in
LAST,FIRST MIDDLE format.
Select a NON-VA PROVIDER: IB,OUTSIDEPROV INDIVIDUAL
NAME: IB,OUTSIDEPROV //:


The following screen will display.

```
NON-VA PROVIDER INFORMATION    Dec 07, 2006@12:40:51    Page:    1 of    1

      Name: IB,OUTSIDEPROV
      Type: INDIVIDUAL PROVIDER
    Credentials: MD
      Specialty: 30
         NPI:
    Taxonomy Code:

      Enter ?? for more actions
```


ED	Edit Demographics	PI	Provider Ins ID
PO	Provider Own ID	EX	Exit
Select Action: Quit//			

Step	Procedure
4	At the Select Action: prompt, enter ED for Edit Demographics.
5	At the Credentials: prompt, press the <Enter> key to accept the default.
6	At the Specialty: prompt, press the <Enter> key to accept the default.
7	At the NPI: prompt, enter 0000000006 for this example.
8	At the Taxonomy: prompt, enter 15 Allopathic and Osteopathic Physicians – Internal Medicine Cardiovascular Disease 207RC0000X for this example.
9	At the Are you adding 'Allopathic and Osteopathic Physicians' as a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No// prompt, enter Yes for this example.
10	At the Primary Code: prompt, enter Yes for this example.
11	At the Status: prompt, enter Active for this example.
	<i>A provider may have more than one Taxonomy Code.</i>
12	At the Allow future updates by FEE BASIS automatic interface? YES// prompt, press t the <Enter> key to accept the default.

```

NAME: IB,OUTSIDEPROV//
CREDENTIALS: MD//
SPECIALTY: 30//
NPI: 0000000006
Select TAXONOMY CODE: 15 Allopathic and Osteopathic Physicians 207RC0000X
                        Internal Medicine
                        Cardiovascular Disease
Are you adding 'Allopathic and Osteopathic Physicians' as
a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No/
/ y (Yes)
PRIMARY CODE: y YES
STATUS: a ACTIVE
Select TAXONOMY CODE:

```

The following screen will display.

NON-VA PROVIDER INFORMATION		Jul 05, 20126@14:49:53	Page: 1 of 1
Name: IB,OUTSIDEPROV			
Type: INDIVIDUAL PROVIDER			
Credentials: MD			
Specialty: 30			
NPI: 0000000006			
Taxonomy Code: 207RC0000X (Primary)			
Allow future updates by FEE BASIS automatic interface? : YES			
Enter ?? for more actions			
ED	Edit Demographics	PI	Provider Ins ID
PO	Provider Own ID	EX	Exit
Select Action: Quit//			

4.5.3 Define a non-VA Physician/Provider's Secondary IDs

4.5.3.1 Define a non-VA Physician/Provider's Own IDs

Non-VA Physicians and other healthcare providers are assigned IDs that identify them. After Patch IB*2*432, it is not necessary to define the outside provider's SSN. The SSN will no longer serve as the Primary ID. The Primary ID will be the provider's NPI. In addition to their provider's SSN, they may also have one or more of the following types of secondary IDs:

- OB – State License Number
- EI – EIN
- TJ – Federal Taxpayer's Number
- X5 – State Industrial Accident Provider Number
- 1G – UPIN
- SY – SSN

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance .
2	At the Select Provider ID Maintenance Option: prompt, enter PO for Provider Own IDs.
3	At the (V)A or (N)on-VA provider: V//: prompt, enter N for Non-VA provider.
4	At the Select Non V.A. PROVIDER NAME: prompt, enter IB,OUTSIDEDOC for this example.

Provider ID Maintenance Main Menu

Enter a code from the list.

Provider IDs

PO Provider Own IDs

PI Provider Insurance IDs

Insurance IDs

BI Batch ID Entry

II Insurance Co IDs

Care Units

CP Care Units for Providers

CB Care Units for Billing Provider

Non-VA Items

NP Non-VA Provider


NF Non-VA Facility

Select Provider ID Maintenance Option: **PO Provider Own IDs**

(V)A or (N)on-VA provider: V// **n NON-VA PROVIDER**

Select Non V.A. PROVIDER NAME: **IB,OUTSIDEDOC**

Step	Procedure
5	At the Select Action: prompt, enter AI for Add an ID.
6	At the Enter Provider ID Qualifier: prompt, enter Social Security Number for this example.
7	At the FORM TYPE APPLIED TO: prompt, enter 0 for this example.
8	At the BILL CARE TYPE: prompt, enter 0 for this example.
9	At the PROVIDER ID: prompt, enter XXXXX1212 for this example.

Step	Procedure
	<i>Note: Users may repeat the above steps to enter additional IDs for a physician/provider.</i>

```

Performing Provider ID      Nov 02, 2005@10:24:46      Page:      1 of      1
      ** Performing Provider's Own IDs (No Specific Insurance Co) **
Provider      : IB,OUTSIDELOC (NON-VA PROVIDER)

      ID Qualifier      Form      Care Type      Care Unit      ID#

No ID's found for provider

      Enter ?? for more actions
AI      Add an ID                      DI      Delete an ID
EI      Edit an ID                     EX      Exit
Select Action: Quit// AI      Add an ID
Select ID Qualifier: ??

      Choose from:
      EIN      EI
      SOCIAL SECURITY NUMBER      SY
      STATE INDUSTRIAL ACCIDENT PROV      X5
      STATE LICENSE      0B
      UPIN      1G

Enter the Qualifier that identifies the type of ID.

Select ID Qualifier: SY Social Security Number
FORM TYPE APPLIED TO: 0 BOTH UB-04 AND CMS-1500 FORMS
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
      INSURANCE: ALL INSURANCE
      PROV TYPE: SOCIAL SECURITY NUMBER
      FORM TYPE: BOTH UB-04 & CMS-1500 FORMS
      CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: XXXXX1212

```

The following screen will display.

```

Performing Provider ID      Nov 02, 2005@10:24:46      Page:      1 of      1
      ** Performing Provider's Own IDs (No Specific Insurance Co) **
Provider      : IB,OUTSIDELOC (NON-VA PROVIDER)

      ID Qualifier      Form      Care Type      Care Unit      ID#
1      SOCIAL SECURITY NUMB      BOTH      INPT/OUTPT      XXXXX1212

      Enter ?? for more actions
AI      Add an ID                      DI      Delete an ID
EI      Edit an ID                     EX      Exit
Select Action: Quit//

```

4.5.3.2 Define a non-VA Physician/Provider's Insurance Company Secondary IDs

Physicians and other healthcare providers are assigned secondary IDs by insurance companies. In addition to their provider's own IDs, they may also have one or more of the following types of secondary IDs:

- 1A – Blue Cross
- 1B – Blue Shield
- 1C – Medicare
- 1G – UPIN
- 1H – CHAMPUS
- G2 – Commercial
- LU – Location #
- N5 – Provider Plan Network

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance .
2	At the Select Provider ID Maintenance Option: prompt, enter NP for Non-VA Provider.
3	At the Select a NON-VA PROVIDER: prompt, enter IB,OUTSIDEDOC .

```

Provider ID Maintenance Main Menu

Enter a code from the list.

      Provider IDs
PO  Provider Own IDs
PI  Provider Insurance IDs

      Insurance IDs
BI  Batch ID Entry
II  Insurance Co IDs


      Care Units
CP  Care Units for Providers
CB  Care Units for Billing Provider

      Non-VA Items
NP  Non-VA Provider
NF  Non-VA Facility

Select Provider ID Maintenance Option: NP Non-VA Provider

(V)A or (N)on-VA provider: V// N Non-VA PROVIDER
Select a NON-VA PROVIDER: IB,OUTSIDEDOC
Select INSURANCE CO: BLUE CROSS OF CALIFORNIA

```

Step	Procedure
4	At the Select Action: prompt, enter PI for Provider Ins ID.
5	At the Select INSURANCE CO: prompt, enter Blue Cross of California for this example.
6	At the Select Action: prompt, enter AI for Add an ID.
6	At the Select ID Qualifier: prompt, enter 1B – Blue Shield for this example.
7	At the FORM TYPE APPLIED TO: prompt, enter CMS-1500 Only for this example.
8	At the BILL CARE TYPE: prompt, enter 0 for this example.
9	At the PROVIDER ID: prompt, enter XXBSHIELD for this example.
	<i>Users can repeat these steps for this Physician/Provider adding more IDs from this insurance company or change insurance company or change physician/provider.</i>

```

Performing Provider ID          Nov 02, 2005@10:24:46          Page:    1 of    1
      ** Performing Provider's IDs from Insurance Co **
Provider      : IB,OUTSIDEDOC (Non-VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

      ID Qualifier      Form      Care Type      Care Unit      ID#

No ID's found for this insurance co.

      Enter ?? for more actions
AI   Add an ID          DI   Delete an ID
EI   Edit an ID         EX   Exit
Select Action: Quit// AI   Add an ID
Select ID Qualifier: ??

Choose from:
BLUE CROSS          1A
BLUE SHIELD         1B
CHAMPUS             1H
COMMERCIAL          G2
LOCATION NUMBER      LU
MEDICARE PART A     1C
MEDICARE PART B     1C
PROVIDER PLAN NETWORK      N5
UPIN                1G

Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: Blue Shield
FORM TYPE APPLIED TO: CMS-1500 FORMS ONLY
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
  INSURANCE: BLUE CROSS OF CALIFORNIA
  PROV TYPE: BLUE SHIELD ID
  FORM TYPE: CMS-1500 FORM ONLY
  CARE TYPE: BOTH INPATIENT AND OUTPATIENT
PROVIDER ID: XXBSHIELD

```

The following screen will display.

```

Performing Provider ID          Nov 02, 2005@10:24:46          Page:    1 of    1
      ** Performing Provider's IDs from Insurance Co **
Provider      : IB,OUTSIDEDOC (Non-VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

      ID Qualifier      Form      Care Type      Care Unit      ID#
1   BLUE SHIELD ID     1500   INPT/OUTPT   XXXXBSHIELD

      Enter ?? for more actions
AI   Add an ID          DI   Delete an ID
EI   Edit an ID         EX   Exit
Select Action: Quit//

```

4.5.4 Define Insurance Company IDs

Both individual Physician/Provider secondary IDs and insurance company default Physician/Provider secondary IDs provided by an insurance company can be entered and copied from within Insurance Company IDs.

There are three options:

- I – Individual IDs
- A – Individual and Default IDs
- D – Default IDs

Option A is the basically the same as I and D combined, so users can add Physician/Provider secondary IDs and/or default secondary IDs.

4.5.4.1 Define Default Physician/Provider Insurance Company Secondary IDs

Users can use the Provider ID Maintenance option, Insurance Company IDs, to enter numbers that are assigned by an insurance company to be used as default Attending, Operating, Other, Rendering, Referring and Supervising Secondary IDs for all physicians and healthcare providers. These IDs will be automatically sent with all 837 claims to the insurance company for which the default IDs are defined.

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance .
2	At the Select Provider ID Maintenance Option: prompt, enter II for Insurance Co IDs.
3	At the Select Insurance Company Name: prompt, enter Blue Cross of California for this example.
4	At the Select Display Content: prompt, enter D .

Provider ID Maintenance Main Menu

Enter a code from the list.

Provider IDs

PO Provider Own IDs
PI Provider Insurance IDs

Insurance IDs

BI Batch ID Entry
II Insurance Co IDs

Care Units

CP Care Units for Providers
CB Care Units for Billing Provider

Non-VA Items

NP Non-VA Provider
NF Non-VA Facility

Select Provider ID Maintenance Option: **II Insurance Co IDs**

Select INSURANCE COMPANY NAME: **BLUE CROSS OF CALIFORNIA PO BOX 60007 LOS ANGELES CALIFORNIA Y**

SELECT DISPLAY CONTENT: A//**D INSURANCE CO DEFAULT IDS**

Step	Procedure
5	At the Select Action: prompt, enter AI for Add an ID.

INSURANCE CO PROVIDER ID		Dec 19, 2005@12:24:41		Page: 1 of 2	
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)					
PROVIDER NAME	FORM	CARE TYPE	CARE UNIT	ID#	
Provider ID Type: BLUE SHIELD					
1	<<INS CO DEFAULT>>	BOTH	INPT/OUTPT	BSDEFAULT	
Provider ID Type: COMMERCIAL					
2	<<INS CO DEFAULT>>	BOTH	INPT/OUTPT	COMDEFAULT	
Provider ID Type: PROVIDER PLAN NETWORK					
3	<<INS CO DEFAULT>>	BOTH	INPT/OUTPT	NETDEFAULT	
Provider ID Type: UPIN					
4	<<INS CO DEFAULT>>	BOTH	INPT/OUTPT	UPINDEFAULT	
+ Enter ?? for more actions					
AI	Add an ID	DP	Display Ins Params	VI	View IDs by Type
DI	Delete an ID	CI	Change Ins Co	CU	Care Unit Maint
EI	Edit an ID	CD	Change Display	EX	Exit
Select Action: Next Screen// AI Add an ID					

Step	Procedure
6	At the Select Provider (optional) : prompt, press the <Enter> key to leave the prompt blank.
7	At the YOU ARE ADDING A PROVIDER ID THAT WILL BE THE INSURANCE CO DEFAULT IS THIS OK?: prompt, enter YES .
8	At the Select Provider ID Type : prompt, enter Blue Cross for this example.
9	At the FORM TYPE APPLIED TO : prompt, enter UB-04 Forms Only for this example.
10	At the BILL CARE TYPE : prompt, enter 0 for BOTH INPATIENT AND OUTPATIENT for this example.
11	At the PROVIDER ID : prompt, enter BCDEFAULT for this example.

```

YOU ARE ADDING A PROVIDER ID THAT WILL BE THE INSURANCE CO DEFAULT

Select Provider ID Type: BLUE CROSS 1A

FORM TYPE APPLIED TO: UB-04// UB-04 FORMS ONLY
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
  INSURANCE: BLUE CROSS OF CALIFORNIA
  PROV TYPE: BLUE CROSS
  FORM TYPE: UB-04 FORM ONLY
  CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: BCDEFAULT

```

The following screen will display.

INSURANCE CO PROVIDER ID		Dec 19, 2005@12:34:01		Page: 1 of 2	
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)					
PROVIDER NAME	FORM	CARE TYPE	CARE UNIT	ID#	
Provider ID Type: BLUE CROSS					
1	<<INS CO DEFAULT>>	UB-04	INPT/OUTPT	BCDEFAULT	
Provider ID Type: BLUE SHIELD					
2	<<INS CO DEFAULT>>	BOTH	INPT/OUTPT	DEFALLProv	
Provider ID Type: COMMERCIAL					
3	<<INS CO DEFAULT>>	BOTH	INPT/OUTPT	COMDEFAULT	
Provider ID Type: PROVIDER PLAN NETWORK					
4	<<INS CO DEFAULT>>	BOTH	INPT/OUTPT	NETDEFAULT	
+ Enter ?? for more actions					
AI	Add an ID	DP	Display Ins Params	VI	View IDs by Type
DI	Delete an ID	CI	Change Ins Co	CU	Care Unit Maint
EI	Edit an ID	CD	Change Display	EX	Exit
Select Action: Next Screen//					



Note: This default ID will be transmitted on all claims where Blue Cross of California is the payer as a Physician/Provider secondary ID.

4.5.4.2 Define Individual Physician/Provider Insurance Company Secondary IDs

Users can use the Provider ID Maintenance option, Insurance Company IDs, to enter numbers that are assigned by an insurance company as individual Attending, Operating, Other, Rendering, Referring, and Supervising Secondary IDs.

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance.
2	At the Select Provider ID Maintenance Option: prompt, enter II for Insurance Co IDs.
3	At the Select Insurance Company Name: prompt, enter Blue Cross of California for this example.

Provider ID Maintenance Main Menu

Enter a code from the list.

Provider IDs

PO Provider Own IDs
PI Provider Insurance IDs

Insurance IDs

BI Batch ID Entry
II Insurance Co IDs

Care Units

CP Care Units for Providers
CB Care Units for Billing Provider

Non-VA Items

NP Non-VA Provider
NF Non-VA Facility

Select Provider ID Maintenance Option: ii Insurance Co IDs

Select INSURANCE COMPANY NAME:	BLUE CROSS OF CALIFORNIA	PO BOX 60007	LOS
ANGELES	CALIFORNIA	Y	

Step	Procedure
4	At the Select Display Content: prompt, enter I for this example.
5	At the Do you want to display IDs for a Specific Provider: prompt, enter No for this example.

```

SELECT DISPLAY CONTENT: A// ??

(D) DISPLAY CONTAINS ONLY THOSE IDS ASSIGNED AS DEFAULTS TO THE FACILITY BY
THE INSURANCE COMPANY
(I) DISPLAY CONTAINS ONLY THOSE IDS ASSIGNED TO INDIVIDUAL PROVIDERS BY THE
INSURANCE COMPANY
(A) DISPLAY CONTAINS ALL IDS ASSIGNED BY THE INSURANCE COMPANY FOR ONE OR ALL PROVIDER
ID TYPES

Select one of the following:

D      INSURANCE CO DEFAULT IDS
I      INDIVIDUAL PROVIDER IDS FURNISHED BY THE INS CO
A      ALL IDS FURNISHED BY THE INS CO BY PROVIDER TYPE

SELECT DISPLAY CONTENT: A// I INDIVIDUAL PROVIDER IDS FURNISHED BY THE INS CO
DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER?: NO//

```

Step	Procedure
6	At the Select Action: prompt, enter AI for Add an ID.

```

INSURANCE CO PROVIDER ID      Dec 15, 2005@15:36:31      Page:      1 of      89
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
PERFORMING PROV ID MAY REQUIRE CARE UNIT

PROVIDER ID TYPE      FORM      CARE TYPE      CARE UNIT      ID#

Provider: IB,DOCTOR3
1 PROVIDER PLAN NETWORK BOTH INPT/OUTPT MDXXXXXA

Provider: IB,DOCTOR9
2 PROVIDER PLAN NETWORK BOTH INPT/OUTPT GXXXXXA

Provider: IB,DOCTOR10
3 PROVIDER PLAN NETWORK BOTH INPT/OUTPT GXXXXXX

Provider: IB,DOCTOR76
4 PROVIDER PLAN NETWORK BOTH INPT/OUTPT GXXXXXX

+ Enter ?? for more actions
AI Add an ID DP Display Ins Params VI View IDs by Type
DI Delete an ID CI Change Ins Co CU Care Unit Maint
EI Edit an ID CD Change Display EX Exit
Select Action: Next Screen// AI Add an ID

```

Step	Procedure
7	At the Select ID Qualifier: prompt, enter 1B – Blue Shield for this example.
8	At the FORM TYPE APPLIED TO: prompt, enter CMS-1500 Only for this example.
9	At the BILL CARE TYPE: prompt, enter 0 for this example.

Step	Procedure
10	At the CARE UNIT : prompt, enter Surgery for this example.
11	At the PROVIDER ID : prompt, enter BSXXXXX for this example.

```

Select PROVIDER: IB,DOCTOR7

Select Provider ID Type: BLUE SHIELD 1B

FORM TYPE APPLIED TO: CMS-1500 FORMS ONLY
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery

THE FOLLOWING WAS CHOSEN:
  INSURANCE: BLUE CROSS OF CALIFORNIA
  PROV TYPE: BLUE SHIELD
  FORM TYPE: CMS-1500 FORM ONLY
  CARE TYPE: BOTH INPATIENT AND OUTPATIENT
  CARE UNIT: Surgery

PROVIDER ID: BSXXXXX

```

The following screen will display.

```

INSURANCE CO PROVIDER ID      Dec 15, 2005@16:11:31      Page:  49 of  89
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
  PERFORMING PROV ID MAY REQUIRE CARE UNIT

      PROVIDER ID TYPE      FORM      CARE TYPE      CARE UNIT      ID#
+
Provider: IB,DOCTOR15
194  PROVIDER PLAN NETWORK  BOTH      INPT/OUTPT      GXXXXX

Provider: IB,DOCTOR54
195  PROVIDER PLAN NETWORK  BOTH      INPT/OUTPT      G4XXXXX

Provider: IB,DOCTOR7
196  BLUE CROSS            UB-04      INPT/OUTPT      BCXXXXXX2
197  BLUE SHIELD           1500      INPT/OUTPT      Surgery      BSXXXXX

Provider: IB,DOCTOR6
+      Enter ?? for more actions
AI   Add an ID              DP   Display Ins Params  VI   View IDs by Type
DI   Delete an ID           CI   Change Ins Co       CU   Care Unit Maint
EI   Edit an ID             CD   Change Display      EX   Exit
Select Action: Next Screen//

```

4.5.5 Define either a Default or Individual Physician/Provider Secondary ID

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance .
2	At the Select Provider ID Maintenance Option : prompt, enter II for Insurance Co IDs.
3	At the Select Insurance Company Name : prompt, enter Blue Cross of California for this example (the Parent company).
4	At the Select Display Content : prompt, enter A for this example.
5	At the DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER ID TYPE?: NO// prompt, accept the default.

Provider ID Maintenance Main Menu

Enter a code from the list.

Provider IDs

PO Provider Own IDs
PI Provider Insurance IDs

Insurance IDs

BI Batch ID Entry
II Insurance Co IDs

Care Units

CP Care Units for Providers
CB Care Units for Billing Provider

Non-VA Items

NP Non-VA Provider
NF Non-VA Facility

Select Provider ID Maintenance Option: **II Insurance Co IDs**

Select INSURANCE COMPANY NAME: **BLUE CROSS OF CALIFORNIA PO BOX 60007**
LOS ANGELES CALIFORNIA Y


SELECT DISPLAY CONTENT: **A// LL IDS FURNISHED BY THE INS CO BY PROVIDER TYPE**

DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER ID TYPE?: **NO//**

Step	Procedure
6	At the Select Action: prompt, enter AI for Add an ID.

INSURANCE CO PROVIDER ID Dec 15, 2005@16:18:07 Page: 1 of 31
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
PERFORMING PROV ID MAY REQUIRE CARE UNIT

PROVIDER NAME	FORM	CARE TYPE	CARE UNIT	ID#
Provider ID Type: BLUE CROSS				
1 IB,DOCTOR7	UB-04	INPT/OUTPT		BCXXXXX
Provider ID Type: BLUE SHIELD				
2 <<INS CO DEFAULT>>	BOTH	INPT/OUTPT		DEFALLProv
3 IB Outside Facility	BOTH	INPT/OUTPT		BSFACXXXX
4 IB,DOCTOR8	BOTH	INPT/OUTPT		BSINDOUT
5 IB,DOCTOR33	BOTH	INPT/OUTPT		BSLIM
6 IB,DOCTOR7	1500	INPT/OUTPT		BSXXXXX
Provider ID Type: PROVIDER PLAN NETWORK				
7 IB,DOCTOR64	BOTH	INPT/OUTPT		MD22356A
+ Enter ?? for more actions				
AI Add an ID	DP	Display Ins Params	VI	View IDs by Type
DI Delete an ID	CI	Change Ins Co	CU	Care Unit Maint
EI Edit an ID	CD	Change Display	EX	Exit
Select Action: Next Screen// AI Add an ID				

Step	Procedure
	At the <i>Select Provider (optional)</i> prompt, enter a Provider's Name to enter an individual ID or leave it blank to enter a default ID and then continue to define the ID as before.

```
Select PROVIDER (optional): IB,DOCTOR7

      Searching for a VA PROVIDER
IB,DOCTOR7      1XXXX      LZZ      114      RESIDENT PHYSICIAN
      ...OK? Yes//      (Yes)

Select Provider ID Type: COMMERCIAL      G2

FORM TYPE APPLIED TO: 0 BOTH UB-04 AND CMS-1500 FORMS
BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
      INSURANCE: BLUE CROSS OF CALIFORNIA
      PROV TYPE: COMMERCIAL
      FORM TYPE: BOTH UB-04 & CMS-1500 FORMS
      CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: CMXXXXXX
```

4.6. Care Units

Some insurance companies assign the same IDs to multiple Physician/Providers, based upon Care Units, to be used as *Physician/Provider Secondary IDs* on claims. This allows more than one person to have the same ID without everyone having the same ID.

Example: Insurance Company A assigns the number XXXXXX1 to a care unit called Care Unit A and assigns this number and care unit to Dr. A, Dr. B, Dr. C and Dr. E. as their Physician/Provider Secondary ID. The same insurance company assigns the number XXXXXX2 to a care unit called Care Unit B and assigns this number and care unit to Dr. F, Dr. G, Dr. H and Dr. I. as their Physician/Provider Secondary IDs.

Some insurance companies assign IDs to be used as *Billing Provider Secondary IDs* on claims for services performed for specific types of care.

Example: Insurance Company A assigns the number XXXXHH to be used as the Billing Provider Secondary ID (Billing Screen 3) when Home Health services are provided. The same insurance company assigns the number XXXXER as the Billing Provider Secondary ID (Billing Screen 3) when Emergency services are provided.

The names of the “care unit” used by insurance companies are specified by the insurance companies and do not relate directly to the medical services or departments of the medical center. For this reason, users must define these Care Units in Provider ID Maintenance.

4.6.1 Define Care Units for Physician/Provider Secondary IDs

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance.

Step	Procedure
2	At the Select Provider ID Maintenance Option: prompt, enter CP for Care Units for Providers.
3	At the Select INSURANCE CO: prompt, enter Blue Cross of California for this example.

Provider ID Maintenance Main Menu

Enter a code from the list.

Provider IDs

PO Provider Own IDs

PI Provider Insurance IDs

Insurance IDs

BI Batch ID Entry

II Insurance Co IDs

Care Units

CP Care Units for Providers

CB Care Units for Billing Provider


Non-VA Items

NP Non-VA Provider

NF Non-VA Facility

Select Provider ID Maintenance Option: **CP Care Units for Providers**

Select INSURANCE CO: **Blue Cross of California**

Step	Procedure
4	At the Select Action: prompt, enter AU for Add a Unit.
5	At the SELECT CARE UNIT FOR THE INSURANCE CO: prompt, enter Surgery for this example. Confirm Surgery.
6	At the IB PROVIDER ID CARE UNIT DESCRIPTION: prompt, enter a free-text description of the Care Unit.
7	At the ID Qualifier: prompt, enter Blue Shield for this example.
8	At the FORM TYPE APPLIED TO: prompt, enter 0 for BOTH UB-04 & CMS-1500 FORMS.
9	At the BILL CARE TYPE: prompt, enter 0 for BOTH INPATIENT AND OUTPATIENT.
	<i>Remember, 'Blue Cross' ID can only be used on Institutional claims.</i>

```

PROVIDER ID CARE UNITS          Nov 03, 2005@11:56:45          Page:    1 of    1

Insurance Co: BLUE CROSS OF CALIFORNIA

      CARE UNIT NAME                DESCRIPTION
No CARE UNITs Found for Insurance Co

      Enter ?? for more actions
AU   Add a Unit                    DU   Delete a Unit
EU   Edit a Unit                   EX   Exit
Select Action: Quit//  AU   Add a Unit
SELECT CARE UNIT FOR THE INSURANCE CO:  Surgery
Are you adding 'Surgery' as a new IB PROVIDER ID CARE UNIT? No//  y  (Yes)
      IB PROVIDER ID CARE UNIT DESCRIPTION: Ambulatory Surgery

ID TYPE:  BLUE SHIELD
FORM TYPE APPLIED TO:  0  BOTH UB-04 & CMS-1500 FORMS
BILL CARE TYPE:  0  BOTH INPATIENT AND OUTPATIENT
CARE UNIT:  Surgery

      >> CARE UNIT COMBINATION FILED FOR THE INSURANCE CO
PRESS ENTER TO CONTINUE

```

The following screen will display.

```

PROVIDER ID CARE UNITS          Nov 03, 2005@11:56:45          Page:    1 of    1

Insurance Co: BLUE CROSS OF CALIFORNIA

      CARE UNIT NAME                DESCRIPTION
1  Surgery                        Ambulatory Surgery
                                   o BLUE SHIELD ID          Both form types Inpt/Outpt

      Enter ?? for more actions
AU   Add a Unit                    DU   Delete a Unit
EU   Edit a Unit                   EX   Exit
Select Action: Quit//

```



Once you have defined a Care Unit, when you go to define physician/provider's IDs furnished by an insurance company, you will be prompted to enter the name of the Care Unit if you enter the same ID Qualifier, Form Type and Bill Care Type as those for which you previously defined a Care Unit.

PROVIDER ID Nov 21, 2005@09:52:39 Page: 1 of 1
 ** Provider IDs Furnished by Insurance Co **
 PROVIDER : IB,DOCTOR7 (VA PROVIDER)
 INSURANCE CO: BLUE CROSS OF CALIFORNIA

PROVIDER ID	TYPE	FORM	CARE TYPE	CARE UNIT	ID #
No ID's found for provider and selected insurance co					

Enter ?? for more actions

AU Add a Unit	DU Delete a Unit
EU Edit a Unit	EX Exit

Select Action: Quit// **AU Add a Unit**

CHOOSE 1-2: 2 BLUE SHIELD ID

FORM TYPE APPLIED TO: 0 BOTH UB-04 AND CMS-1500 FORMS


BILL CARE TYPE: 0 BOTH INPATIENT AND OUTPATIENT

Select IB PROVIDER ID CARE UNIT: **Surgery Ambulatory Surgery BLUE CROSS OF CALIFORNIA**

THE FOLLOWING WAS CHOSEN:

INSURANCE: BLUE CROSS OF CALIFORNIA
 PROV TYPE: BLUE SHIELD ID
 FORM TYPE: BOTH UB-04 & CMS-1500 FORMS
 CARE TYPE: BOTH INPATIENT AND OUTPATIENT
 CARE UNIT: Surgery

PROVIDER ID: XXXXBS

 When creating a bill for a patient with this payer, if IB,Doctor7 is entered on Screen 8, this ID for the Care Unit, Surgery, will be one of the Physician/Provider's Secondary IDs available.

**** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS OF CALIFORNIA
 PROVIDER: IB,DOCTOR7 (RENDERING)

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

1	-	NO SECONDARY ID NEEDED
2	-	ADD AN ID FOR THIS CLAIM ONLY
3	-	XXXXBS BLUE SHIELD ID Surgery

Selection: 1//

4.6.2 Define Care Units for Billing Provider Secondary IDs

Step	Procedure
1	Access the option MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance .
2	At the Select Provider ID Maintenance Option: prompt, enter CB for Care Units for Billing Provider.
3	At the Select INSURANCE CO: prompt, enter Blue Cross of California for this example.

```

Provider ID Maintenance Main Menu

Enter a code from the list.

      Provider IDs
PO  Provider Own IDs
PI  Provider Insurance IDs



      Insurance IDs
BI  Batch ID Entry
II  Insurance Co IDs

      Care Units
CP  Care Units for Providers
CB  Care Units for Billing Provider

      Non-VA Items
NP  Non-VA Provider
NF  Non-VA Facility

Select Provider ID Maintenance Option: CB Care Units for Billing Provider
Select INSURANCE CO: Blue Cross of California

```

Step	Procedure
4	At the Select Action: prompt, enter AU for Add a Unit.
5	At the Enter the Division for this Care Unit: prompt, press the <Enter> key to accept the default.
6	At the Enter Care Unit Name: prompt, enter Anesthesia for this example.
7	At the Enter a Care Unit Description: prompt, enter a free text description.
	<i>Users may repeat these steps to create multiple Care Units for multiple divisions.</i>
	<i>Refer to Section 3.1.2.3 to learn how to assign Billing Provider Secondary IDs to Care Units.</i>

```

Care Units - Billing Provider  May 27, 2005@11:17:46          Page:    1 of    0

Insurance Co: BLUE CROSS OF CALIFORNIA

Care Unit Name          Division          Description
No Care Units defined for this Insurance Co.

      Enter ?? for more actions
AU  Add a Unit          DU  Delete a Unit
EU  Edit a Unit         EX  Exit
Select Action: Quit// AU Add a Unit
Enter the Division for this Care Unit: Main Division//
Enter Care Unit name: Anesthesia
Are you adding 'Anesthesia' as
a new Care Unit for Main Division? No// y (Yes)
Enter a Care Unit Description: Free Text Description

Care Unit combination filed for this Insurance Co.

```

The following screen will display.

Care Units - Billing Provider May 27, 2005@11:17:46		Page: 1 of 0
Insurance Co: BLUE CROSS/BLUE SHIELD		
Care Unit Name	Description	

Division: Main Division		
Anesthesia	Free Text Description	
Reference Lab	Free Text Description	
Home Health	Free Text Description	
Division: Remote Clinic		
Reference Lab	Free Text Description	
Enter ?? for more actions		
AU Add a Unit	DU Delete a Unit	
EU Edit a Unit	EX Exit	
Select Action: Quit// QUIT		

4.7. ID Parameters by Insurance Company

In addition to defining Care Units and Physician/Provider IDs in Provider ID Maintenance, there are also ID parameters that can be set for an insurance company that effect which IDs get sent on 837 claims transmissions to an insurance company.

Users need to be aware of these parameters so they can be set *if needed*. They do not need to be set unless there is a specific need for a particular insurance company.

Step	Procedure
1	Access the option Insurance Company Entry/Edit .
2	At the Select INSURANCE COMPANY NAME: prompt, enter BLUE CROSS OF CALIFORNIA for this example.
3	From the Insurance Company Editor , enter the Prov IDs/ID Param action.

Insurance Company Editor	Oct 01, 2007@14:27:13	Page: 1 of 9
Insurance Company Information for: BLUE CROSS OF CALIFORNIA		
Type of Company: HEALTH INSURANCE	Currently Active	

Billing Parameters

Signature Required?: NO	Filing Time Frame:
Reimburse?: WILL REIMBURSE	Type Of Coverage: HEALTH INSURAN
Mult. Bedsections:	Billing Phone: 800/933-9146
Diff. Rev. Codes:	Verification Phone: 800/933-9146
One Opt. Visit: NO	Precert Comp. Name:
Amb. Sur. Rev. Code:	Precert Phone: 800/274-7767
Rx Refill Rev. Code:	

EDI Parameters

Transmit?: YES-LIVE	Insurance Type: HMO
---------------------	---------------------

+ Enter ?? for more actions >>>

BP Billing/EDI Param	IO Inquiry Office	EA Edit All
MM Main Mailing Address	AC Associate Companies	AI (In)Activate Company
IC Inpt Claims Office	ID Prov IDs/ID Param	CC Change Insurance Co.
OC Opt Claims Office	PA Payer	DC Delete Company
PC Prescr Claims Of	RE Remarks	VP View Plans
AO Appeals Office	SY Synonyms	EX Exit

Action: Next Screen// **ID Prov IDs/ID Param**

Step	Procedure
4	From the Billing Provider IDs screen, enter the ID Parameters action.

Billing Provider IDs (Parent) May 27, 2005@12:48:29	Page: 1 of 1
Insurance Co: BLUE CROSS OF CALIFORNIA	Billing Provider Secondary IDs

ID Qualifier	ID #	Form Type
--------------	------	-----------


Division: Name of Main Division/Default for All Divisions

1	Electronic Plan Type	XXXXXXXXXX	UB-04
2	Electronic Plan Type	XXXXXXXX1X	1500

Enter ?? for more actions

Add an ID	Additional IDs	Exit
Edit an ID	ID Parameters	
Delete an ID	VA-Lab/Facility IDs	

Select Action: Edit// **ID Parameters**

Step	Procedure
	<i>Note: The ID Parameter Maint. Screen displays the current parameter values.</i>
5	At the Select Action: prompt, enter the Edit Params action.

```

ID Parameter Maint.          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Attending/Rendering Provider Secondary ID
Default ID (1500): BLUE SHIELD
Default ID (UB): BLUE CROSS
Require ID on Claim: BOTH UB-04 AND CMS-1500 REQUIRED

Referring Provider Secondary ID
Referring Provider Secondary ID
Default ID (1500): BLUE SHIELD
Require ID on Claim: CMS-1500

Billing Provider Secondary IDs
Use Attending/Rendering ID as Billing Provider Sec. ID?: NO
Transmit no Billing Provider Sec ID for the following Electronic Plan Types:

Billing Provider/Service Facility
+          Enter ?? for more actions
  Edit Params      Edit Billing Prov Params      Exit

Select Action: Next Screen// Edit Params

```

The following will display.

```

Attending/Rendering Provider Secondary ID
Default ID (1500): BLUE SHIELD//
Default ID (UB): BLUE CROSS//
Require ID on Claim: BOTH UB-04 AND CMS-1500 REQUIRED
//

Referring Provider Secondary ID
Default ID (1500): BLUE SHIELD//
Require ID on Claim: CMS-1500//

Billing Provider Secondary IDs
Use Att/Render ID as Billing Provider Sec. ID (1500)?: NO
//
Use Att/Render ID as Billing Provider Sec. ID (UB)?: NO
//

Billing Provider/Service Facility
Always use main VAMC as Billing Provider (1500)?: NO
//
Always use main VAMC as Billing Provider (UB-04)?: NO
//

```

4.7.1 Define Attending/Rendering Provider Secondary ID Parameters

Users can define the type of ID that will be the default secondary ID for the Rendering Provider or Attending Physician during the creation of a claim.

A type of default secondary ID can be defined for a CMS-1500 claim and/or a UB-04 claim.

Users can also set a parameter that will make these IDs required on a claim. If they are required, and the physician/provider on the claim does not have a secondary ID of the type required, the claim cannot be authorized.

Attending/Rendering Provider Secondary ID Default ID (1500): BLUE SHIELD ID Default ID (UB04): BLUE CROSS ID Require ID on Claim: BOTH

4.7.2 Define Referring Provider Secondary ID Parameters

Users can define the type of ID that will be the default secondary ID for the Referring Provider during the creation of a CMS-1500 claim.

A type of default secondary ID can be defined for a CMS-1500 claim.

Users can also set a parameter that will make this ID required on a claim. If it is required, and the referring provider on the claim does not have a secondary ID of the type required, the claim cannot be authorized.

The default type of ID for a Referring Provider is a UPIN; users can, however, override this default.

Referring Provider Secondary ID Default ID (1500): UPIN // BLUE SHIELD ID Require ID on Claim: CMS-1500 REQUIRED

4.7.3 Define Billing Provider Secondary ID Parameters

If an insurance company wants the Billing Provider Secondary ID (Billing Screen 3) to be the same as the Attending Physician's or the Rendering Provider's ID, users can set the Send Attending/Rendering ID as Billing Provider Sec. ID?: parameter to Yes. The default value is No.

Billing Provider Secondary IDs Send Attending/Rendering ID as Billing Provider Sec. ID?: No // Yes
--



If the payer requires the Attending/Rendering Physician/Provider's Secondary ID as the Billing Provider Secondary ID, this parameter can be set and a default Attending/Rendering ID type can be set and then users can just accept the default ID on Billing Screen 8 and it will be transmitted as the Physician/Provider's Secondary ID and the Billing Provider Secondary ID.

4.7.4 Define Billing Provider/Service Facility Parameters

For those payers who are unable to accept claims where the Billing Provider is the lowest enumerated entity such as a CBOC or Pharmacy, users can set one of the following parameters, by payer and form type, which will force the Billing Provider to always be the main division in the database (VAMC).

Billing Provider/Service Facility Always use main VAMC as Billing Provider (1500)?: NO// YES Always use main VAMC as Billing Provider (UB-04)?: NO
--

Once one or both of these parameters has been set to YES, then the following parameters will become available.

Send VA Lab/Facility IDs or Facility Data for VAMC?: YES// Use the Billing Provider (VAMC) Name and Street Address?: NO//
--

When set to NO, the first parameter will suppress the transmission of the Service Facility loop data when the service is provided at the VAMC. When set to YES, the second parameter will cause the VAMC's street address from the Institution file to be transmitted as the Billing Provider's address instead of the Pay-to Provider's address.



*This group of parameters was designed to allow a site to return, as much as possible, to a pre-Patch IB*2*400 state where the Billing Provider was always the VAMC and the Service Facility was where the care was provided.*

4.7.5 Define VA Service Facility Parameters

This parameter was changed with Patch IB*2*400. The parameter will only exist as part of the Billing Provider/Service Facility parameters in Section 4.7.4. The VA Billing Provider information will no longer be repeated in the Service Facility loops for non-Fee Basis claims. The Service Facility will be blank for *most* VA claims.

```
VA-Laboratory or Facility IDs
Send VA Lab/Facility IDs or Facility Data?: No//
```

4.7.6 Define No Billing Provider Secondary IDs by Plan Type

Some insurance companies do not want any Billing Provider Secondary IDs to be transmitted in the 837 claim transmission for claims to specific plan types.

To define which plan types require no Billing Provider Secondary IDs, users must enter the plan types.

Step	Procedure
1	From the ID Parameter Maint. screen, enter the Edit Billing Prov Params action.
	The first Billing Provider Secondary ID will still be sent with the claim regardless of this parameter. The first ID is a calculated value used by the clearinghouse for sorting purposes.
2	At the Select Action: prompt, enter Add Plan .
3	At the Enter Electronic Plan Type: prompt, enter PPO for this example.

```
Billing Provider Parameters    May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Transmit No Billing Provider Sec ID for the following Electronic Plan Types:
1 HMO

          Enter ?? for more actions
Add Plan      Delete Plan      Exit

Select Action: Add Plan
Enter Electronic Plan Type: PPO
```

The following screen will display.

Billing Provider Parameters	May 27, 2005@12:48:29	Page:	1 of	1
Insurance Co.: BLUE CROSS OF CALIFORNIA				
<i>Transmit No Billing Provider Sec ID for the following Electronic Plan Types:</i>				
1 HMO				
2 PPO				
Enter ?? for more actions				
Add Plan		Delete Plan		Exit
Select Action: Add Plan				

4.7.7 View Associated Insurance Companies, Provider IDs, and ID Parameters

When in the Insurance Company Editor, users can scroll through the information that has been defined for a particular insurance company.

Patch IB*2.0*320 added sections to display: Associated Insurance Companies; Provider IDs and ID Parameters.

Insurance Company Editor Nov 22, 2005@10:26:11 Page: 5 of 7
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: BLUE CROSS Currently Active

+

Associated Insurance Companies

This insurance company is defined as a Parent Insurance Company.
There are 4 Child Insurance Companies associated with it.
Select the "AC Associate Companies" action to enter/edit the children.

Provider IDs

Billing Provider Secondary ID
Main Division and Default for All Divisions/1500:
Main Division and Default for All Divisions/UB-04:
Main Division Care Units:
Anesthesia/1500:
Reference Lab/1500:
Reference Lab/UB-04:
Home Health/UB-04:
2nd Division Name/1500:
2nd Division Name/UB-04:

Additional Billing Provider Secondary IDs
Main Division and Default for All Divisions/1500:
1st ID
2nd ID
3rd ID
Maximum of 6 additional IDs
Main Division and Default for All Divisions/UB-04:
1st ID
2nd ID
3rd ID
Maximum of 6 additional IDs

VA-Laboratory or Facility Secondary IDs
Main Division and Default for All Divisions/1500:
1st ID
2nd ID
3rd ID
Maximum of 5 additional IDs

ID Parameters

Attending/Rendering Provider Secondary ID Qualifier (1500):
Attending/Rendering Provider Secondary ID Qualifier (UB-04):
Attending/Rendering Secondary ID Requirement: NONE REQUIRED
Referring Provider Secondary ID Qualifier (1500):
Referring Provider Secondary ID Requirement:
Use Attending/Rendering ID as Billing Provider Sec. ID: No
Transmit no Billing Provider Sec. ID for the Electronic Plan Types:
HMO
PPO
Send VA Lab/Facility IDs or Facility Data: No

4.8. Associated Insurance Companies and Copying Physician/Provider Secondary IDs and Additional Billing Provider Secondary IDs

Patch IB*2.0*320 provides the ability for users to associate multiple Insurance Company entries with each other. **Example:** If there are 45 Blue Cross/Blue Shield entries in the Insurance Company file, users can make one of these entries the Parent company and make 1 to 44 of the other entries a Child company.

Making these associations will cause the software to automatically make the Physician/Provider Secondary IDs and the Additional Billing Provider Secondary IDs the same for all associated companies.

Once these associations are made and the IDs synchronized for all the associated companies, users can Add, Edit, and/or Delete IDs for the associated companies from the Parent company. Changes to the IDs from a Child company, however, are prohibited.

If a situation changes and it becomes necessary for a Child company to have IDs that differ from those of the Parent company, users may disassociate the Child company from the Parent company.

4.8.1 Designate a Parent Insurance Company

Step	Procedure
1	Access the Insurance Company Editor .
2	At the Select INSURANCE COMPANY NAME: prompt, enter Blue Cross of California for this example.
3	At the Define Insurance Company as Parent or Child: prompt, enter Parent .




```

Insurance Company Editor      Oct 01, 2007@14:27:13      Page:      1 of      9
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: HEALTH INSURANCE      Currently Active

      Billing Parameters
Signature Required?: NO      Filing Time Frame:
      Reimburse?: WILL REIMBURSE      Type Of Coverage: HEALTH INSURAN
      Mult. Bedsections:      Billing Phone: 800/933-9146
      Diff. Rev. Codes:      Verification Phone: 800/933-9146
      One Opt. Visit: NO      Precert Comp. Name:
      Amb. Sur. Rev. Code:      Precert Phone: 800/274-7767
      Rx Refill Rev. Code:

      EDI Parameters
      Transmit?: YES-LIVE      Insurance Type: GROUP
+      Enter ?? for more actions      >>>
BP Billing/EDI Param      IO Inquiry Office      EA Edit All
MM Main Mailing Address AC Associate Companies AI (In)Activate Company
IC Inpt Claims Office ID Prov IDs/ID Param CC Change Insurance Co.
OC Opt Claims Office PA Payer DC Delete Company
PC Prescr Claims Of RE Remarks VP View Plans
AO Appeals Office SY Synonyms EX Exit
Select Action: Next Screen//AC Associate Companies

Define Insurance Company as Parent or Child: P PARENT
  
```


Step	Procedure
4	At the Select Action: prompt, enter Associate Companies for this example.
5	At the Select INSURANCE COMPANY NAME: prompt, enter BLUE CROSS/BLUE SHIELD 801 PINE ST. CHATTANOOGA,TN for this example.
	<i>Steps 2 - 4 can be repeated to associate additional Insurance Companies with Blue Cross of California.</i>
	<i>A Parent – Child association can be removed using the Disassociate Companies action.</i>
	To stop an insurance company from being a Parent, all associations with any Child entries must be removed. After disassociating all the Child entries, users may delete the Parent using the '@' sign at the Define Insurance Company as Parent or Child: PARENT// prompt.

```

Associated Insurance Co's      Nov 21, 2005@11:13:53      Page:      1 of      1
Parent Insurance Company:
    BLUE CROSS OF CALIFORNIA      PO BOX 60007      LOS ANGELES,CA

    Ins Company Name      Address      City

    No Children Insurance Companies Found

    Enter ?? for more actions
    Associate Companies      Exit
    Disassociate Companies
Select Action: Quit// as Associate Companies

Select Insurance Company: BLUE CROSS/BLUE SHIELD801 PINE ST. CHATTANOOGA,TN

```

The following screen will display.

```

Associated Insurance Co's      Nov 21, 2005@11:30:25      Page:      1 of      1
Parent Insurance Company:
    BLUE CROSS OF CALIFORNIA      PO BOX 60007      LOS ANGELES,CA

    Ins Company Name      Address      City
1 BLUE CROSS FEP      PO BOX 70000      VAN NUYS,CA
2 BLUE CROSS/BLUE SHIELD      9901 LINN STA RD      LOUISVILLE,KY
3 BLUE CROSS/BLUE SHIELD      801 PINE ST.      CHATTANOOGA,TN


    Enter ?? for more actions
    Associate Companies      Exit
    Disassociate Companies
Select Action: Quit//

```

4.8.2 Designate a Child Insurance Company

An insurance company can be designated as a Child, from the Parent insurance company as demonstrated in **Section 4.8.1**.

If users want to quickly define a single insurance company as a Child, they can do this from the Insurance Company Editor.

Step	Procedure
1	Access the Insurance Company Editor.
2	At the Select INSURANCE COMPANY NAME: prompt, enter Aetna for this example.
3	At the Define Insurance Company as Parent or Child: prompt, enter Child for this example.
4	At the Associate with which Parent Insurance Company: prompt, enter the name of the insurance company that will be the Parent.
	'??' will provide a list of available Parent insurance companies.

Insurance Company Editor	Oct 01, 2007@14:33:41	Page: 1 of 8
Insurance Company Information for: AETNA		
Type of Company: HEALTH INSURANCE	Currently Inactive	
Billing Parameters		
Signature Required?: NO	Filing Time Frame: 12 MOS	
Reimburse?: WILL REIMBURSE	Type Of Coverage: HEALTH INSURAN	
Mult. Bedsections:	Billing Phone:	
Diff. Rev. Codes:	Verification Phone:	
One Opt. Visit: NO	Precert Comp. Name:	
Amb. Sur. Rev. Code:	Precert Phone:	
Rx Refill Rev. Code:		
EDI Parameters		
Transmit?: YES-LIVE	Insurance Type: GROUP POLICY	
+ Enter ?? for more actions >>>		
BP Billing/EDI Param	IO Inquiry Office	EA Edit All
MM Main Mailing Address	AC Associate Companies	AI (In)Activate Company
IC Inpt Claims Office	ID Prov IDs/ID Param	CC Change Insurance Co.
OC Opt Claims Office	PA Payer	DC Delete Company
PC Prescr Claims Of	RE Remarks	VP View Plans
AO Appeals Office	SY Synonyms	EX Exit
Select Action: Next Screen// ac Associate Companies		
Define Insurance Company as Parent or Child: Child CHILD		
Associate with which Parent Insurance Company: AetNA LIFE INSURANCE 3541 W		
INCHESTER RD. ALLENTOWN PENNSYLVANIA Y.....		

4.8.3 Copy Physician/Provider Secondary IDs

Individual Physician/Provider Secondary IDs can be entered, edited or deleted one time from the Parent insurance company and these changes will be copied to all associated insurance companies (Child).

This can be done using the following Provider ID Maintenance options:

- Provider ID Maint→PI Provider Insurance IDs;
- Provider ID Maint→II Insurance Co IDs; and
- Provider ID Maint→BI Batch ID Entry

4.8.4 Copy Additional Billing Provider Secondary IDs

When users are done adding, editing, or deleting Additional IDs from the Parent insurance company, the changes will be copied to all associated insurance companies.

4.8.5 Synchronizing Associated Insurance Company IDs

There is an IRM option for synchronizing the IDs of a Parent insurance company with all of the associated Child companies. This option is intended as a back-up option if the IDs of a Parent have become out of synch with the Child companies due to a system problem.

5. Subscriber and Patient ID Set-Up

Insurance Companies issue identification numbers to the people that they insure. The person who pays for the insurance policy or whose employer pays for the insurance policy or who receives Medicare is referred to as the subscriber. A veteran can be the subscriber, or a veteran can be insured through an insurance policy that belongs to some other subscriber such as the veteran's spouse or parent.

5.1. Subscriber and Patient Insurance Provided IDs

Some insurance companies issue identification numbers only to the subscriber. Some others issue unique identification numbers to each person covered by the subscriber's policy.

Insurance companies can issue both Subscriber Primary and Secondary ID numbers and Patient Primary and Secondary ID numbers.

These ID numbers can be entered when a policy is initially added in VistA through Add a policy. Sometimes the primary IDs will be added during the initial Patient Registration process and placed in the insurance company buffer.

Both Patient and Subscriber, Primary and Secondary IDs can be added or edited at any time using the option Patient Insurance Info View/Edit.

5.1.1 Define Subscriber Primary ID

When the patient is the subscriber, users will be prompted for the Subscriber's Primary ID.

Step	Procedure
1	Access the option Patient Insurance Info View/Edit.
2	At the Select Patient Name: prompt, enter IB,PATIENT TWO .
3	At the Select Items: prompt, enter Policy Edit/View .
4	At the Select Policy(s): prompt, enter 1 for this example.

Patient Insurance Management Sep 24, 2007@10:18:49						Page: 1 of 1
Insurance Management for Patient: IB,PATIENT TWO IXXXX XX/XX/XXXX						
	Insurance Co.	Type of Policy	Group	Holder	Effect.	Expires
1	AETNA US HEALTH	COMPREHENSIVE M	655555-19-	SELF	03/06/07	
2	BLUE CROSS CA (PREFERRED PROVI	173084	SPOUSE	05/15/07	
3	IB INSURANCE CO	COMPREHENSIVE M	XXXPLANNUM	OTHER	05/16/07	
4	NEW YORK LIFE	MEDIGAP (SUPPLE	F	OTHER	09/29/06	
Enter ?? for more actions						>>>
AP	Add Policy	EA	Fast Edit All	CP	Change Patient	
VP	Policy Edit/View	BU	Benefits Used	WP	Worksheet Print	
DP	Delete Policy	VC	Verify Coverage	PC	Print Insurance Cov.	
AB	Annual Benefits	RI	Personal Riders	EB	Expand Benefits	
RX	RX COB Determination	EX	Exit			
Select Item(s): Quit// VP Policy Edit/View						
Select Policy(s): (1-4): 1						

The following screen will display.

Patient Policy Information Sep 24, 2007@11:20:54 Page: 1 of 6
 For: IB,PATIENT TWO XXX-XX-XXXX XX/XX/XXXX DOD: XX/XX/XXXX
 AETNA US HEALTHCARE Insurance Company ** Plan Currently Active **

Insurance Company

Company: AETNA US HEALTHCARE
 Street: PO BOX 2561
 City/State: FT. WAYNE, IN 46801
 Billing Ph: 800/367-4552
 Precert Ph:

Plan Information

Is Group Plan: YES
 Group Name: FT JAMES CORP
 Group Number: 655555-19-230
 BIN:
 PCN:
 Type of Plan: COMPREHENSIVE MAJOR MED
 Electronic Type: COMMERCIAL
 Plan Filing TF: 2 YRS

Utilization Review Info

Require UR:





Effective Dates & Source



Effective Date: 03/06/07

+ Enter ?? for more actions

PI	Change Plan Info	GC	Group Plan Comments	CP	Change Policy Plan
UI	UR Info	EM	Employer Info	VC	Verify Coverage
ED	Effective Dates	CV	Add/Edit Coverage	AB	Annual Benefits
SU	Subscriber Update	PT	Pt Policy Comments	BU	Benefits Used
IP	Inactivate Plan	EA	Fast Edit All	EB	Expand Benefits
EX	Exit				

Select Action: Next Screen// **SU Subscriber Update**

Step	Procedure
5	At the Select Action: prompt, enter Subscriber Update .
6	At the Pt. Relationship to Subscriber: prompt, enter Patient .
	<i>Note: With Patch IB*2*371, the Whose Insurance? prompt was removed.</i>
	<i>With Patch IB*2*377, the list of available choices for Pt. Relationship to Insured was modified to have an expanded list of HIPAA valid choices.</i>
7	At the Name of Subscriber: prompt, press the <Enter> key to accept the default of IB,Patient Two.
	<i>Note: Once Patch IB*2*547 is installed, a patient and/or a subscriber with only a last name will be acceptable in Enter/Edit Billing Information.</i>
	<i>With Patch IB*2*371, users will have the ability to update the patient's name for any patient and any insurance company. This will allow users to make the patient's name match what is on file at the payer even when it is different from what is in the VistA patient file.</i>
8	At the Effective Date of Policy: prompt, press the <Enter> key to accept the default of MAR 6, 2007.
9	At the Coordination of Benefits: prompt, enter Primary for this example.
10	At the Source of Information: prompt, press the <Enter> key to accept the default of Interview.
11	At the Subscriber Primary ID: prompt, enter IDXXXXX for this example.

Step	Procedure
12	At the Do you want to enter/update Subscriber Secondary IDs? Prompt, press the <Enter> key to accept the default of No.
13	At the Subscriber's DOB: prompt, press the <Enter> key to accept the default.
14	At the Subscriber's Sex: prompt, press the <Enter> key to accept the default.
	<i>With Patch IB*2*361, the Insured's Sex prompt was added. This is required by HIPAA as is the Insured's DOB.</i>
	<i>The Insured's address is not required by HIPAA but HIPAA will not accept a partial address. When the insured is the patient, the patient's address will be defaulted from the patient file.</i>

```


Select Action: Next Screen//  Subscriber Update
PT. RELATIONSHIP TO SUBSCRIBER: PATIENT
NAME OF SUBSCRIBER: IB,PATIENT TWO//
EFFECTIVE DATE OF POLICY: MAR 6,2007
INSURANCE EXPIRATION DATE:
PRIMARY CARE PROVIDER:
PRIMARY PROVIDER PHONE:
COORDINATION OF BENEFITS: PRIMARY
SOURCE OF INFORMATION: INTERVIEW//

SUBSCRIBER PRIMARY ID: IDXXXXX

Do you want to enter/update Subscriber Secondary IDs? No//  NO

SUBSCRIBER'S DOB: XXX XX,XXXX//
SUBSCRIBER'S SEX: MALE//
SUBSCRIBER'S BRANCH: NAVY//
SUBSCRIBER'S RANK:
SUBSCRIBER'S STREET 1: 123 E.TEST BLVD//
SUBSCRIBER'S STREET 2:
SUBSCRIBER'S CITY: CHEYENNE//
SUBSCRIBER'S STATE: WYOMING//
SUBSCRIBER'S ZIP: 82001//

```

	<i>Patch IB*2*377 will provide the ability for the Name of the Subscriber and the Subscriber's primary ID (HIC#) to be automatically updated in the Patient's Medicare (WNR) Insurance when an MRA is received in VistA that contains a corrected name and/or ID. The PATIENT file will not be changed.</i>
---	---

5.1.2 Define Subscriber and Patient Primary IDs

When the patient is not the subscriber, users will be prompted for the Patient's Primary ID as well as the Subscriber's Primary ID.

Step	Procedure
1	Access the option Patient Insurance Info View/Edit.
2	At the Select Patient Name: prompt, enter IB,PATIENT TWO .
3	At the Select Items: prompt, enter Policy Edit/View .
4	At the Select Policy(s): prompt, enter 3 for this example.

Patient Insurance Management Sep 24, 2007@10:18:49				Page: 1 of 1	
Insurance Management for Patient: IB,PATIENT TWO I4444 XX/XX/XXXX					
	Insurance Co.	Type of Policy	Group	Holder	Effect. Expires
1	AETNA US HEALTH	COMPREHENSIVE M	655555-19-	SELF	03/06/07
2	BLUE CROSS CA (PREFERRED PROVI	173084	SPOUSE	05/15/07
3	IB INSURANCE CO	COMPREHENSIVE M	XXXPLANNUM	SPOUSE	05/16/07
4	NEW YORK LIFE	MEDIGAP (SUPPLE	F	OTHER	09/29/06

Enter ?? for more actions >>>

AP Add Policy	EA Fast Edit All	CP Change Patient
VP Policy Edit/View	BU Benefits Used	WP Worksheet Print
DP Delete Policy	VC Verify Coverage	PC Print Insurance Cov.
AB Annual Benefits	RI Personal Riders	EX Exit

Select Item(s): Quit// **VP Policy Edit/View**

Select Policy(s): (1-4): 3.....

The following screen will display.

Patient Policy Information Sep 24, 2007@10:33:49		Page: 2 of 6	
For: IB,PATIENT TWO XXX-XX-XXXX XX/XX/XXXX		DOD: XX/XX/XXXX	
IB INSURANCE CO Insurance Company		** Plan Currently Active **	

+

Subscriber Information	Subscriber's Employer Information
Whose Insurance: SPOUSE	Emp Sponsored Plan: No
Subscriber Name:	Employer:
Relationship:	Employment Status:
Primary ID:	Retirement Date:
Coord. Benefits:	Claims to Employer: No, Send to Insurance
Primary Provider:	Street:
Prim Prov Phone:	City/State:
	Phone:

Insured Person's Information (use Subscriber Update Action)



Insured's DOB: XX/XX/XXXX Str 1: 123 E.TEST BLVD




+

Enter ?? for more actions

PI Change Plan Info	GC Group Plan Comments	CP Change Policy Plan
UI UR Info	EM Employer Info	VC Verify Coverage
ED Effective Dates	CV Add/Edit Coverage	AB Annual Benefits
SU Subscriber Update	PT Pt Policy Comments	BU Benefits Used
IP Inactivate Plan	EA Fast Edit All	EB Expand Benefits
EX Exit		

Select Action: Next Screen// **SU Subscriber Update**

Step	Procedure
5	At the Select Action: prompt, enter Subscriber Update .
6	At the PT. RELATIONSHIP TO SUBSCRIBER: prompt, enter SPOUSE for this example.
	<i>With Patch IB*2*377, an expanded list of HIPAA compliant codes for Pt. Relationship to Insured, was added.</i>
	<i>With Patch IB*2*371, the Whose Insurance? prompt was removed.</i>
7	At the Name of Subscriber: prompt, enter IB,Spouse Two for this example.
8	At the Effective Date of Policy: prompt, press the <Enter> key to accept the default of May 15, 2007.

Step	Procedure
9	At the Coordination of Benefits: prompt, enter Secondary for this example.
10	At the Source of Information: prompt, press the <Enter> key to accept the default of Interview.
11	At the Subscriber Primary ID: prompt, enter XXXXXID for this example.
12	At the Do you want to enter/update Subscriber Secondary IDs? Prompt, press the <Enter> key to accept the default of No.
13	At the Patient Primary ID: prompt, enter XXXXXID2 for this example.
14	At the Do you want to enter/update Patient Secondary IDs? Prompt, press the <Enter> key to accept the default of No.
15	At the Subscriber's DOB: prompt, enter August 12, 1945 for this example.
16	At the Subscriber's Sex: prompt, enter Female for this example.
	<i>With Patch IB*2*361, the Insured's Sex prompt was added. This is required by HIPAA as is the Insured's DOB.</i>
	<i>If the Patient's Relationship to the Insured is spouse, then the patient's address will be the default address of the Insured. Users may enter different values if the spouse's address is different from the patient's.</i>
	<i>The Insured's address is not required by HIPAA but HIPAA will not accept a partial address.</i>

```

Select Action: Next Screen// SU Subscriber Update
PT. RELATIONSHIP TO SUBSCRIBER: SPOUSE//
NAME OF SUBSCRIBER: IB,SPOUSE TWO
EFFECTIVE DATE OF POLICY: MAY 15,2007
INSURANCE EXPIRATION DATE:
PRIMARY CARE PROVIDER:
PRIMARY PROVIDER PHONE:
COORDINATION OF BENEFITS: SECONDARY
SOURCE OF INFORMATION: INTERVIEW//

SUBSCRIBER PRIMARY ID: XXXXXID

Do you want to enter/update Subscriber Secondary IDs? No// NO

PATIENT PRIMARY ID: XXXXXID2

Do you want to enter/update Patient Secondary IDs? No// NO

SUBSCRIBER'S DOB: AUG 12,1945
SUBSCRIBER'S SEX: FEMALE
SUBSCRIBER'S BRANCH:
SUBSCRIBER'S RANK:
SUBSCRIBER'S STREET 1: 123 E.TEST BLVD//
SUBSCRIBER'S STREET 2:
SUBSCRIBER'S CITY: CHEYENNE//
SUBSCRIBER'S STATE: WYOMING//
SUBSCRIBER'S ZIP: 82001//

```

5.1.3 Define Subscriber and Patient Secondary IDs

In addition to Subscriber and Patient Primary IDs, it is possible for insurance companies to issue secondary IDs, although this is unusual. A subscriber or a patient may also have one or more secondary IDs of the following types:

- 23 Client Number

- IG Insurance Policy Number
- SY Social Security Number

```

SUBSCRIBER PRIMARY ID: XXXXXID//

Do you want to enter/update Subscriber Secondary IDs? No// y YES



SUBSCRIBER'S SEC QUALIFIER(1):??
Enter a Qualifier to identify the type of ID number.
Choose from:
23 Client Number
IG Insurance Policy Number
SY Social Security Number
SUBSCRIBER'S SEC QUALIFIER(1): IG Insurance Policy Number
SUBSCRIBER'S SEC ID(1): XXXXID2
SUBSCRIBER'S SEC QUALIFIER(2):

PATIENT PRIMARY ID: IDXXXXX//

Do you want to enter/update Patient Secondary IDs? No// y YES

PATIENT'S SEC QUALIFIER(1): IG Insurance Policy Number
PATIENT'S SECONDARY ID(1): ID2XXXX
PATIENT'S SEC QUALIFIER(2):

```

Step	Procedure
1	Access Subscriber Update again.
2	At the Do you want to enter/update Subscriber Secondary IDs? No//: prompt, enter Yes .
3	At the Subscriber's Sec Qualifier (1): prompt, enter IG for this example.
	<i>23 Client Number is used for claims to the Indian Health Service/Contract Health Services (HIS/CHS).</i>
	<i>VistA will not allow users to enter SY for SNN if the payer is Medicare. Medicare will not accept the SSN as a subscriber's secondary ID.</i>
4	At the Subscriber's Sec ID (1): prompt, enter XXXXID2 for this example.
5	At the Subscriber's Sec Qualifier (2): prompt, press the <Enter> key if you do not want to add another ID.
6	At the Patient Primary ID (1): prompt, press the <Enter> key to accept the default.
7	At the Do you want to enter/update Patient Secondary IDs? No//: prompt, enter Yes .
8	At the Patient's Sec Qualifier (1): prompt, enter IG for this example.
9	At the Patient's Sec ID (1): prompt, enter ID2XXXX for this example.
10	At the Patient's Sec Qualifier (2): prompt, press the <Enter> key if you do not want to add another ID.



6. Entering Electronic Claims

This section briefly identifies the screens used in the billing process that contain fields critical to EDI billing. It is important that all the data transmitted in an electronic claim be accurate and appropriate. This section is just meant to highlight some specific fields that pertain to electronic processing.

6.1. Summary of Enter/Edit Billing Information to Support ASC X12N/5010

There have been numerous changes with Patch IB*2*447 to the Enter/Edit Billing Information option to support changes in the Health Care Claim (837) Technical Reports (ASC X12N/ 5010) for both Institutional and Professional claims.

Screen	Section	Change
5	3	Addition of Priority (Type) of Admission
5	3	Addition of Default Priority (Type) of Admission
8		Screen 9 contains all information previously found on Screen 8 section 3
9		Added Ambulance Transport Information (Claim Level)
9		Added Ambulance Certification Data (Claim Level)
11		Local screen 9 information was moved to screen 11

	<i>Note: After Patch IB*2*432 is installed, users will no longer receive Warnings when there is more than one division or non-matching providers on a claim. It will be possible to have multi-divisional claims with line-level and claim-level providers, of the same type, who do not match.</i>
	<i>Note: After Patch IB*2*432 is installed, users will no longer receive an Error when a human provider does not have an SSN or EIN defined.</i>

6.2. Changes Made by Specific Patches

6.2.1 Patch IB*2*447

The following changes are in Patch IB*2*447 not covered elsewhere in this document.

6.2.1.1 Enter/Edit Billing Information

- The procedure in the first line-level position (first entered or set to 1 by user) on a claim, will no longer be designated a claim level Principal procedure (Qualifier BR) on an outpatient, institutional claim.
- The additional procedures in the line items of an outpatient, institutional will no longer be designated a claim level Other procedures (Qualifier BQ).
- IB will calculate the amount due from the MediGap secondary payer based upon the beginning Date of Service on a claim and the effective date of the MediGap Plans.

6.2.1.2 MEDIGAP Calculations

This option is currently not available and can be turned on at a future time.

- The amount due from the Medicare secondary Medigap payer will be based upon the Type of Plan of the Insurance Plan
- MEDIGAP A (COINS, NO DED, NO B EXC)
- MEDIGAP B (COINS, A DED, NO B DED, NO B EXC)
- MEDIGAP C (COINS, A/B DED, NO B EXC)
- MEDIGAP D (COINS, A DED, NO B DED, NO B EXC)
- MEDIGAP F (COINS, DED, NO B EXC)

- MEDIGAP G (COINS, A DED, NO B DED, NO B EXC,)
- MEDIGAP K (A COINS, 50% B COINS, 50% A DED, NO B DED, NO B EXC)
- MEDIGAP L (A COINS, 75% B COINS, 75% A DED, NO B DED, NO B EXC)
- MEDIGAP M (COINS, 50% A DED, NO B DED, NO B EXC)
- MEDIGAP N (COINS, A DED, NO B DED, NO B EXC)
- The amount due from the Medicare Secondary payer will be based upon the Type of Plan defined for the Insurance Plan:
 - Medicare Secondary (COINS, DED, No B EXC)
 - Medicare Secondary (COINS, DED, B EXC)
- The amount due from the Medicare Secondary Supplemental payer will be based upon the Type of Plan defined for the Insurance Plan. Medicare (Supplemental) (COINS, DED, No B EXC)
- The amount due from the Medicare Secondary Employer Group Health Plan (EGHP) payer will be based upon the Type of Plan defined for the Insurance Plan:
 - CARVE-OUT (COINS, DED, B EXC)
 - COMPREHENSIVE (COINS, DED, B EXC)
 - MEDICAL EXPENSE (OPT/PROF) (COINS, DED, B EXC)
 - MENTAL HEALTH (COINS, DED, B EXC)
 - POINT OF SERVICE (COINS, DED, B EXC)
 - PREFERRED PROVIDER ORGANIZATION (PPO) (COINS, DED, B EXC)
 - RETIREE (COINS, DED, B EXC)
 - SURGICAL EXPENSE INSURANCE (COINS, DED, B EXC)
- The monetary value entered by users in Section 5 of Screen 7, Rev. Code, for outpatient and inpatient Professional claims will be retained unless users:
 - Remove the procedure that generated the Revenue Code and monetary value;
 - Execute the Rate Schedule recalculation of charges function;
 - Change the division associated with the procedure;
 - Change the Charge Type;
 - Change the division associated with the claim.
- It will be possible to transmit Revenue/Procedure codes which generate zero charge amounts in an 837 Health Care Claim Transmissions (PRF, Piece 5 and INS, Piece 9).
- Users will be able to enter and transmit a Priority (Type) of Visit (Admission Type Code) code field in an outpatient, institutional 837 Health Care Claim Transmission (CL1, Piece 23). There will no longer be a hard-coded value, 9, transmitted or printed.
- Users will be able to enter and transmit the following Ambulance Transport Data in a professional 837 Health Care Claim Transmission:
 - Patient's Weight Qualifier = LB
 - Patient's Weight
 - Transport Reason Code
 - Transport Distance Qualifier = DH
 - Transport Distance
 - Round Trip Purpose Description (Free Text)
 - Stretcher Purpose Description (Free Text)
 - Users will be able to enter and transmit the following Ambulance Certification Data in a professional 837 Health Care Claim Transmission:
 - Code Category – 07
 - Certification Condition Indicator – YES
 - Condition Codes (1-5 codes)

6.2.2 Patch IB*2*488:

Patch IB*2*488 includes the following changes not covered elsewhere in this document.

6.2.2.1 Enter/Edit Billing Information

- The system no longer provides the ability for users to force institutional or professional claims to be printed at the Health Care Clearing House (HCCH)

6.2.2.2 MRA Management Worklist (MRW)

Patch IB*2*488 modified the way message storage errors (created when an EEOB or MRA is received and all the line items cannot be matched correctly) are displayed in TPJI. Internal code will no longer be displayed to the users. In addition to the changes in TPJI, similar changes exist in MRW for Medicare claims.

The Following types of errors will be displayed:

- Procedure Code mismatch
- Procedure Modifier mismatch
- Revenue Code mismatch
- Charge Amount mismatch
- Number of Units mismatch

The type of mismatch error and the values that were in the outbound 837 transaction will be displayed along with the values that were received in the inbound 835 transaction.

View an EOB	Apr 14, 2014@18:25:55	Page: 4 of 6
BILL #:442-K101EVT		
CURRENT INSURANCE COMPANY (PRIMARY): MEDICARE (WNR)		
+		
VistA could not match all of the Line Level data received in the EEOB (835 Record 40) to the claim in VistA.		
Mismatched Procedure Code:		
Payer reported the following was billed via the Claim (837):		
Proc:71010 Mods:59 Rev Cd:324 Chg:227.40 Units:1		
Payer reported adjudication via the EOB (835) as follows:		
Proc:71015 Mods:59 Rev Cd:324 Chg:227.40 Units:1		
Amt:100.00		

Service line adjustment (EEOB Record 41) has no matching service line		
+ Enter ?? for more actions		
General Info	Claim Level Adj	Review Info
Payer Info	Medicare Info	Exit
Claim Level Pay	Line Level Adj	
Select Action: Next Screen//		

Users can now identify those Medicare claims with associated MSEs as an exclamation point will appear to the left of the claim number.

MRA Management WorkList		Nov 25, 2013@14:06:58		Page: 1 of 35	
Bill #	Svc Date	Patient Name	SSN	Pt Resp	Bill Amt Type
BILLER: IB,CLERK F					
1 !442-KXXXXXX*	06/02/10	IB,PATIENT 234	XXXX	0.00	1710.76 O/I
Insurers: MEDICARE (WNR), NAT'L ASSOC OF LETTER CARRIERS					
MRA Status: DENIED, Jul 12, 2010					
2 442-KXXXXXX	06/02/10	IB,PATIENT 33	XXXX	0.00	380.22 O/P
Insurers: MEDICARE (WNR), NAT'L ASSOC OF LETTER CARRIERS					
MRA Status: DENIED, Jul 07, 2010					
3 442-KXXXXXX	05/14/10	IB,PATIENT 12	XXXX	0.00	132.20 O/P

	Insurers:	MEDICARE (WNR), UNITEDHEALTHCARE					
	MRA Status:	DENIED, Aug 16, 2010					
4	442-KXXXXXX	06/11/10	IB,PATIENT 12	XXXX	0.00	132.20	O/P
	Insurers:	MEDICARE (WNR), UNITEDHEALTHCARE					
	MRA Status:	DENIED, Aug 16, 2010					
5	442-KXXXXXX	06/14/10	IB,PATIENT 103	XXXX	0.00	81.22	I/P
+	!=835 Data Mismatch Enter ?? for more actions						
PC	Process COB	VC	View Comments	PM	Print MRA		
VE	View an EOB	CB	Cancel Bill	TP	Third Party Joint Inq.		
SU	Summary MRA Info	CR	Correct Bill	Q	Exit		
EC	Enter Comments	CC	Cancel/Clone A Bill				
RS	Review Status	VB	View Bill				
Select Action: Next Screen//							

If users attempt to access any of the following Actions, the system will display a warning message.

- PC - Process COB
- VE - View an EOB
- SU – Summary MRA Info
- PM - Print MRA

Warning : The MRA for this claim caused a Data Mismatch/Message Storage Error. If you continue, the secondary claim may not contain the correct data.
Do you wish to continue?: No//

6.2.2.3 Enhanced CMS-1500 Printed Claim Form

The CMS-1500 Printed Claim Form has been updated to comply with the new National Uniform Claim Committee (NUCC) standards.

6.2.3 Patch IB*2*516

Patch IB*2*516 includes the following changes not covered elsewhere in this document.

6.2.3.1 TRICARE/TRICARE REIMB. Pay-to Providers

If the Rate Type of a claim is either TRICARE or TRICARE REIMB., the new TRICARE Pay-to Provider will be printed or transmitted in the same manner as the regular Pay-to Provider information is for other Rate Types.

- The TRICARE Pay-to Provider's address will print on the CMS – 1500 form in Box 32
- The TRICARE Pay-to Provider's data will print on the UB04 in FL2 only when the information is not exactly the same as the Billing Provider information
- The TRICARE Pay-to Provider data will be transmitted in the 837 claim transaction in Record PRV1/Loop 2010A/B

6.2.3.2 NDC Numbers for non-RX Claims

If an NDC number and the units administered to the patient are entered on either a professional or institutional claim, the information will print in the following locations if the claim is printed locally:

- CMS – 1500 – Box 24: Shaded area – Format: N4NDC#<space>Unit Qualifier#of Units – if transmitted, the NDC number is transmitted in Record PRF/Loop 2410
- UB04 – FL43 - Format: N4NDC#<space>Unit Qualifier#of Units – if transmitted the NDC number is transmitted in Record INS/Loop 2410



*Note: The ability to select a Unit Qualifier was added in patch IB*2*577.*

6.2.4 Patch IB*2*547

Patch IB*2*547 includes the following changes not covered elsewhere in this document:

6.2.4.1 Service Lines with No Print Order

Identical CPT/HCPCS procedures that have the exact same data elements and no print order will be assigned to the same Revenue code with a combined number of units and monetary value.

6.2.4.2 Last Names Only

Claims can now be submitted for both patients and/or subscribers who have only one name (last name). A patient and/or subscriber with only a last name will no longer trigger a fatal error when trying to authorize a claim.

6.2.4.3 Blank Present on Admission

Inpatient institutional claims no longer require a Present on Admission (POA) value for all diagnosis codes. If a POA indicator is needed, the allowable values are now the following:

- Y – Yes
- N – No
- U – No Information in the Record
- W – Clinically Undetermined

6.2.4.4 Printed CMS 1500 Forms

Printed secondary/tertiary claims on CMS 1500 forms will display the dollar amount of previous primary and secondary payer payments in Box 29 - Amount Paid.

6.2.4.5 Printed UB04 Forms

The admission date and time will print on the UB04 form in FL 12 and 13 on claims for inpatient admissions only.

6.2.4.6 Insurance Company Entry/Edit/View Insurance Company

Though IB will continue to use only complete addresses in 837 transactions, the address fields in the insurance company editor will display whatever address data is stored in VistA for the following fields even when the address data is incomplete:

- Main Mailing Address
- Inpt Claims Office
- Opt Claims Office
- Prescr Claims Office
- Appeals Office
- Inquiry Office



Note: View Insurance Company, which is just a view only option of what is in the Insurance Company Entry/Edit option, will display the same address information.

6.2.4.7 EDI Menu for Electronic Bills.... Print EOB

Print EOB will display the complete and current textual description associated with the Claims Adjustment Reason Codes/Remittance Advice Remark Codes (CARC/RARC) received in an electronic EOB.

6.2.4.8 Copy and Cancel (CLON)

The existing CLON option logic for the inclusion of Coordination of Benefits (COB) data was enhanced to incorporate the following rules:

- Copy primary claim with EOB to a new primary claim – Do not copy COB data
- Copy secondary claim to new secondary claim – Copy primary COB data
- Copy tertiary claim to new tertiary claim – Copy primary and secondary COB data

6.2.4.9 ASC X12N 5010 Health Care Claim (837) Transactions

The following changes were made to 837 transactions:

- An inpatient institutional 837 transaction no longer requires a POA for each diagnosis
- An inpatient admission date can no longer be transmitted on outpatient claims
- All Rate Types for which the responsible party is equal to insurer can now be transmitted electronically when appropriate
- Institutional 837 transactions can now transmit up to twenty-five procedure codes
- Institutional 837 transactions can now transmit up to 12 External Cause of Injury codes

6.2.5 Patch IB.2.576

Patch IB*2*576 includes the following changes not covered elsewhere in this document:

6.2.5.1 Enhanced CMS-1500 Printed Claim Form

- The CMS-1500 Printed Claim Form has been updated to comply with the National Uniform Claim Committee (NUCC) standards:
 - The Event Date will no longer be used as a default value for Box 14. If there is no Occurrence Code 10 – Last Menstrual Period Date or Occurrence Code 11 – Onset of Illness Date on the claim, no date or date qualifier will print in Box 14
 - The Timeframe of Bill value of either 7 – REPLACEMENT CLAIM or 8 – VOID/CANCEL PRIOR CLAIM will print in Box 22 (left-hand side) and the Internal Control Number (ICN) from the payer will print in Box 22 (right-hand side) for replacement claims 7 or 8.

6.2.5.2 MRA Management Worklist (MRW)

- The legend on the MRW screen has been enhanced to include the explanation for an asterisks displaying next to a claim number.

MRA Management WorkList			Nov 25, 2013@14:06:58		Page: 1 of 35		
Bill #	Svc Date	Patient Name	SSN	Pt Resp	Bill Amt	Type	
BILLER: IB,CLERK F							
1	!442-KXXXXXX*	06/02/10 IB,PATIENT 234	XXXX	0.00	1710.76	O/I	
	Insurers: MEDICARE (WNR), NAT'L ASSOC OF LETTER CARRIERS						
	MRA Status: DENIED, Jul 12, 2010						
2	442-KXXXXXX	06/02/10 IB,PATIENT 33	XXXX	0.00	380.22	O/P	
	Insurers: MEDICARE (WNR), NAT'L ASSOC OF LETTER CARRIERS						
	MRA Status: DENIED, Jul 07, 2010						
3	442-KXXXXXX	05/14/10 IB,PATIENT 12	XXXX	0.00	132.20	O/P	
	Insurers: MEDICARE (WNR), UNITEDHEALTHCARE						
	MRA Status: DENIED, Aug 16, 2010						
4	442-KXXXXXX	06/11/10 IB,PATIENT 12	XXXX	0.00	132.20	O/P	
	Insurers: MEDICARE (WNR), UNITEDHEALTHCARE						
	MRA Status: DENIED, Aug 16, 2010						
5	442-KXXXXXX	06/14/10 IB,PATIENT 103	XXXX	0.00	81.22	I/P	
+	!=835 Data Mismatch *Review in Process						
PC	Process COB	VC	View Comments	PM	Print MRA		
VE	View an EOB	CB	Cancel Bill	TP	Third Party Joint Inq.		
SU	Summary MRA Info	CR	Correct Bill	Q	Exit		
EC	Enter Comments	CC	Cancel/Clone A Bill				
RS	Review Status	VB	View Bill				
Select Action: Next Screen//							

6.2.5.3 Insurance Company Entry/Edit

The Insurance Company Editor has been modified to prevent the creation of new 5 character ZIP codes or 9 digit codes which include invalid final four digits (0000 or 9999). This change will affect the following addresses:

- Main Mailing Address
- Inpatient Claims Office Address
- Appeals Office Address
- Inquiry Office Address
- Outpatient Claims Office Address
- Prescription Claims Office Address

This change will not affect existing ZIP code values or usage unless someone attempts to update the current value.

All new ZIP codes should be 9 valid digits. If users do not enter the correctly formatted data, they will not be able to proceed. The following will be displayed:

Answer must be nine (999999999) or ten characters (99999-9999) in length. The last 4 cannot be '0000' or '9999'.

6.2.6 Patch IB*2*577

Patch IB*2*577 includes the following changes not covered elsewhere in this document:

6.2.6.1 CLON

In addition to the changes made to CLON in patch IB*2*547, CLON has been enhanced to recalculate the monetary amount being billed to the destination payer when a claim is Canceled and Copied and the payer sequence is changed.

Example: A secondary claim is Clon'd to make a new claim and then the payer sequence is changed to Primary, to be resubmitted as an adjustment claim. Because the claim is going to the primary payer, the amount billed will be equal to the original amount billed to the primary payer.

6.3. Handling Error Messages and Warnings



Note: Warnings will not prevent users from authorizing a claim, Errors will. If one or more errors exist, the user will be prompted to correct them. If a user answers Yes, the system will display the billing screens to allow the user to make changes.

IB Edit Checks are done before claim authorization.

```
... Executing national IB edits

ERROR/WARNING OUTPUT DEVICE: HOME//  TELNET TERMINAL

**Warnings**:
Prov secondary id type for the PRIMARY RENDERING is invalid/won't transmit
BLUE CROSS CA (WY) requires Amb Care Certification

**Errors**:
A CPT procedure is missing an associated diagnosis.
Place of Service not entered for at least one procedure.
Type of Service not entered for at least one procedure.
Claims with multiple payers require all Payer IDs.
A claim cannot have a Primary Payer ID value of HPRNT/SPRNT.

Do you wish to edit the inconsistencies now? NO// y  YES
```


6.3.1 Patch IB*2*488

Patch IB*2*488 added several new error messages to Enter/Edit Billing Information:

- Error - when a professional claim contains no procedures codes
- Error - when an outpatient, institutional claim contains no procedures codes
- Error - when a Primary Payer ID is a PRNT/prnt value

6.3.2 Patch IB*2*516

Patch IB*2*516 made several changes to existing error and warnings messages:

- Error - when a claim contains a procedure code outside the 100-999 range – Removed
- Error - when a human provider has no NPI - Added
- Error - when a non-VA facility has no NPI – Added
- Warning - when a non-VA Facility has no Taxonomy code – Removed



Note: The system will try to automatically remove non-billable providers from a claim as the auto biller creates a claim. The new error is for those cases where the provider has not been removed.

6.3.3 Patch IB*2*547

Patch IB*2*547 made several changes to the existing logic for these error messages. The following error messages will no longer be triggered if the patient or subscriber only has a last name defined in VistA:

- Error - Patient's first and last name must begin with an alpha character
- Error - Primary insurance subscriber's name is missing or invalid
- Error - Secondary insurance subscriber's name is missing or invalid
- Error - Tertiary insurance subscriber's name is missing or invalid

6.3.4 Patch IB.2.576

Patch IB*2*576 made changes to the existing logic for this error message. The following error message will only display when there are both Occurrence Codes 10 – Last Menstrual Period and 11 – Onset of Illness on a claim:

- Error - Occ. Codes Onset of Illness (11) and LMP (10) not allowed on same bill.

6.4. Claim versus Line Level Data

With the introduction of additional Line Level data (including Line Level providers) in Patch IB*2*447, it is important to understand the concept of Claim Level data applying to all the line items on a claim. Claim Level data applies to all the line items on a claim, while Line Level data should be used to provide *exceptions* to the Claim Level data.

Example: If all the procedures on a claim were performed by the same Rendering provider, the claim should only have a Claim Level Rendering provider. If all but one procedure is done by the same Rendering provider and one procedure is done by a second Rendering provider, the claim should have a Claim Level Rendering provider and one different Line Level Rendering provider. Line Level providers will be transmitted in 837 Health Care Claim transmissions.

In addition, Institutional claims can have both line-level and/or claim-level Rendering, Referring, and Other Operating Providers. The Attending Provider is still the only provider required on an institutional claim and there is no longer a generic Other Provider.

Professional claims continue to allow Rendering, Referring, and Supervising Providers on a claim. The Rendering Provider is still the only provider required on a professional claim.

6.5. Screen 3 – Payer Information

6.5.1 EDI Fields

Section 1 – Transmit	When a payer has been set up to transmit claims electronically, this field will say “Yes”. If the field says “No” the claim will be printed locally.
Section 2 – Primary, Secondary and Tertiary Payer	These fields display the Billing Provider Secondary IDs for the payers on the bill. These IDs are defined in the Insurance Company Editor. <i>Note: If users set the ID Parameter: Send Attending/Rendering ID as Billing Provider Sec. ID? to Yes for a payer on the claim, the Attending/Rendering ID will be sent.</i>
Section 3 – Mailing Address	This field should contain a valid mailing address for the current payer. In order to avoid EDI errors, there should be no periods or dashes such as P.O. Box, Winston-Salem, St. Paul, etc. <i>Exception: Medicare does not have a valid address.</i>
Section 3 – Electronic ID	This field contains the Inst Payer Primary ID or Prof Payer Primary ID defined in the Insurance Company Editor. Payer Primary IDs are provided by the clearinghouse and can be found at www.emdeon.com .

```

IB,PATIENT 1   XX-XX-XXXX   BILL#: K501XXX - Outpat/1500   SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type   : REIMBURSABLE INS.           Form Type: CMS-1500
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer  : CIGNA                       Transmit: Yes

    Ins 1: CIGNA                               Policy #: 126781678
    Grp #: GRP NUM 2277                       Whose: VETERAN           Rel to Insd: PATIENT
    Grp Nm: TEST GROUP                       Insd Sex: MALE          Insured: IB,PATIENT IN



    Ins 2: BLUE CROSS CA (W                   Policy #: R76543210
    Grp #: UNSPECIFIED                       Whose: SPOUSE           Rel to Insd: SPOUSE
    Grp Nm: TEST BCBS                       Insd Sex: FEMALE        Insured: ib,wife in

                                *** Patient has Insurance Buffer entries ***

[2] Billing Provider Secondary IDs:
    Primary Payer:
    Secondary Payer: XXXXXXXX               Tertiary Payer:


[3] Mailing Address :                               Electronic ID: XXXID
    CIGNA
    PO BOX 9358
    SHERMAN, TX 75091
<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:

```

	The 3-line mailing address displayed here is used also used by the clearinghouse to look up the Electronic ID for the payer when a claim is sent without a defined Electronic Bill ID.
	Note: Patch IB*2*432 made changes so that the Federal Tax ID Number will no longer be used as a default value when no other Billing Provider Secondary ID is defined for a payer – Section 2.

6.5.2 Using Care Units for Billing Provider Secondary IDs

Section 2 of Billing Screen 3 contains fields for the Billing Provider Secondary IDs for the primary, secondary and tertiary payers on a claim. Normally the default values for the site or the defined values for the division on the claim populate these fields. If any insurance company on the claim requires different Billing Provider Secondary IDs based upon Care Units, users can change the default values to the value defined for the Care Unit where the services were provided.

Step	Procedure
1	At the <RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT: prompt, enter 2.
2	At the Current Bill Payer Sequence: prompt, press the <Enter> key to accept the default.
3	At the Define Primary Payer ID by Care Unit?: prompt, press the <Enter> key to accept the default.
4	At the Primary Payer ID: prompt, press the <Enter> key to accept the default.
5	At the Define Secondary Payer ID by Care Unit?: prompt, enter Yes for this example.
6	At the Division: prompt, press the <Enter> key to accept the default for this example.
7	At the Care Unit: prompt, enter Anesthesia for this example.
8	At the Secondary Payer ID: prompt, press the <Enter> key to accept the default.
	<i>Note: The Care Units must be defined in Provider ID Maintenance and the ID numbers must be defined in the Insurance Company Editor.</i>

```

IB,PATIENT 1   XX-XX-XXXX   BILL#: K501XXX - Outpat/1500   SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type   : REIMBURSABLE INS.           Form Type: CMS-1500
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer  : MRA NEEDED FROM MEDICARE    Transmit: Yes

    Ins 1: MEDICARE (WNR)      WILL NOT REIMBURSE   Policy #: XXXXXXXXXA
    Grp #: PART A              Whose: VETERAN        Rel to Insd: PATIENT
    Grp Nm: PART A            Insd Sex: MALE         Insured: IB,PATIENT 1

    Ins 2: BLUE CROSS OF CA   Policy #: MES3456
    Grp #: PLAN 2             Whose: VETERAN        Rel to Insd: PATIENT
    Grp Nm: PROTECTION PLUS   Insd Sex: MALE         Insured: IB,PATIENT 1

[2] Billing Provider Secondary IDs:
    Primary Payer: 670899
    Secondary Payer: XXXXXX1X           Tertiary Payer:

[3] Mailing Address :                      Electronic ID: XXXXID
    NO MAILING ADDRESS HAS BEEN SPECIFIED! (Patient has Medicare)
    Send Bill to PAYER listed above.
<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT: 2
Current Bill Payer Sequence: PRIMARY INSURANCE//
Define Primary Payer ID by Care Unit? No//
Primary Payer ID: 670899//
Define Secondary Payer ID by Care Unit? No//Yes
Division: Main Division//
Care Unit: ??
    1 Anesthesia
    2 Reference Lab
    3 Home Health
Care Unit: 1 Anesthesia
Secondary Payer ID: XXXXXX//
  
```

6.6. Screen 10 – Physician/Provider and Print Information

6.6.1 EDI Fields UB-04/CMS-1500

Section 3/3 – Providers	When a Physician/Provider is entered here, the system finds the appropriate IDs and Taxonomy Codes for him/her. The Primary IDs are the providers' NPIs and their secondary IDs are those IDs that users have defined as the provider's own or as those provided by an insurance company. Claim Level providers may not be required if each Line Item has a provider associated with it.
Section 4 – Other Facility, CLIA#, Mammography Certification Number	These are the sections through which outside facilities are entered. The primary and secondary Laboratory or Facility IDs and Taxonomy Codes are then transmitted with the claim. The CLIA# and Mammography Certification Number can also be sent with a professional laboratory claim or mammography claim.
Section 5/7 – Billing Provider	These sections display the calculated Billing Provider and the Billing Provider's Taxonomy Code. Only the taxonomy code can be edited
Section 6/8 – Force to Print	Users can set this field to force a claim to print locally. Patch IB*2*488 removed the former option to force a Professional or Institutional claim to print at the clearinghouse.
Section 7/9 – Provider ID Maint	This is a link to the Provider ID Maintenance function.

```
IB,PATIENT2    XX-XX-XXXX    BILL#: K300XX - Outpat/UB-04    SCREEN <10>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Bill Remarks
    - FL-80                : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)             : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral          : UNSPECIFIED [NOT REQUIRED]
    Admission Source       : UNSPECIFIED
[2] Pt Reason f/Visit : UNSPECIFIED
[3] Providers :
    - ATTENDING           : UNSPECIFIED
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
[5] Billing Provider   : CHEYENNE VAMC
    Taxonomy Code      : 282N00000X
[6] Force To Print?   : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

```
IB,PATIENT 3    XX-XX-XXXX    BILL#: K600XX - Outpat/1500    SCREEN <10>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To   : UNSPECIFIED [NOT REQUIRED]
[2] ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral       : UNSPECIFIED [NOT REQUIRED]
[3] Providers :
    - RENDERING (MD)    : IB,DOCTOR 1    Taxonomy: UNSPECIFIED
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #          : UNSPECIFIED [NOT REQUIRED]
    Mammography Cert #  : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data  : UNSPECIFIED [NOT REQUIRED]
```

```

[6] Form Locator 19      : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider     : CHEYENNE VAMC
    Taxonomy Code       : 282N00000X
[8] Force To Print?     : NO FORCED PRINT
[9] Provider ID Maint   : (Edit Provider ID information)

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT: 8
FORCE CLAIM TO PRINT: NO FORCED PRINT// ??
    If this field is set to 1, the claim will be printed locally.
    If field is set to 0, the claim will be transmitted
    electronically to the payer.

Choose from:
0          NO FORCED PRINT
1          FORCE LOCAL PRINT
FORCE CLAIM TO PRINT: NO FORCED PRINT//

```



*Note that with Patch IB*2*488, the former option to force a claim to print at the clearinghouse has been removed.*

6.7. UB-04 Claims

The following screens provide a simplified example of a UB-04 claim:

Step	Procedure
1	When processing a UB-04 claim, information on Screens 1 and 2 should be reviewed for correctness. Press the <Enter> key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press the <Enter> key to continue to Screen 5.
	<i>Note: With Patch IB*2*516, users will have the ability to add a one-time HPID, per payer, to a claim if the HPID in the Insurance Company file is not the correct one. The HPID will not be stored in the Insurance Company file. It will only apply to the claim.</i>

```




IB,PATIENT3    XX-XX-XXXX    BILL#: K300XX - Outpat/UB-04    SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type   : REIMBURSABLE INS.          Form Type: UB-04
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer  : Blue Cross Fep             Transmit: Yes

    Ins 1: Blue Cross Fep                     Policy #: RXXXXXXXXX
    Grp #: 100                               Whose: VETERAN      Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY                   Insd Sex: MALE       Insured: IB,PATIENT3

[2] Billing Provider Secondary IDs:
    Primary Payer: 00059001
    Secondary Payer:
[3] Mailing Address :                      Tertiary Payer:
    Blue Cross Fep                               Electronic ID: 12B54
    P O Box 10401
    Birmingham, AL 352020401

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:

```




Step	Procedure
3	On Screen 5, enter sections 1-7 to type in the diagnosis information, the services/procedures provided and the date of service. Include the Admission Type Code, Occurrence, and Condition Code when required. Press the <Enter> key to move to Screen 7.
	<i>Note: With Patch IB*2*516, users will be able to look up Occurrence Codes, Condition Codes, and Value Codes by the external NUBC code numbers.</i>
	<i>Note: After Patch IB*2*477 is installed users can enter a Priority (Type) of Visit to an outpatient, institutional claim. The value will no longer be hard-coded with 9 – Information not available. The default value will be elective. This is a required field.</i>
	<i>Note: A new fatal error message will prevent the authorization of a claim when the Total Charge dollar amount does not equal the sum of the dollar amounts for the line items on the claim.</i>

```

IB,PATIENT3    XX-XX-XXXX    BILL#: K300XX - Outpat/UB-04    SCREEN <5>
=====
                                EVENT - OUTPATIENT INFORMATION
[1] Event Date : XXX XX, XXXX
[2] Prin. Diag.: ABDOM PAIN, L L QUADR - 789.04
   Other Diag.: BENIGN NEOPLASM LG BOWEL - 211.3
   Other Diag.: DIVERTICULOSIS OF COLON - 562.10
[3] OP Visits  : XXX XX, XXXX
   Type       :
[4] Cod. Method: HCPCS
   CPT Code   : LESION REMOVE COLONOSCOPY 45384          XXX XX, XXXX
   CPT Code   : OFFICE/OUTPATIENT VISIT, NEW 99201        XXX XX, XXXX
   CPT Code   : CHEST X-RAY 71010-ET                     XXX XX, XXXX
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : ONSET OF SYMPTOMS/ILLNESS              XXX XX, XXXX
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:

```

Step	Procedure
4	If all information has been entered correctly, Screen 7 will be auto-populated (as shown below) with the necessary information to send the claim electronically. <i>Make sure that the Disch Stat field in Section 1 is populated.</i> Press the <Enter> key to move to Screen 8.
	<i>Note: Allowable dollar amounts have been increased to 9999999.99 before users will be forced to split lines.</i>
	<i>Note: With Patch IB*2*516, new prompts have been added to Screens 4 and 5 to allow users to enter NDCs and Units to non-RX procedures for medications administered in an outpatient setting. With Patch IB*2*577, users will gain the ability to define the type of Units. They will no longer default to Units. The new choices are: International Unit; Gram; Milligram; Milliliter or Unit.</i>
	<i>Note: With Patch IB*2*516, new prompts have been added to Screens 4 and 5 to allow users to enter 80 character descriptions to CPT/HCPCS procedure codes for services Not Otherwise Classified.</i>



```

IB,PATIENT3    XX-XX-XXXX    BILL#: K300XX - Outpat/UB-04    SCREEN <7>
=====
                                BILLING - GENERAL INFORMATION
[1] Bill Type   : 131                      Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
   Charge Type  : INSTITUTIONAL            Disch Stat: DISCHARGED TO HOME OR SELF CAR

```


Form Type	: UB-04	Timeframe:	ADMIT THRU DISCHARGE
Bill Classif:	OUTPATIENT	Division:	CHEYENNE VAMROC
[2] Sensitive?	: UNSPECIFIED	Assignment:	YES
[3] Bill From	: XXX XX, XXXX	Bill To:	XXX XX, XXXX
[4] OP Visits	: XXX XX, XXXX		
[5] Rev. Code	: 750-GASTR-INST SVS	45384	\$2,137.44 OUTPATIENT VISIT
Rev. Code	: 324-DX X-RAY/CHEST	71010	\$225.53 OUTPATIENT VISIT
Rev. Code	: 510-CLINIC	99201	\$108.92 OUTPATIENT VISIT
OFFSET	: \$0.00	[NO OFFSET RECORDED]	
BILL TOTAL	: \$2,471.89		
[6] Rate Sched	: (re-calculate charges)		
[7] Prior Claims:	UNSPECIFIED		

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:

Step	Procedure
	<i>Note: After Patch IB*2*432, it will no longer be possible to authorize a Sensitive claim unless users indicated that a Release of Information has been completed.</i>
5	On Screens 8 and 9, enter any necessary Claim level data to the claim.
	<i>Note: IB*2*447 moved Screen 8, Section 3 Ambulance Information to a new Screen 9.</i>

IB,PATIENT MRA	XX-XX-XXXX	BILL#: K20003D - Inpat/UB04	SCREEN <8>
=====			
BILLING - CLAIM INFORMATION			
[1] COB Non-Covered Charge Amt:			
[2] Property Casualty Information			
Claim Number:		Contact Name:	
Date of 1st Contact:		Contact Phone:	
[3] Surgical Codes for Anesthesia Claims			
Primary Code:		Secondary Code:	
[4] Paperwork Attachment Information			
Report Type: NN		Transmission Method: XX	
Attachment Control #: 1234890701			
[5] Disability Start Date:		Disability End Date:	
[6] Assumed Care Date:		Relinquished Care Date:	

<RET> to CONTINUE '^N' for screen N, or '^' to QUIT:

	<i>Note: For Worker's Compensation Claims Only (Rate Type = Worker's Comp.): The Paperwork Attachment Information will now AUTOMATICALLY print in CMS-1500 Box 19, in the following format: PWKNNFX1234890701.</i>
---	--




IB,PATIENT F	BILL#: K10001D - Outpat/1500	SCREEN <9>
=====		
AMBULANCE INFORMATION		
[1] Ambulance Transport Data		
P/U Address1:		D/O Location:
P/U Address2:		D/O Address1:
P/U City:		D/O Address2:
P/U State/Zip:		D/O City:
Patient Weight: 195		D/O State/Zip:
Transport Reason: Patient was transported to nearest facility for care of symptoms, complaints or both.		Transport Distance: 200
R/T Purpose: Patient fell and sustained possible injuries to neck		
Stretcher Purpose: Patient unable to walk due to possible injuries to		


```

neck
[2] Ambulance Certification Data
    Condition Indicator: 01 - Admitted to hospital
                        04 - Moved by stretcher
                        06 - Transported in emergency situation
                        08 - Visible hemorrhaging
                        09 - Medically necessary service

<RET> to CONTINUE '^N' for screen N, or '^' to QUIT:

```

Step	Procedure
6	On Screen 10, enter 3 to enter the name of the Attending Physician. The claim level attending is still required. An outpatient UB-04 claim can also contain a line-level or claim level Referring, Operating and/or Other Operating Physician(s).
	<i>Remember: Patch IB*2*432 will make it possible to enter and transmit Line Level providers. Line Level and Claim Level providers should not be the same. Claim Level providers apply to the entire claim. Line Level providers are exceptions.</i>
	<i>Note: With Patch IB*2*432, users cannot authorize a claim which has an Other Operating Physician unless there is an Operating Physician on the claim.</i>
	<i>Note: Patch IB*2*432 will make it possible to enter a Referral Number for each payer on the claim.</i>

```





IB,PATIENT3    XX-XX-XXXX    BILL#: K300XX - Outpat/UB-04    SCREEN <10>
=====

                                BILLING - SPECIFIC INFORMATION

[1] Bill Remarks
    - FL-80                : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)             : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral          : UNSPECIFIED [NOT REQUIRED]
    Admission Source       : UNSPECIFIED
[2] Pt Reason f/Visit      : UNSPECIFIED
[3] Providers              :
    - ATTENDING            : UNSPECIFIED
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
[5] Billing Provider       : CHEYENNE VAMC
    Taxonomy Code          : 282N00000X
[6] Alt Prim Payer ID     : P: ALTIDHOSPICE123
[7] Force To Print?       : NO FORCED PRINT
[8] Provider ID Maint     : (Edit Provider ID information)

<RET> to CONTINUE, 1-8 to EDIT, '^N' for screen N, or '^' to QUIT:

```

	<i>The Primary ID (NPI) for the Attending, Operating or Other Operating Physician is always transmitted with a claim.</i>
	<i>The Secondary IDs for the Attending, Operating or Other Operating Physician are determined from what the user enters and from entries in Provider ID Maintenance.</i>
	<i>If users have set a default ID type and made it required for the current or other payers, the claim cannot be authorized if the physician does not have an ID of that type defined.</i>
	<i>Note: A fatal error message will prevent users from authorizing an adjustment claim, Type of Bill Frequency Code of 7 or 8, in which the destination payer (primary/secondary/tertiary) individual control number (ICN/DCN) is not present</i>



*Patch IB*2*547 added a field to Screen 10 for alternative payer primary IDs which are used to direct claims to administrative contractors who process specialized claims such as Durable Medical Equipment (DME) claims. Unless an alternative ID is added to the claim by the billing clerk, the regular EDI – Primary Payer ID will be sent with a claim.*

When a provider is first added to Screen 10, the user will be shown a screen that contains a list of all the provider's IDs, the ID type and, optionally, the care unit on file for the provider's IDs. This will include the provider's own IDs, the provider's IDs assigned by the insurance company, the insurance company defaults, if any, and all IDs assigned to the provider by care unit.

The first 2 entries in this list will always be:

- 1 - NO SECONDARY ID NEEDED
- 2 - ADD AN ID FOR THIS CLAIM ONLY



Any ID entered on Screen 10 will automatically override any default provider secondary ID that exists for the same ID Qualifier for this claim ONLY.

```

**** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS CA (WY)
PROVIDER: IB,PHYSICIAN4 (ATTENDING)

INS. COMPANY'S DEFAULT SECONDARY ID TYPE IS: BLUE CROSS ID

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

1 - NO SECONDARY ID NEEDED
2 - ADD AN ID FOR THIS CLAIM ONLY
3 - <DEFAULT> XXXXBCROSS          BLUE CROSS ID
4 - WYXXXX                      ST LIC (WY)

Selection: 3//

```

If there is a default secondary ID found, based on the insurance company parameters and the Provider ID is defined in the Provider ID Maintenance, this will be the 3rd entry in the list and will be preceded with the text <DEFAULT>. If this ID exists, the default for the Selection prompt will be **3**.

If no default ID exists, the default for the selection prompt will be **1** – No Secondary ID needed.

Any care units assigned to an ID using Provider ID Maintenance are displayed at the far right of the ID line. You no longer have to enter a care unit on the bill.

You can make a selection from the list by choosing the number preceding the ID you want to assign to the provider for the bill. This will add both the ID Qualifier and the ID number to the claim.



Note: If the Provider has multiple IDs defined, the one you select or the new one time only ID that you enter, will appear on Screen 10 and will be the first ID sent but the system will still transmit the remaining IDs. The one you select will just be the first one transmitted. The maximum number that will be transmitted is five.



*Note: With Patch IB*2*432, IDs for Line Level providers are determined in the same manner as Claim Level Providers.*

If none of the IDs are valid for the provider for the claim, you can add a new ID *for this claim only*.

Step	Procedure
7	At the Selection prompt, type 2 to add an ID for this claim only.
8	At the PRIM INS PERF PROV SECONDARY ID TYPE: prompt, enter the ID Qualifier that the primary payer requires as a secondary ID type. Type two question marks (??) to see the list of possible choices. (For this example, type Location Number as the secondary ID Qualifier).
9	At the PRIM INS PERF PROV SECONDARY ID: prompt, enter the ID number provided by the payer. In this example, type XXXXA .

```

Selection: 3// 2
PRIM INS PERF PROV SECONDARY ID TYPE: ??
Choose from:
BLUE CROSS ID
BLUE SHIELD ID
COMMERCIAL ID
LOCATION NUMBER
MEDICARE PART A
MEDICARE PART B

PRIM INS PERF PROV SECONDARY ID TYPE: LOCATION NUMBER
PRIM INS PERF PROV SECONDARY ID: XXXXA

```

After an ID and ID Qualifier are added to the claim for a provider, the provider's name and the selected ID are displayed on Screen 10. These fields can be edited/deleted.

If a physician/provider is deleted, the next time the provider entry is accessed, the list of valid IDs will be displayed again.

Valid Secondary ID Types for Current Payer	
Attending/Referring/Operating/Other Operating (UB-04)	State License; Blue Cross; Blue Shield; Medicare Part A; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider
Rendering/Referring/Supervising (1500)	State License; Blue Shield; Medicare Part B; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider

Valid Secondary ID Types for Other Payer (Not Current)	
Attending/Operating/Other (UB-04)	Blue Cross; Blue Shield; Medicare; Commercial ID; Location Number
Rendering (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Referring (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Supervising (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Network ID

Step	Procedure
10	At the <RET> to Continue: prompt (any screen), enter ?PRV to see summary information about a particular provider.

```

IB,PATIENT3    XX-XX-XXXX    BILL#: K300XX - Outpat/UB-04    SCREEN <10>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Bill Remarks
    - FL-80                : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)             : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral          : UNSPECIFIED [NOT REQUIRED]
    Admission Source       : PHYSICIAN REFERRAL
[2] Pt Reason f/Visit    : COUGH - 786.2
[3] Providers            :
    - ATTENDING (MD)      : IB,DOCTOR4          Taxonomy: 208G00000X (33)
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
[5] Billing Provider      : CHEYENNE VAMC
    Taxonomy Code         : 282N00000X
[6] Force To Print?      : NO FORCED PRINT
[7] Provider ID Maint    : (Edit Provider ID information)

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?PRV
(V)A or (N)on-VA Provider: V// A PROVIDER

This is a display of provider specific information.
This bill is UB-04/Outpatient

This is a display of provider specific information.
This bill is UB-04/Outpatient

The valid provider functions for this bill are:
1  REFERRING             SITUATIONAL - ALREADY ON BILL
2  OPERATING             SITUATIONAL - NOT ON BILL
3  RENDERING             SITUATIONAL - ALREADY ON BILL
4  ATTENDING             REQUIRED - ALREADY ON BILL
9  OTHER OPERATING       OPTIONAL - NOT ON BILL

Select PROVIDER NAME: IB,Doctor RAD          PI
-----
Signature Name: DOCTOR RAD IB
Signature Title:
Degree: MD
NPI: 1112220037

License(s): WY: 1289340B

Person Class: V183001
PROVIDER TYPE: Allopathic and Osteopathic Physicians
CLASSIFICATION: Radiology
SPECIALIZATION: Body Imaging
TAXONOMY: 2085B0100X (888)
EFFECTIVE: 6/7/10

RC Provider Group: None
-----
Select PROVIDER NAME:

```

Step	Procedure
11	At the <RET> to Continue: prompt (any screen), enter ?ID to see what IDs will be transmitted with the claim.

```

IB,PATIENT3    XX-XX-XXXX    BILL#: K300XX - Outpat/UB-04    SCREEN <10>
=====

```

BILLING - SPECIFIC INFORMATION	
[1] Bill Remarks	
- FL-80	: UNSPECIFIED [NOT REQUIRED]
ICN/DCN(s)	: UNSPECIFIED [NOT REQUIRED]
Auth/Referral	: UNSPECIFIED [NOT REQUIRED]
Admission Source	: PHYSICIAN REFERRAL
[2] Pt Reason f/Visit	: COUGH - 786.2
[3] Providers	:
- REFERRING (MD)	: IB,DOCTOR GP Taxonomy: 208G00000X (33)
	[P]VAD000 [S]830168494
- RENDERING (MD)	: IB,DOCTOR CARD Taxonomy: 207RA0000X (33)
	[P]VAD000 [S]830168494
- ATTENDING (MD)	: IB,DOCTOR4 Taxonomy: 207XS0106X (40)
	[P]VAD000 [S]830168494
[4] Other Facility (VA/non):	UNSPECIFIED [NOT REQUIRED]
[5] Billing Provider	: CHEYENNE VAMC
Taxonomy Code	: 282N00000X
[6] Force To Print?	: NO FORCED PRINT
[7] Provider ID Maint	: (Edit Provider ID information)
 <RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?ID	
If this bill is transmitted electronically, the following IDs will be sent:	
Primary Ins Co:	BLUE CROSS CA (WY) <<<Current Ins
Secondary Ins Co:	AETNA US HEALTHCARE
Provider IDs: (VistA Records OP1,OP2,OP4,OP8,OP9,OPR2,OPR3,OPR4,OPR5,OPR8):	
ATTENDING: IB,DOCTOR4	
NPI:	8731245386
Secondary IDs	
(P) BLUE CROSS	VAD000
REFERRING: IB,DOCTOR GP	
NPI:	8731245394
(P) BLUE CROSS	VAD000
RENDERING: IB,DOCTOR CARD	
NPI:	1112220029
(P) BLUE CROSS	VAD000
Billing Provider Name and ID Information	
Billing Provider:	CHEYENNE VAMC
Billing Provider NPI:	1164471991
Billing Provider Tax ID (VistA Record PRV):	830168494
Billing Provider Secondary IDs (VistA Record CI1A):	
(P) PROVIDER SITE NUMBER	0000 <<<System Generated ID
(P) BLUE CROSS	007484
Service Line Providers	
Service Line:	3
RENDERING: IB,DOCTOR RAD	
NPI:	1112220037
(P) BLUE CROSS	VAD000
(P) EIN	022221111
(P) STATE LICENSE	1289340B
Press ENTER to continue	

Step	Procedure
12	Press the <Enter> key to move through the fields. At the Want To Authorize Bill At This Time?: and Authorize Bill Generation?: prompts, enter Yes . The claim is now complete and will be transmitted to the FSC in Austin at the next regularly scheduled transmission time.

WANT TO EDIT SCREENS? NO// <ENTER>
WANT TO AUTHORIZE BILL AT THIS TIME? No// **YES**

AUTHORIZE BILL GENERATION?: **YES**

Adding bill to BILL TRANSMISSION File.

Bill will be submitted electronically


Passing completed Bill to Accounts Receivable. Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

This Bill Can Not Be Printed Until Transmit Confirmed

This Outpatient INSTITUTIONAL bill may have corresponding PROFESSIONAL charges.

6.8. CMS-1500 Claims

The following screens provide a simplified example of a CMS-1500 claim.

Step	Procedure
1	When processing a CMS-1500 claim, information on Screens 1 and 2 should be reviewed for correctness. Press the <Enter> key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press the <Enter> key to continue to Screen 4.
	<i>Note: With Patch IB*2*516, users will have the ability to add a one-time HPID, per payer, to a claim if the HPID in the Insurance Company file is not the correct one. The HPID will not be stored in the Insurance Company file. It will only apply to the claim.</i>



```
IB,PATIENT3    XX-XX-XXXX    BILL#: K300XX - Inpat/1500    SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type   : REIMBURSABLE INS.                Form Type: CMS 1500
    Responsible: INSURER                          Payer Sequence: Primary
    Bill Payer  : Blue Cross Fep                   Transmit: Yes

    Ins 1: Blue Cross Fep                          Policy #: R00000000
    Grp #: 100                                     Whose: VETERAN
    Grp Nm: STANDARD FAMILY   Insd Sex: MALE        Rel to Insd: PATIENT
                                                Insured: IB,PATIENT3

[2] Billing Provider Secondary IDs:
    Primary   : 010100
    Secondary:                                     Tertiary :

[3] Mailing Address :                               Electronic ID: 12B54
    Blue Cross Fep
    P O Box 10401
    Birmingham, AL 352020401

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
3	Specify the correct diagnosis and procedure code(s) that must be on this claim. Press the <Enter> key to move to Screen 6.
	<i>Note: With Patch IB*2*516, users will have the ability to re-sequence diagnosis codes that have been linked to a specific procedure without breaking the link.</i>
	<i>Note: With Patch IB*2*516, new prompts have been added to Screens 4 and 5 to allow users to enter NDCs and Units to non-RX procedures for medications administered in an outpatient setting. With Patch IB*2*577, users can also select the type of units.</i>








*Note: With Patch IB*2*516, new prompts have been added to Screens 4 and 5 to allow users to enter 80 character descriptions to CPT/HCPCS procedure codes for services Not Otherwise Classified.*

```

IB,PATIENT3    XX-XX-XXXX    BILL#: K300XX - Outpat/1500    SCREEN <5>
=====
EVENT - OUTPATIENT INFORMATION
<1> Event Date : OCT 12, 2010
[2] Prin. Diag.: ACUTE BRONCHITIS - 466.0
    Other Diag.: DMI WO CMP NT ST UNCNTRL - 250.01
[3] OP Visits  : OCT 12,2010,
[4] Cod. Method: HCPCS
    CPT Code   : CHEST X-RAY 71010-26                466.0    OCT 12, 2010
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
<9> Value Code : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:

```



Step	Procedure
4	Verify that the Form Type is CMS-1500 and that the date of billing is entered. Make sure the Disch Stat field is populated. If all the data have been entered correctly, section 5 should display the correct revenue codes and costs. Press the <Enter> key to move to Screen 8.
	<i>Note: There is a new non-fatal Warning message when a claim contains a Revenue code(s) which generates a zero dollar amount charge.</i>
	<i>Note: After Patch IB*2*432, it will no longer be possible to authorize a Sensitive claim unless users indicated that a Release of Information has been completed.</i>
	<i>Note: After Patch IB*2*432, Section 1 of screens 6/7 will no longer have fields for Covered, non-Covered or Co-insurance Days. This information will need to be added to a claim using Condition Codes.</i>
	<i>Note: Allowable dollar amounts have been increased to 9999999.99 before users will be forced to split lines.</i>
	<i>Note: After Patch IB*2*432, it will be possible to add line-level Additional OB Minutes to an anesthesia claim for an Obstetric procedure that requires more than the normal amount of minutes.</i>

```

IB,PATIENT3    XX-XX-XXXX    BILL#: K300XX - Outpat/1500    SCREEN <7>
=====
                                BILLING - GENERAL INFORMATION
[1] Bill Type   : 131                      Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Charge Type : PROFESSIONAL              Disch Stat: DISCHARGED TO HOME OR SELF CAR
    Form Type   : CMS-1500                  Timeframe: ADMIT THRU DISCHARGE
    Bill Classif: OUTPATIENT                 Division: CHEYENNE VAMROC
[2] Sensitive?  : NO                        Assignment: YES
[3] Bill From   : OCT 12, 2010              Bill To: OCT 13, 2010
[4] OP Visits   : OCT 12,2010,
[5] Rev. Code   : 324-DX X-RAY/CHEST        71010                $45.30  OUTPATIENT VISIT
    OFFSET      : $0.00 [NO OFFSET RECORDED]
    BILL TOTAL  : $45.30
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:

```

Step	Procedure
5	On Screens 8 and 9, enter any necessary Claim level data to the claim.
	<i>Note: IB*2*447 moved Screen 8, Section 3 Ambulance Information to a new Screen 9.</i>
	<i>Note: IB*2*448 moved Screen 10</i>

```

IB,PATIENT MRA   XX-XX-XXXX   BILL#: K20003D - Outpat/1500   SCREEN <8>
=====
                        BILLING - CLAIM INFORMATION
[1] COB Non-Covered Charge Amt:
[2] Property Casualty Information
    Claim Number:                Contact Name:
    Date of 1st Contact:         Contact Phone:
[3] Surgical Codes for Anesthesia Claims
    Primary Code:                Secondary Code:
[4] Paperwork Attachment Information
    Report Type:                Transmission Method:
    Attachment Control #:
[5] Disability Start Date:       Disability End Date:
[6] Assumed Care Date:         Relinquished Care Date:
[7] Special Program:??
    This is the Special Program with which a claim is associated. Refer to
    MEDICARE regulations to decide when to use this field.



    Choose from:
    01      EPSDT/CHAP
    02      Phys Handicapped Children Program
    03      Special Fed Funding
    05      Disability
    07      Induced Abortion - Danger to Life
    08      Induced Abortion - Rape or Incest
    09      2nd Opinion/Surgery
Special Program:
[8] Homebound: ??
    This is to indicate that the patient is homebound or
    institutionalized. Refer to MEDICARE regulations on when to
    use this field.

    Choose from:
    0      NO
    1      YES
Homebound:
[9] Date Last Seen:??
    This is the date a patient was last seen. Refer to MEDICARE
    regulations on when to use this field.

Date Last Seen:

<RET> to CONTINUE '^N' for screen N, or '^' to QUIT:

```

	<i>Note: IB*2*488 moved the following Screen 10 fields to Screen 8: Special Program; Date Last Seen; Homebound. These fields no longer print in Box 19.</i>
	<i>Note: The prompts on Screen 8 are smart prompts, available for the correct form type.</i>

IB,PATIENT MRA XX-XX-XXXX BILL#: K20003E - Outpat/1500 SCREEN <9>

=====

AMBULANCE INFORMATION

[1] Ambulance Transport Data

P/U Address1:	D/O Location:
P/U Address2:	D/O Address1:
P/U City:	D/O Address2:
P/U State/Zip:	D/O City:
Patient Weight:	D/O State/Zip:
Transport Reason:	Transport Distance:
R/T Purpose:	
Stretcher Purpose:	

[2] Ambulance Certification Data

Condition Indicator: 12 - Confined to a bed or chair
 01 - Admitted to hospital

<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: 1

P/U Address1:
P/U Address 2:
P/U City:
P/U State:
P/U Zip:
D/O Location:
D/O Address1:
D/O Address2:
D/O City:
D/O State:
D/O Zip:
Patient Weight:
Transport Distance:
Transport Reason:
R/T Purpose:
Stretcher Purpose:

<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: 2

Select Ambulance Condition Indicator: 01// ?

Answer with AMBULANCE CONDITION INDICATOR

Choose from:

12
01



You may enter a new AMBULANCE CONDITION INDICATOR, if you wish
Select an Ambulance Condition Indicator. Answer must be 1-2
characters in length.
This limits the entry to five condition indicators.

Answer with AMBULANCE CONDITION INDICATORS CODE

Choose from:

12	Confined to a bed or chair
01	Admitted to hospital
04	Moved by stretcher
05	Unconscious or in Shock
06	Transported in emergency situation
07	Had to be physically restrained
08	Visible hemorrhaging
09	Medically necessary service

Select Ambulance Condition Indicator: 01//




Step	Procedure
6	From Screen 10, select section 3 to enter the name of the Rendering Provider if necessary. Enter a Referring Provider and/or Supervising Provider if required by the payer for the procedure codes on the claim.
	<i>Remember: Patch IB*2*432 will make it possible to enter and transmit Line Level providers. Line Level and Claim Level providers should not be the same. Claim Level providers apply to the entire claim. Line Level providers are exceptions.</i>
	<i>Note: After Patch IB*2*432, it will no longer be possible to authorize a Sensitive claim unless users indicate that a Release of Information has been completed.</i>

```

IB,PATIENT3    XX-XX-XXXX    BILL#: K300XX - Outpat/1500 SCREEN <10>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To   : UNSPECIFIED [NOT REQUIRED]
[2] ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)    : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
    - RENDERING (MD)    : IB,DOCTOR4          Taxonomy: 000000000X
                        [P]XXXXBCROSS
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #          : UNSPECIFIED [NOT REQUIRED]
    Mammography Cert #  : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data   : UNSPECIFIED [NOT REQUIRED]
[6] Form Locator 19     : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider    : CHEYENNE VAMC
    Taxonomy Code       : 282N00000X
[8] Force To Print?    : NO FORCED PRINT
[9] Provider ID Maint   : (Edit Provider ID information)

<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:


```

	<i>The Primary ID (NPI) for the Attending, Operating or Other Physician is always transmitted with a claim.</i>
	<i>The Secondary IDs for the Attending, Operating or Other Physician are determined from what the user enters and from entries in Provider ID Maintenance.</i>
	<i>If users have set a default ID type and made it required for the current or other payer, the claim cannot be authorized if the physician does not have an ID of that type defined.</i>

When a provider is first added to Screen 10, the user will be shown a screen that contains a list of all the provider's IDs, the ID type and, optionally, the care unit on file for the provider's IDs. This will include the provider's own IDs, the provider's IDs assigned by the insurance company, the insurance company defaults, if any, and all IDs assigned to the provider by care unit.

The first 2 entries in this list will always be:

- 1 - NO SECONDARY ID NEEDED
- 2 - ADD AN ID FOR THIS CLAIM ONLY

	<i>Any ID entered on Screen 10 will automatically override any default provider secondary ID that exists for the same ID Qualifier for this claim ONLY.</i>
---	---

```

**** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS CA (WY)
PROVIDER: IB,PHYSICIAN4 (ATTENDING)

INS. COMPANY'S DEFAULT SECONDARY ID TYPE IS: BLUE SHIELD ID

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

1 - NO SECONDARY ID NEEDED
2 - ADD AN ID FOR THIS CLAIM ONLY
3 - <DEFAULT> XXXXBSHIELD          BLUE SHIELD ID
4 - WYXXXX                        ST LIC (WY)

Selection: 3//


```

If there is a default secondary ID found, based on the insurance company parameters and the Provider ID is defined in the Provider ID Maintenance, this will be the 3rd entry in the list and will be preceded with the text <DEFAULT>. If this ID exists, the default for the Selection prompt will be **3**.

If no default ID exists, the default for the selection prompt will be **1** – No Secondary ID needed.

Any care units assigned to an ID using Provider ID Maintenance are displayed at the far right of the ID line. You no longer have to enter a care unit on the bill.

You can make a selection from the list by choosing the number preceding the ID you want to assign to the provider for the bill. This will add both the ID Qualifier and the ID number to the claim.



Note: If the Provider has multiple IDs defined, the one you select or the new one time only ID that you enter, will appear on Screen 10 and will be the first ID sent but the system will still transmit the remaining IDs. The one you select will just be the first one transmitted. The maximum number that will be transmitted is five.

If none of the IDs are valid for the provider for the claim, you can add a new ID *for this claim only*.

Step	Procedure
7	At the Selection prompt, type 2 to add an ID for this claim only.
8	At the PRIM INS PERF PROV SECONDARY ID TYPE: prompt, enter the ID Qualifier that the primary payer requires as a secondary ID type. Type two question marks (??) to see the list of possible choices. (For this example, type Location Number as the secondary ID Qualifier).
9	At the PRIM INS PERF PROV SECONDARY ID: prompt, enter the ID number provided by the payer. In this example, type XXXXA .

```

Selection: 3// 2
PRIM INS PERF PROV SECONDARY ID TYPE: ??
Choose from:
BLUE CROSS ID
BLUE SHIELD ID
COMMERCIAL ID
LOCATION NUMBER
MEDICARE PART A
MEDICARE PART B

```

PRIM INS PERF PROV SECONDARY ID TYPE: **LOCATION NUMBER**
 PRIM INS PERF PROV SECONDARY ID: **XXXXA**

After an ID and ID Qualifier are added to the claim for a provider, the provider's name and the selected ID are displayed on Screen 8. These fields can be edited/deleted.

If a physician/provider is deleted, the next time the provider entry is accessed, the list of valid IDs will be displayed again.

Valid Secondary ID Types for Current Payer	
Attending/Operating/Other (UB-04)	State License; Blue Cross; Blue Shield; Medicare Part A; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider
Rendering/Referring/Supervising (1500)	State License; Blue Shield; Medicare Part B; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider

Valid Secondary ID Types for Other Payer (Not Current)	
Attending/Operating/Other (UB-04)	Blue Cross; Blue Shield; Medicare Part A and Part B; UPIN; TRICARE; Commercial ID; Location Number
Rendering (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Referring (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Supervising (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Network ID

Step	Procedure
10	At the <RET> to Continue: prompt (any screen), enter ?PRV to see summary information about a particular provider.

```

IB,PATIENT3   XX-XX-XXXX   BILL#: K300XX - Outpat/UB04   SCREEN <10>
=====
                                BILLING - SPECIFIC INFORMATION
[1] Bill Remarks
    - FL-80           : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)        : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral      : UNSPECIFIED [NOT REQUIRED]
    Admission Source   : PHYSICIAN REFERRAL
[3] Providers        :
    - RENDERING (MD)  : IB,DOCTOR4           Taxonomy: 390200000X
                                [P]XXXXBCROSS
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED [NOT REQUIRED]
    Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data  : UNSPECIFIED [NOT REQUIRED]
[6] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider    : MONTGOMERY VAMC
    Taxonomy Code      : 282N00000X
[8] Force To Print?    : NO FORCED PRINT
  
```

```

[9] Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?PRV
(V)A or (N)on-VA Provider: V// NON-VA PROVIDER

Select NON-VA PROVIDER NAME: IB,OUTSIDEDOC OI
-----
Signature Name: OUTSIDEDOC IB
NPI: 1234567892

License(s): None Active on X/X/XX

Person Class: V115500
PROVIDER TYPE: Allopathic and Osteopathic Physicians
CLASSIFICATION: Resident, Allopathic (includes Interns, Residents, Fellows)
SPECIALIZATION:
TAXONOMY: 390200000X (144)
-----
Select NON-VA PROVIDER NAME:

```

Step	Procedure
11	At the <RET> to Continue: prompt (any screen), enter ?ID to see what IDs will be transmitted with the claim.

```

IB,PATIENT3   XX-XX-XXXX   BILL#: K300XX - Outpat/UB04   SCREEN <10>
=====
BILLING - SPECIFIC INFORMATION
[1] Bill Remarks
    - FL-80 : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s) : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral : UNSPECIFIED [NOT REQUIRED]
    Admission Source : PHYSICIAN REFERRAL
[3] Providers :
    - RENDERING (MD) : IB,DOCTOR4 Taxonomy: 000000000X
                          [P]XXXXBCROSS
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA # : UNSPECIFIED [NOT REQUIRED]
    Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data : UNSPECIFIED [NOT REQUIRED]
[6] Form Locator 19 : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider : MONTGOMERY VAMC
    Taxonomy Code : 282N00000X
[8] Force To Print? : NO FORCED PRINT
[9] Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?ID

IF THIS BILL IS TRANSMITTED ELECTRONICALLY, THE FOLLOWING IDS WILL BE SENT:
PRIMARY INS CO: BLUE CROSS CA (WY) <<<Current Ins
SECONDARY INS CO: TPM TRUST

PROVIDER IDs: (VISTA RECORDS OP1,OP2,OP4,OP8,OP9,OPR2,OPR3,OPR4,OPR5,OPR8):
ATTENDING/RENDERING: IB,DOCTOR 4
NPI: 000000000X
SSN: XXXXXXXXXX

```

SECONDARY IDs	
(P) LOCATION NUMBER	XXXXA
(P) BLUE CROSS ID	XXXXBCROSS
(P) ST LIC (WY)	WYXXXX

Step	Procedure
12	Press the <Enter> key to move through the fields. At the Want To Authorize Bill At This Time?: and Authorize Bill Generation?: prompts, enter Yes . The claim is now complete and will be transmitted to the FSC at the next regularly scheduled transmission time.

```

Executing A/R edits
No A/R errors found

WANT TO EDIT SCREENS? NO//

THIS BILL WILL BE TRANSMITTED ELECTRONICALLY

WANT TO AUTHORIZE BILL AT THIS TIME? No// YES
AUTHORIZE BILL GENERATION?: YES
Adding bill to BILL TRANSMISSION File.

Bill will be submitted electronically
Passing completed Bill to Accounts Receivable. Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.


This Bill Can Not Be Printed Until Transmit Confirmed

```

6.9. Lab Claims

EDI Enhanced HIPAA format allows users to enter a CLIA# when billing for certain laboratory procedures. The VA's CLIA # must be entered on Screen 8 when billing a Medicare secondary payer for laboratory and pathology procedures that are not reimbursed in full by Medicare.

The following screens provide a simplified example of a lab claim:

Step	Procedure
1	When processing a Laboratory claim, information on Screens 1 and 2 should be reviewed for correctness. Press the <Enter> key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press the <Enter> key to continue to Screen 5.
	<i>Note: With Patch IB*2*516, users will have the ability to add a one-time HPID, per payer, to a claim if the HPID in the Insurance Company file is not the correct one. The HPID will not be stored in the Insurance Company file. It will only apply to the claim.</i>

```

IB,PATIENT3   XX-XX-XXXX   BILL#: K300XX - Outpat/1500   SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type   : REIMBURSABLE INS.           Form Type: CMS 1500
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer  : Blue Cross Fep              Transmit: Yes

    Ins 1: Blue Cross Fep                     Policy #: R00000000
    Grp #: 100                               Whose: VETERAN      Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY                   Insd Sex: MALE        Insured: IB,PATIENT3

```

[2] Billing Provider Secondary IDs:

Primary : 010100

Secondary:

Tertiary :

[3] Mailing Address :

Blue Cross Fep

P O Box 10401

Birmingham, AL 352020401

Electronic ID: 12B54

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:

Step	Procedure
3	Specify the correct diagnosis and procedure code(s) that must be on this claim. Press the <Enter> key to move to Screen 7.

IB,PATIENT3 XX-XX-XXXX BILL#: K300XX - Outpat/1500 SCREEN <5>

=====

EVENT - OUTPATIENT INFORMATION

[1] Event Date : XX XX,XXXX

[2] Prin. Diag.: URINARY FREQUENCY - 788.41

[3] OP Visits : XXX XX,XXXX

[4] Cod. Method: HCPCS

CPT Code : URINALYSIS, AUTO W/SCOPE 81001 XXX XX,XXXX

CPT Code : URINE BACTERIA CULTURE 87088 XXX XX,XXXX

[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]

[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]

[7] Occ. Code : UNSPECIFIED [NOT REQUIRED]

[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]

[9] Value Code : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:

Step	Procedure
4	Verify that the Form Type is CMS-1500 and that the date of billing is entered. Make sure the Disch Stat field is populated. If all the data have been entered correctly, section 5 should display the correct revenue codes and costs. Press the <Enter> key to move to Screen 8.

IB,PATIENT3 XX-XX-XXXX BILL#: K300XX - Outpat/1500 SCREEN <7>

=====

BILLING - GENERAL INFORMATION

[1] Bill Type : 131

Loc. of Care: HOSPITAL - INPT OR OPT (INCLU

Charge Type : PROFESSIONAL

Disch Stat: DISCHARGED TO HOME OR SELF CAR

Form Type : CMS-1500

Timeframe: ADMIT THRU DISCHARGE

Bill Classif: OUTPATIENT

Division: CHEYENNE VAMROCY VAMC

[2] Sensitive? : UNSPECIFIED

Assignment: YES

[3] Bill From : XXX XX,XXXX

Bill To: XXX XX,XXXX

[4] OP Visits : XXX XX,XXXX

[5] Rev. Code : 306-LAB/BACT-MICRO 87088 \$33.20 OUTPATIENT VISIT

Rev. Code : 307-GASTR-INST SVS 81001 \$12.77 OUTPATIENT VISIT


OFFSET : \$0.00 [NO OFFSET RECORDED]

BILL TOTAL : \$45.97

[6] Rate Sched : (re-calculate charges)

[7] Prior Claims: UNSPECIFIED

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:


Step	Procedure
5	On Screens 8 and 9, enter any necessary Claim level data to the claim and press the ENTER key to move to Screen 10.
	<i>Note: IB*2*447 moved Screen 8, Section 3 Ambulance Information to a new Screen 9.</i>

```

IB,PATIENT MRA   XX-XX-XXXX   BILL#: K20003D - Outpat/1500   SCREEN <8>
=====
                                BILLING - CLAIM INFORMATION
[1] COB Non-Covered Charge Amt:
[2] Property Casualty Information
    Claim Number:                      Contact Name:
    Date of 1st Contact:                Contact Phone:
[3] Surgical Codes for Anesthesia Claims
    Primary Code:                      Secondary Code:
[4] Paperwork Attachment Information
    Report Type:                      Transmission Method:
    Attachment Control #:
[5] Disability Start Date:             Disability End Date:
[6] Assumed Care Date:               Relinquished Care Date:
[7] Special Program:
[8] Homebound:
[9] Date Last Seen:

<RET> to CONTINUE '^N' for screen N, or '^' to QUIT:

```

 *Note: IB*2*488 moved the following Screen 10 fields to Screen 8: Special Program; Date Last Seen; Homebound. These fields no longer print in Box 19.*

```

IB,PATIENT MRA   XX-XX-XXXX   BILL#: K20003E - Outpat/1500   SCREEN <9>
=====
                                AMBULANCE INFORMATION
[1] Ambulance Transport Data
    P/U Address1:                      D/O Location:
    P/U Address2:                      D/O Address1:
    P/U City:                          D/O Address2:
    P/U State/Zip:                     D/O City:
    Patient Weight:                    D/O State/Zip:
    Transport Reason:                  Transport Distance:
    R/T Purpose:
    Stretcher Purpose:
[2] Ambulance Certification Data
    Condition Indicator: 12 - Confined to a bed or chair
                        01 - Admitted to hospital

<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: 1
P/U Address1:
P/U Address 2:
P/U City:
P/U State:
P/U Zip:
D/O Location:
D/O Address1:
D/O Address2:
D/O City:
D/O State:

```





D/O Zip:
 Patient Weight:
 Transport Distance:
 Transport Reason:
 R/T Purpose:
 Stretcher Purpose:

<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: 2
 Select Ambulance Condition Indicator: 01// ?
 Answer with AMBULANCE CONDITION INDICATOR
 Choose from:
 12
 01

You may enter a new AMBULANCE CONDITION INDICATOR, if you wish
 Select an Ambulance Condition Indicator. Answer must be 1-2
 characters in length.
 This limits the entry to five condition indicators.

Answer with AMBULANCE CONDITION INDICATORS CODE
 Choose from:
 12 Confined to a bed or chair
 01 Admitted to hospital
 04 Moved by stretcher
 05 Unconscious or in Shock
 06 Transported in emergency situation
 07 Had to be physically restrained
 08 Visible hemorrhaging
 09 Medically necessary service

Select Ambulance Condition Indicator: 01//

Step	Procedure
6	From Screen 10, enter 3 to add a Rendering and Referring and Supervising provider, if necessary.
7	To edit, select Section 5 and enter the CLIA # if required by the payer.
	<i>After Patch IB*2.0*320, the billing software will automatically populate the CLIA# for the division on the claim when the claim is for the Service Type = 5 (Diagnostic Laboratory) if the CLIA# exists in the VistA Institution file. Users may override this value for the current claim only.</i>
	<i>For outside laboratory services, the billing software will automatically populate the CLIA# if there is a Laboratory or Facility secondary ID defined for the outside facility with a ID Qualifier of X4 (CLIA #).</i>
	<i>There will be an Error Message for laboratory claims to Medicare when there is no CLIA# on the claim and a Warning Message for laboratory claims to other payers when there is no CLIA# on the claim.</i>

```




IB,PATIENT3    XX-XX-XXXX    BILL#: K300XXX - Outpat/1500    SCREEN <10>
=====
                        BILLING - SPECIFIC INFORMATION
[[1] Bill Remarks
    - FL-80          : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)       : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral    : UNSPECIFIED [NOT REQUIRED]
    Admission Source : PHYSICIAN REFERRAL
[[3] Providers      :
    - REFERRING (MD) : IB,DOCTOR5    Taxonomy: XXXXXXXXXX (XX)
                        [P]XX0000
  
```

```

- RENDERING (MD) : IB,DOCTOR4 Taxonomy: XXXXXXXXXX (XX)
[P]XXX123
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
Lab CLIA # : DXXXX000
Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data : UNSPECIFIED [NOT REQUIRED]
[6] CMS-1500 Box 19 : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider : CHEYENNE VAMC
Taxonomy Code : 282N00000X
[8] Alt Prim Payer ID : UNSPECIFIED [NOT REQUIRED]
[9] Force To Print? : NO FORCED PRINT
[10] Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-10 to EDIT, '^N' for screen N, or '^' to QUIT: 6
CMS-1500 Box 19: ??
This is an 71 character free-text field that will print in Box 19
of the CMS-1500. Use this field to enter additional Payer required
IDs in the format of Qualifier<no space>ID number<3 spaces>
Qualifier<no space>ID number.
CMS-1500 Box 19: ??
DISPLAY THE FULL CMS-1500 BOX 19?: NO//



```

	<i>Note: Patch IB*2*488 changed the prompt Form Locator 19 to CMS-1500 Box 19 and updated the Help text.</i>
	<i>Note: There is a new field in Section 4 for the Mammography Certification Number where users can enter a certification number on claims for mammography exams. The known Mammography Certification Numbers will be stored in the Institution file, one per site.</i>
	<i>Patch IB*2*547 added a field to Screen 10 for alternative payer primary IDs which are used to direct claims to administrative contractors who process specialized claims such as Durable Medical Equipment (DME) claims.</i>

6.10. Pharmacy Claims

1500 pharmacy claims can be submitted electronically to the clearinghouse where they will be printed and mailed. If a pharmacy claim is entered on a UB04, it must be printed locally.

The following screens give a simplified example of a pharmacy claim.


Step	Procedure
1	When processing a Pharmacy claim, information on Screens 1 and 2 should be reviewed for correctness. Press the <Enter> key to move from one screen to the next.
2	On Screen 3, the payer information should be reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press the <Enter> key to continue to Screen 5.
	<i>For Pharmacy claims, change the form type to a CMS-1500.</i>
	<i>Note: With Patch IB*2*516, users will have the ability to add a one-time HPID, per payer, to a claim if the HPID in the Insurance Company file is not the correct one. The HPID will not be stored in the Insurance Company file. It will only apply to the claim.</i>

```

IB,PATIENT5    XX-XX-XXXX    BILL#: K303XXX - Outpat/1500    SCREEN <3>
=====
                                PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.    Form Type: CMS-1500
    Responsible: INSURER              Payer Sequence: Primary

```

Bill Payer : CIGNA	Transmit: Yes
Ins 1: CIGNA	Policy #: 126781678
Grp #: GRP NUM 2277	Whose: VETERAN
Grp Nm: CHALKER	Insd Sex: MALE
	Rel to Insd: PATIENT
	Insured: IB,PATIENT5
Ins 2: BLUE CROSS CA (W	Policy #: R76543210
Grp #: GRP NUM 10891	Whose: SPOUSE
Grp Nm: HARTLY	Insd Sex: FEMALE
	Rel to Insd: SPOUSE
	Insured: IB,WIFE5
[2] Billing Provider Secondary IDs: UNSPECIFIED [NOT REQUIRED]	
[3] Mailing Address :	
NO MAILING ADDRESS HAS BEEN SPECIFIED! (Patient has Medicare)	
Send Bill to PAYER listed above.	
<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:	

Step	Procedure
3	The highlighted fields are auto-populated. Remember that this is a professional bill that is being transmitting as a CMS-1500, so each HCPCS code will have to be associated with a diagnosis code. To begin this process, type 4 to edit the Cod. Method field and press the <Enter> key.
	<i>Note: With Patch IB*2*432, when adding a refill to a claim, users will be able to view the date a prescription was order along with the other data.</i>

```

ADD/EDIT RX FILL 2054788 FOR Oct 26, 2010 CORRECT? YES//
Date RX Ordered: Oct 26, 2010
RX #: 2054788//
DATE: OCT 26,2010//
DRUG: HYDROCHLOROTHIAZIDE 25MG TAB//
DAYS SUPPLY: 30//
QTY: 15//
NDC #: 00172-2083-80//
FORMAT OF NDC#: 5-4-2 FORMAT//

```

```

IB,PATIENT5      XX-XX-XXXX    BILL#: K303XXX - Outpat/1500      SCREEN <5>
=====
                        EVENT - OUTPATIENT INFORMATION
<1> Event Date : XXX XX,XXXX
[2] Prin. Diag.: ISSUE REPEAT PRESCRIPT - V68.1
[3] OP Visits  : UNSPECIFIED
[4] Cod. Method: HCPCS
    CPT Code   : Oral prescrip drug non chemo J8499      V68.1      XXX XX,XXXX
[5] Rx. Refills: HYDROCHLOROTHIAZIDE 25MG TAB          XXX XX,XXXX
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
<9> Value Code : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:

```

Step	Procedure
4	At the Select Procedure Date field, re-type the date.
5	At the Select Procedure field, type the appropriate code. Once the code auto-populates the data, type YES to confirm.
6	At the Provider field, type the name of the physician. Information related to that provider will auto-populate.

7	Type the appropriate data related to the Place of Service and the Type of Service .
8	Press the <Enter> key until Screen 5 appears.

```

<<CURRENT PROCEDURAL TERMINOLOGY CODES>>

LISTING FROM VISIT DATES WITH ASSOCIATED CPT CODES
IN OUTPT ENCOUNTERS FILE

=====
NO.   CODE   SHORT NAME                CLINIC                DATE
=====

NO CPT CODES ON FILE FOR THE VISIT DATES ON THIS BILL

PROCEDURE CODING METHOD: HCPCS (1500 COMMON PROCEDURE CODING SYSTEM)
//
Select PROCEDURE DATE (X/XX/XX-XX/XX/XX): XX-XX-XX
* Patient has no Visits for this date...

Select PROCEDURE: J
Searching for a CPT,(pointed-to by PROCEDURES)
J8499      Oral prescrip drug non chemo
...OK? Yes// Yes Oral prescrip drug non chem Rx: 0000000D
PROCEDURES: J8499//
Select CPT MODIFIER SEQUENCE:
PROVIDER: IB,DOCTOR6//
ASSOCIATED CLINIC: CARDIAC CONSULT
DIVISION: MONTGOMERY VAMC// 619
PLACE OF SERVICE: 22      OUTPATIENT HOSPITAL
TYPE OF SERVICE: 1        MEDICAL CARE
EMERGENCY PROCEDURE?: NO// NO
PRINT ORDER:


```

Step	Procedure
9	Notice the association has been made between the diagnosis code and the required procedure code. Press the <Enter> key to move to Screen 7.

IB,PATIENT5	XX-XX-XXXX	BILL#: K303XX - Outpat/1500	SCREEN <5>
=====			
EVENT - OUTPATIENT INFORMATION			
<1> Event Date : XXX XX,XXXX			
[2] Prin. Diag.: ISSUE REPEAT PRESCRIPT - V68.1			
[3] OP Visits : XXX XX,XXXX			
[4] Cod. Method: HCPCS			
CPT Code : Oral prescrip drug non chemo J8499 V68.1 XXX XX,XXXX			
[5] Rx. Refills: RANITIDINE HCL 150MG (ZANTAC) TAB XXX XX,XXXX			
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]			
[7] Occ. Code : UNSPECIFIED [NOT REQUIRED]			
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]			
<9> Value Code : UNSPECIFIED [NOT REQUIRED]			
<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:			

Step	Procedure
10	If all the data have been entered correctly, section 5 should display the correct revenue code and charges.. Press the <Enter> key to move to Screen 8.


IB,PATIENT5	XX-XX-XXXX	BILL#: K303XX - Outpat/1500	SCREEN <7>
=====			
BILLING - GENERAL INFORMATION			
[1] Bill Type : 131	Loc. of Care: HOSPITAL - INPT OR OPT (INCLU		
Covered Days: UNSPECIFIED	Bill Classif: OUTPATIENT		
Non-Cov Days: UNSPECIFIED	Timeframe: ADMIT THRU DISCHARGE		
Charge Type : UNSPECIFIED	Disch Stat:		
Form Type : CMS-1500	Division: MONTGOMERY VAMC		
[2] Sensitive? : UNSPECIFIED	Assignment: YES		
[3] Bill From : XXX XX,XXXX	Bill To: XXX XX,XXXX		
[4] OP Visits : UNSPECIFIED			
[5] Rev. Code : 253-WARFARIN SODIUM 5 J8499 1	\$36.00	PRESCRIPTION	
OFFSET: \$0.00 [NO OFFSET RECORDED]			
BILL TOTAL : \$36.00			
[6] Rate Sched : (re-calculate charges)			
[7] Prior Claims: UNSPECIFIED			

Step	Procedure
11	On Screens 8 and 9, enter any necessary claim-level data to the claim and press the <Enter> key to move to Screen 10.
	Note: IB*2*447 moved Screen 8, Section 3 Ambulance Information to a new Screen 9.

IB,PATIENT MRA	XX-XX-XXXX	BILL#: K20003D - Outpat/1500	SCREEN <8>
=====			
BILLING - CLAIM INFORMATION			
<1> COB Non-Covered Charge Amt:			
<2> Property Casualty Information			
Claim Number:		Contact Name:	
Date of 1st Contact:		Contact Phone:	
<3> Surgical Codes for Anesthesia Claims			
Primary Code:		Secondary Code:	
<4> Paperwork Attachment Information			
Report Type:		Transmission Method:	
Attachment Control #:			
<5> Disability Start Date:		Disability End Date:	
<6> Assumed Care Date:		Relinquished Care Date:	

[7] Special Program:
 [8] Homebound:
 [9] Date Last Seen:
 <RET> to CONTINUE '^N' for screen N, or '^' to QUIT:

IB,PATIENTM M XXX-XX-XXXX BILL#: K101ES8 - Outpat/UB04 SCREEN <9>
 =====
 AMBULANCE INFORMATION
 <1> Ambulance Transport Data
 P/U Address1: D/O Location:
 P/U Address2: D/O Address1:
 P/U City: D/O Address2:
 P/U State/Zip: D/O City:
 Patient Weight: D/O State/Zip:
 Transport Reason: Transport Distance:
 R/T Purpose:
 Stretcher Purpose:
 <2> Ambulance Certification Data
 Condition Indicator:
 <RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT:

Step	Procedure
12	From Screen 10, enter 3 to add a Rendering provider.
	<i>Patch IB*2*547 added a field to Screen 10 for alternative payer primary IDs which are used to direct claims to administrative contractors who process specialized claims such as Durable Medical Equipment (DME) claims.</i>

IB,PATIENT5 XX-XX-XXXX BILL#: K303XXX - Outpat/1500 SCREEN <10>
 =====
 BILLING - SPECIFIC INFORMATION
 [1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
 Unable To Work To : UNSPECIFIED [NOT REQUIRED]
 [2] ICN/DCN(s) : UNSPECIFIED [NOT REQUIRED]
 Auth/Referral : UNSPECIFIED [NOT REQUIRED]
 [3] Providers :
 - RENDERING : UNSPECIFIED
 [4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
 Lab CLIA # : UNSPECIFIED [NOT REQUIRED]
 Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
 [5] Chiropractic Data : UNSPECIFIED [NOT REQUIRED]
 [6] CMS-1500 Box 19 : UNSPECIFIED [NOT REQUIRED]
 [7] Billing Provider : CHEYENNE VAMC
 Taxonomy Code : 282N00000X
 [8] Alt Prim Payer ID : UNSPECIFIED [NOT REQUIRED]
 [9] Force To Print? : NO FORCED PRINT
 [10] Provider ID Maint : (Edit Provider ID information)

<RET> to CONTINUE, 1-10 to EDIT, '^N' for screen N, or '^' to QUIT:
 This claim is now ready for authorization.





6.11. Correct Rejected or Denied Claims

A claim can be rejected at some stage during either the electronic or manual process. A claim can be denied by the payer during the adjudication process. When a claim is either rejected or denied, it may be for a reason that can be corrected. Once the claim is corrected, it can be retransmitted or resent through the mail to the payer.

With Patch IB*2*433, a new option has been added to the IB Module that allows users to correct a claim while maintaining the original claim number on the resubmitted claim.

With Patch IB*2*447, users are able to correct all types of claims including a claim that processes to a non-accruing funds. It is now possible to correct a claim with one of the following rate types:

- INTERAGENCY
- SHARING AGREEMENT
- TRICARE
- WORKMAN'S COMP

Step	Procedure
1	Access the option Third Party Billing Menu .
2	At the Select Third Party Billing Menu Option: prompt, enter CRD for Correct Rejected/Denied Bill.
3	At the Enter BILL NUMBER or Patient NAME: prompt, enter the claim number of the claim that requires correction.
4	At the ARE YOU SURE YOU WANT TO CANCEL THIS BILL? No// prompt, enter Yes to override the default.
5	At the CANCEL BILL?: prompt, enter YES .
6	At the REASON CANCELLED: prompt, enter a free-text comment .
	<i>Note: This new option was designed to replace the existing option CLON Copy and Cancel under the majority of circumstances. The existing CLON Copy and Cancel option will now be locked with a new Security Key named IB CLON.</i>
	<i>Note: The existing CLON Copy and Cancel option should only be used to correct denied claims against which a payment has been posted or to correct a claim with one of the Bill Rate Types that are excluded from the new processes..</i>
	<i>Note: The existing CLON Copy and Cancel option should be used to correct denied claims against which a payment has been posted, a secondary/tertiary claim or a claim in MRA Request status.</i>
	<i>Note: The IB CLON security key which restricted the use of the CLON option , was removed with Patch IB*2*516.</i>


The following screen will display.

IB,PATIENT4	(XX-XX-XXXX)	DOB: XXX XX,XXXX
=====		
Rate Type	: REIMBURSABLE INS.	
Event Date	: XXX XX XXXX	
Sensitive	: NO	
Responsible	: INSURANCE CARRIER (Specify CARRIER on SCREEN 3)	
Loc of Care	: HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.	
Event Source	: Outpatient	
Timeframe	: ADMIT THRU DISCHARGE	
	(Specify actual bill type fields on SCREENs 6/7)	

Bill From : XXX XX,XXXX
 Bill To : XXX XX,XXXX
 Initial Bill# : K701XXX-01
 Copied Bill# : K701XXX-01

Please verify the above information for the bill you just entered. Once this information is accepted it will no longer be editable and you will be required to CANCEL THE BILL if changes to this information are necessary.

IS THE ABOVE INFORMATION CORRECT AS SHOWN? Yes//

Step	Procedure
7	Return through the claim screens correcting whatever data requires correction.
8	Complete and authorize the claim.
	<i>Note: The number of the original claim has been incremented and now displays with a -01 after the claim number. The original claim number has been assigned to the new claim. Each time a claim is corrected, the previous cancelled version will be incremented -01, -02, -03, etc..</i>

When users attempt to use the **CRD Correct Rejected/Denied Bill** option to correct a claim against which a payment has been posted, they will be warned that they must use the existing **CLON Copy and Cancel** option.

Select Third Party Billing Menu Option: CRD Correct Rejected/Denied Bill

Enter BILL NUMBER or Patient NAME: K600XXX IB,PATIENT1 XX-XX-XX
 Outpatient REIMBURSABLE INS. PRNT/TX

Please note a PAYMENT of **\$45** has been POSTED to this bill. Copy and cancel (CLON) must be used to correct this bill.

When users attempt to use the **CRD Correct Rejected/Denied Bill** option to correct a denied claim which has received only one of its associated split Explanation of Benefits (EOB), they will be warned that they must wait for the arrival of the second EOB before they can use this new option.

Select Third Party Billing Menu Option: CRD Correct Rejected/Denied Bill

Enter BILL NUMBER or Patient NAME: K600XXX IB,PATIENT1 XX-XX-XX
 Outpatient REIMBURSABLE INS. PRNT/TX

There is a split EOB associated with this claim. You cannot use this option to Correct this claim until the second EOB has been received.

When users attempt to use the **CRD Correct Rejected/Denied Bill** option to correct a rejected or denied claim which has an excluded Billing Rate Type, they will be warned that they must use the existing **CLON Copy and Cancel** option.

Select Third Party Billing Menu Option: CRD Correct Rejected/Denied Bill

Enter BILL NUMBER or Patient NAME: K600XXX IB,PATIENT1 XX-XX-XX
 Outpatient REIMBURSABLE INS. PRNT/TX

This option cannot be used to correct some Billing Rate Types (Example: TRICARE). Use Copy and Cancel (CLON) to correct this bill.

When users attempt to use the **CRD Correct Rejected/Denied Bill** option to correct a rejected or denied secondary or tertiary claim, they will be notified that they must use the existing **CLON Copy and Cancel** option.

Please note that COB data exists for this bill.
Copy and cancel (CLON) must be used to correct this bill.

When users attempt to use the CRD Correct Rejected/Denied Bill option to correct a claim with a status of MRA Request, they will receive the following message.

This bill is in a status of REQUEST MRA.
No MRAs have been received and there are no rejection messages on file
for the most recent transmission of this MRA request bill.



*Note: The new **CRD Correct Rejected/Denied Bill** option has been added to the **CSA Claims Status Awaiting Resolution** option and the **MRW MRA Worklist** option as **Correct Bill**.*

The history of corrected claims will be available from the following locations:

- BILL - Enter/Edit Billing Information
- INQ – Patient Billing Inquiry

6.12. Viewed Cancelled Claims

If a claim has been cancelled, users can view the data stored in the Bill/Claims file (#399) for the cancelled claim.

The View Cancelled Bill option is on the Third Party Billing Menu.

ADPR	Print Bill Addendum Sheet
AUTH	Authorize Bill Generation
BILL	Enter/Edit Billing Information
CANC	Cancel Bill
CLA	Multiple CLAIMSMANAGER Claim Send
CLON	Copy and Cancel
CRD	Correct Rejected/Denied Bill
DLST	Delete Auto Biller Results
GEN	Print Bill
INQU	Patient Billing Inquiry
LIST	Print Auto Biller Results
PRNT	Print Authorized Bills
RETN	Return Bill Menu ...
VCB	View Cancelled Bill
VIEW	View Bills Pending Transmission
VIST	Outpatient Visit Date Inquiry

Select Third Party Billing Menu <TEST ACCOUNT> Option:

6.13. Printed Claims

Some claims should not be transmitted electronically and should be printed locally.

These include:



- Claims requiring clinical attachments such as progress notes;

- Professional claims containing more than the maximum number of 8 diagnosis codes;
- Professional claims containing more than the maximum number of diagnosis pointers (4);
- Institutional claims containing more than the maximum number of procedure codes (999);
- Professional claims containing more than the maximum number of procedure codes/line items (50);
- Institutional pharmacy claims; and
- Secondary claims to Medicare WNR (When Medicare WNR is NOT the primary insurance).

6.14. View/Resubmit Claims – Live or Test – Synonym: RCB

A new option, **View/Resubmit Claims – Live or Test**, has been added to the EDI menu. This option replaces: **Resubmit a Bill**; **Resubmit a Batch of Bills** and **View/Resubmit Claims as Test**. This option provides the ability to resubmit claims as test claims for testing or production claims for payment.

Patch IB*2*547 will add the ability to run the RCB option to find previously printed claims and to resubmit them to the test queue *only*. They cannot be retransmitted to the production queue. The patch will also provide the ability to look-up claims to specific payers using the EDI - Inst Payer Primary ID or EDI - Prof Payer Primary ID.

Step	Procedure
1	At the Select EDI Menu For Electronic Bills Option , type RCB and press the Return key.
2	At the Run report for (P)rinted or (T)ransmitted claims?: Transmitted// prompt, press the Enter key to accept the default
3	At the SELECT BY: (C)LAIM, (B)ATCH OR SEE A (L)IST TO PICK FROM: prompt, press the Enter key to accept the default of List .
4	At the Run for (A)ll payers or (S)electd Payers? prompt, type S for Selected Payers.
	<i>If you choose Selected payers, after you enter Blue Cross of CA, for example, you will be prompted to included all insurance companies with the same Electronic Billing ID. This will prevent you from having to enter every BC/BS company defined in your Insurance file.</i>
5	At the Select Insurance Company: prompt, enter an EDI Payer Primary ID
6	At the Select Insurance Company prompt, press the Enter key when done selecting payers
7	At the Run for (U)B-04, (C)MS-1500 or (B)OTH: prompt, press the Enter key to accept the default of Both.
	<i>The Date Range for the search for claims has been restricted to a maximum of 90 days to minimize the impact of the search on the system.</i>
8	At the Start with Date Last Transmitted: prompt, type T-200 for this example.
9	At the Go to Date Last Transmitted: prompt, press the Enter key to accept the default of 12/1/04. This will return results for 90 days.
10	At the Select Additional Limiting Criteria (optional): prompt, press the Enter key without selecting anything additional.

```
Select EDI Menu For Electronic Bills Option: RCB  View/Resubmit Claims-Live or Test

*** NOTE: 2 '^' ARE NEEDED TO ABORT THE OPTION (^ ^)
          1 '^' BRINGS YOU BACK TO THE PREVIOUS SELECTION PROMPT(^)

Run report for (P)rinted or (T)ransmitted claims?: Transmitted//Transmitted

Select By: (C)laim or see a (L)ist to pick from?: List//

PAYER SELECTION:
Run for (A)ll Payers or (S)electd Payers?: Selected Payers//Selected Payers
```

Include all payers with the same electronic Payer ID? Yes// **YES**

Select Insurance Company: **60054**

```
1 60054 AETNA HEALTH PLANS4501 N STERLING PEORIA,IL 60054/60054
2 60054 AETNA HEALTH PLANS620 ERIE BLVD WEST SYRACUSE,NY 60054/60054
3 60054 AETNA HEALTH PLANSPO BOX 16516 COLUMBUS,OH 60054/60054
4 60054 AETNA HEALTH PLANS3541 WINCHESTER ROAD ALLENTOWN,PA 60054/60054
4
5 60054 AETNA HEALTH PLANSPO BOX 112 PORTLAND,OR 60054/60054
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1 AETNA HEALTH PLANS4501 N STERLING PEORIA,IL 60054/60054
```

Select Another Insurance Company:

BILL FORM TYPE SELECTION:

Run for (U)B-04, (C)MS-1500 or (B)oth: Both// **Both**


LAST BATCH TRANSMIT DATE RANGE SELECTION:

Start with Date Last Transmitted: T-200 (XXX XX, XXXX)

Go to Date Last Transmitted:(T-200 - T-110): T-110// (XXX XX, XXXX)

ADDITIONAL SELECTION CRITERIA:

- 1 - MRA Secondary Only
- 2 - Primary Claims Only
- 3 - Secondary Claims Only
- 4 - Claims Sent to Print at Clearinghouse Only

Step	Procedure
11	At the Would you like to include cancelled claims? No//: prompt, enter No.
12	At the Would you like to include claims Forced to Print at the Clearinghouse? No// prompt, enter No.
13	At the Sort By prompt, enter B to override the default of Current Payer.
	<i>Sort by Batch if you want to resubmit batches of claims or Current Payer if you want to resubmit a variety of individual claims.</i>
14	At the DO YOU WANT A (R)EPORT OR A (S)CREEN LIST FORMAT?: prompt, press the <Enter> key to accept the default of Screen List.

Would you like to include cancelled claims? No// NO

Would you like to include claims Forced to Print at the Clearinghouse? **No**// NO

Sort By: Current Payer// ??

Enter a code from the list.

Select one of the following:

- 1 Batch By Last Transmitted Date (Claims within a Batch)
- 2 Current Payer (Insurance Company)

Sort By: Current Payer// Batch By Last Transmitted Date (Claims within a Batch)Do you want a (R)eport or a (S)creen List format?: Screen List//

The following screen is displayed:

PREVIOUSLY TRANSMITTED CLAIMS Mar 21, 2005@15:52:10 Page: 1 of 1215

** A claim may appear multiple times if transmitted more than once. **

** T = Test Claim ** R = Batch Rejected


>>># of Claims Selected: 0 (marked with *)

Claim #	Form	Type	Seq	Status	Current Payer
Batch: 6050011182 Date Last Transmitted: Nov 30, 2004					
1	K500XXX	UB-04	OUTPT	P PRNT/TX	AETNA US HEALTHCARE
Batch: 6050011183 Date Last Transmitted: Nov 30, 2004					
2	K500XXX	UB-04	OUTPT	P PRNT/TX	AETNA US HEALTHCARE
Batch: 6050011184 Date Last Transmitted: Nov 30, 2004					
3	K500XXX	1500	OUTPT	P PRNT/TX	AETNA
Batch: 6050011185 Date Last Transmitted: Nov 30, 2004					
4	K500XXX	1500	OUTPT	S PRNT/TX	AETNA Batch: 6050011186 Date Last Transmitted: Nov 30, 2004
Batch: 6050011187 Date Last Transmitted: Nov 30, 2004					
6	K500XXX	1500	OUTPT	P PRNT/TX	AETNA US HEALTHCARE

+ Enter ?? for more actions >>>

Claim(s) Select/De select	View Claims Selected
Batch Select/De select	Print Report
Resubmit Claims	Exit

Action: Next Screen//

Step	Procedure
15	At the Action prompt, type B to select batches of claims to resubmit as test or ' C ' to select claims.
16	At the Select EDI Transmission Batch Number: prompt, enter the number of the desired batch.
	<i>You may repeat the above, entering as many batch numbers as you want.</i>

PREVIOUSLY TRANSMITTED CLAIMS Mar 21, 2005@16:07:38 Page: 1 of 1215

** A claim may appear multiple times if transmitted more than once. **

>>># of Claims Selected: 1 (marked with *)


Claim #	Form	Type	Seq	Status	Current Payer
Batch: 6050011182 Date Last Transmitted: Nov 30, 2004					
1	*K500YRJ	UB-04	OUTPT	P PRNT/TX	UNITED HEALTHCARE
Batch: 6050011183 Date Last Transmitted: Nov 30, 2004					
2	K50092T	UB-04	OUTPT	P REQUEST MRA	MEDICARE (WNR)
Batch: 6050011184 Date Last Transmitted: Nov 30, 2004					
3	K500YSF	1500	OUTPT	P PRNT/TX	UNITED HEALTHCARE
Batch: 6050011185 Date Last Transmitted: Nov 30, 2004					
4	K500YSZ	1500	OUTPT	S PRNT/TX	SOUTHWEST ADMINISTRATORS
Batch: 6050011186 Date Last Transmitted: Nov 30, 2004					
5	K500YUD	UB-04	OUTPT	P PRNT/TX	AETNA US HEALTHCARE
Batch: 6050011187 Date Last Transmitted: Nov 30, 2004					
6	K500YUE	1500	OUTPT	P PRNT/TX	AETNA US HEALTHCARE

+ Enter ?? for more actions >>>

Claim(s) Select/De select	View Claims Selected
Batch Select/Deselect	Print Report
Resubmit Claims as TEST	Exit

Action: Next Screen// **b Batch Select/De select**

Select EDI TRANSMISSION BATCH NUMBER: **6050011183**

Step	Procedure
17	When you have entered all of the batches you want, at the ACTION prompt, type ' R ' for Resubmit Claims .
18	At the Resubmit Claims: prompt, press the <Enter> key to resubmit the claims for payment.
	<i>The system will inform you of the number of claims that will be resubmitted and whether or not they are being submitted for payment or testing.</i>
19	At the Are You Sure You Want To Continue?: prompt, type YES to override the default.

```

You are about to resubmit 2 claims as Production claims.
Are you sure you want to continue?: NO// y YES
Resubmission in process...

```

7. Processing of Secondary/Tertiary Claims

With Patch IB*2*432 installed, the procedures for the processing of secondary and tertiary non-MRA claims have changed.

When electronic Explanation of Benefits (EOBs) are received for claims that are NOT Medicare (WNR) claims and the payments are processed in AR, the EOBs will be evaluated and if the data in the EOBs meets certain criteria, the secondary or tertiary claims will either be processed automatically or sent to the new COB Management Worklist for manual processing.

When a claim is processed in AR and its status becomes Collected/Closed, no MailMan message will be generated. Either the subsequent claim will be automatically processed or the claim will appear on the new worklist.



Patch IB*2*447 removed the option, Copy for Secondary/Tertiary Bill [IB COPY SECOND/THIRD]. This option became obsolete with the install of IB*2.0*432 and the introduction of the new CBW (COB Management Work list).

A new, non-human user, IB,AUTHORIZER REG, will be the clerk responsible for the automatic processing of non-MRA secondary and tertiary claims.

In order to be able to either create a subsequent claim, or to send a claim to the new COB Management Worklist for manual processing, the following conditions must be met:

- All Explanation of Benefit (EOBs), 835 Health Care Claim Payment Advice, have been received ; and
- Payment from the previous payer has been posted by AR; and
- The bill status for the previous payer is Collected/Closed.

Electronic Secondary and Tertiary claim will contain the Coordination of Benefits data from the EOBs in the 837 Health Care Claim transmission to FSC.

	<i>Note: Secondary and Tertiary claims will be created with a new claim number.</i>
	<i>Remember: Whether or not a Secondary or Tertiary claim to an electronic payer is transmitted or printed, is determined by the new parameter in the Insurance Company Editor. Refer to Section 2.1.1.1.</i>

7.1. Criteria for the Automatic Processing of Secondary or Tertiary Claims





When a non-MRA claim has received all associated EOBs and they meet the following criteria, the subsequent claim will be automatically created and either transmitted electronically to the next payer, or printed (along with the associated MRAs/EOBs) and mailed to the next payer:

- EOB contains only Adjustment Group Codes = Contractual Obligation (CO) associated with one of the following Reason Codes: A2; B6; 45; 102; 104; 118; 131; 23; 232; 44; 59; 94; 97; or 10; and
- EOB contains only Adjustment Group Codes = Patient Responsibility (PR) associated with one of the following Reason Codes; 1; 2; or 66; and
- The sum of the deductible, coinsurance and co-payment amounts is greater than \$0.00; and

- The EOB status is Processed (The Claim Status Code is either 1, 2, or 3).

7.2. COB Management Worklist

Any non-MRA claim that does not meet the criteria for the automatic creation of a Secondary or Tertiary claim will be placed on the COB Management Worklist.

Step	Procedure
1	Access the EDI Menu For Electronic Bills menu.
2	At the Select EDI Menu For Electronic Bills Option: prompt, enter CBW for COB Management Worklist.
	<i>Note: Patch IB*2*516 provided the ability for users to run the worklist by one or more divisions.</i>
3	At the Select Division: ALL// prompt; press the <Enter> key to accept the default.
4	At the Select BILLER: ALL// prompt, press the <Enter> key to accept the default.
5	At the Sort By: BILLER// prompt, press the <Enter> key to accept the default.
6	At the Do you want to include Denied EOBs for Duplicate Claim/Service? No// prompt, press the <Enter> key to accept the default.
	<i>Note: A non-MRA claim which receives a DENIED EOB and which is Collected/Closed by AR and which has a subsequent payer, will also be placed on the CBW. This includes claims that have potential patient responsibility such as TRICARE and CHAMPVA.</i>
	<i>Note: Patch IB*2*547 provides additional search and sort criteria for this worklist. Users can create a list of just primary claims or just secondary claims or both and they can now sort by primary or secondary insurance company.</i>
	<i>Note: Complete CARC/RARC textual descriptions will display from Print or View an EOB from within the COB Management Worklist.</i>

The following screen will display.

COB Management WorkList			JAN 01, 2011@13:41:16			Page: 1 of 20	
Bill #	Svc Date	Patient Name	SSN	Pt Resp	Bill Amt	Care/Form	
BILLER: IB,CLERK 1							
1	442-K401XXX*	12/07/10 IB,PATIENT 27	XXXX	0.00	87.58	OP/1500	
	Insurers:	AETNA US HEALTHCARE					
	EOB Status:	DENIED, Feb 25, 2004					
2	442-K401XXX*	12/07/10 IB,PATIENT 4	XXXX	86.40	72.00	OP/UB-04	
	Insurers:	AETNA US HEALTHCARE					
	EOB Status:	DENIED, Jun 09, 2004					
3	442-K401XXX	12/08/10 IB,PATIENT 33	XXXX	0.00	243.16	OP/UB-04	
	Insurers:	AETNA US HEALTHCARE					
	EOB Status:	DENIED, Jul 28, 2004					
4	442-K401XXX	12/08/10 IB,PATIENT 102	XXXX	0.00	45.61	OP/1500	
	Insurers:	AETNA US HEALTHCARE					
	EOB Status:	DENIED, Jun 09, 2004					
5	442-K402XXX	12/14/10 IB,PATIENT 10	XXXX	0.00	30.74	OP/1500	
	Insurers:	AETNA US HEALTHCARE					
+ Enter ?? for more actions							
PC	Process COB	CB	Cancel Bill	RM	Remove from Worklist		
VE	View an EOB	CR	Correct Bill	PE	Print EOB/MRA		
EC	Enter/View Comments	CC	Cancel/Clone A Bill	TP	Third Party Joint Inq.		
RS	Review Status	VB	View Bill	EX	Exit		
Select Action: Next Screen//							

7.2.1 Data Displayed for Claims on the COB Management Worklist



The following data is displayed on the COB Management Worklist:

- List number
- Claim number
- Asterisk – when claim is under review
- Claim date
- Patient name
- Last 4 numbers of patient's SSN
- Patient Responsibility monetary amount
- Monetary amount on the claim
- Patient status, Inpatient/Outpatient
- Claim form type
- Status of EOB
- Insurance company(s)
- Clerk name – depends on Sort criteria
- Division(s)
- Days since last transmission – depends on Sort criteria
- Date of EOB - depends on Sort criteria

7.2.2 Available COB Management Worklist Actions

The following actions are available to users to help them managed those claims which failed to meet the automatic processing criteria:

- PC Process COB – Process a claim on the list to the next payer on the bill
- VE View an EOB – View the EOB(s) associated with a claim on the list
- EC Enter/View Comments – Enter new comments for a claim on the list or view previously entered comments
- RS Review Status – Change the review status for a claim on the list
- CB Cancel Bill – Cancel a bill that does not need to be resubmitted
- CR Correct Bill – Correct a bill that needs to be resubmitted
- CC Cancel/Clone A Bill – Clon a bill that needs to be resubmitted (locked with IB CLON)
- VB View Bill – View the billing screens
- RM Remove from Worklist – Remove claim from worklist if no need to resubmit
- PE Print EOB/MRA – Print associated MRAs or EOB
- TP Third Party Joint Inq. – Select a claim and go directly to it in TPJI
- EX Exit – Exit the worklist and return to the EDI Menu

	<i>Note: Remove from Worklist was added so that claims that have been Collected/Closed and place on the worklist can be removed if there is no reason to process it to the next payer (i.e. no Patient Responsibility). These claims should not be cancelled as they have been Collected/Closed in AR.</i>
	<i>Remember: It is possible that a tertiary claim on the COB Management Worklist began as an MRA claim. The Print EOB/MRA action will provide users with the option to print both EOBs and MRAs.</i>

8. Requests for Additional Data to Support Claims

Patch IB*2*547 added a new worklist and a new inbound transaction, the ASC X12N 5010 Health Care Claim Request for Additional Information (277RFAI) to VistA. The 277RFAI transaction is initiated by the payer in response to a claim for health care services when they need additional information in order to adjudicate the claim correctly. A 277RFAI might, for example, request an image, a test result or a Certificate of Medical Necessity. At the time that Patch IB*2*547 is installed, the methods for providing this additional data will be manual. In the future, it will be possible to respond to a 277RFAI with a ASC X12N 5010 Additional Information to Support a Health Care Claim or Encounter (275) transaction.

The RFAI Management Worklist was added to provide a method for displaying and managing these requests for additional documentation to support the adjudication of a claim.

Step	Procedure
1	Access the EDI Menu For Electronic Bills menu.
2	At the Select EDI Menu For Electronic Bills Option: prompt, enter RFI for RFAI Management Worklist
3	At the Select Authorizing Biller: ALL// prompt, press the Enter key to accept the default
4	At the Select Primary Sort: LOINC Code// prompt, press the Enter key to accept the default of LOINC

The following screen is displayed:

RFAI Management Worklist		Apr 28, 2015@14:25:12		Page:		1 of 16	
	Bill #	Payer Name	Patient Name	SSN	Svc Date	Curr Bal	
1	K100XXX	MEDICARE (WNR)	IB,PATIENT 333	XXXX	06/29/09	\$43851.78	
	55115-0 - Requested imaging studies information Document						
2	K100XXX	MEDICARE (WNR)	IB,PATIENT 22	XXXX	11/05/10	\$1226.18	
	64286-8 - Deprecated Diagnostic imaging order						
3	K100XXX	UNITEDHEALTHCARE	IB,PATIENT 765	XXXX	11/05/10	\$9.65	
	55115-0 - Requested imaging studies information Document						
4	K100XXX	MEDICARE (WNR)	IB,PATIENT 22	XXXX	11/05/10	\$1226.18	
	22034-3 - Path report.total Cancer						
+ * Indicates RFAI review in progress							
Select Message			Exit				
ReSort Messages							
Select Action: Next Screen//Select Message							
Select RFAI Message: (1-4):1							

Step	Procedure
5	At the Select RFAI Message: (1-4) : prompt, enter 1 to select a message to expand

The following screen is displayed:

RFAI Message		Apr 28, 2015@14:43:44		Page:	1 of 2
Bill #	Payer Name	Patient Name	SSN	Svc Date	Curr Bal
K100XXX	IB INSURANCE CO	IB,PATIENT 33	XXXX	06/29/09	\$43851.78
Information Source					
Payer Name: IB INSURANCE COMPANY					
Payer Contact 1: FAX Number ← There can be up to 3 contact methods					

Payer Contact #: XXX XXX-XXXX
 Payer Contact 2: Telephone
 Payer Contact #: XXX XXX-XXXX EXT: XXXXXXX
 Payer Response Contact 1: ← There can be up to 3 contact methods
 Payer Response Contact #: XXX XXX-XXXX
 Payer Response Contact 2: Telephone
 Payer Response Contact #: XXX XXX-XXXX EXT: XXXXXXX
 Payer Address: PO BOX XYZ New York, New York 10001
 Payer Claim Control Number: XXX

Claim Level Status Information

Patient Control #: XXXXXXX ← Claim Number
 Date of Service: XX/XX/XX
 Medical Records Number: XXXXXXX
 Member Identification Number: XXXXXXX
 Type of Service: XXX ← Institutional Only Type of Bill
 Health Care Claim Status Category: ← These 3 can repeat
 Additional Information Request Modifier: ← Show LOINC Code Text not just code
 Status Information Effective Date: XX/XX/XX
 Response Due Date: XX/XX/XX

Service Line Information/ Service Line Status Information

Line Item Control Number: XXXXXXX
 Service Line Date:
 Revenue Code:
 Coding Method: HCPCS
 Procedure Code: XXXXXXX
 Procedure Modifier: ← There can be up to 4
 Procedure Modifier:
 Line Item Charge Amount: XXXXXXXXXXXXXXXXXXXX
 Health Care Claim Status Category: ← These 3 can repeat
 Additional Information Request Modifier: ← Show LOINC Code Text not just code
 Status Information Effective Date: XX/XX/XX
 Response Due Date: XX/XX/XX

+ Enter ?? for more actions

EC	Enter Comments	TJ	Third Party Joint Inq.
RS	Review Status	EX	Exit
RE	Remove Entry		

Select Action: Next Screen// Remove Entry

From the RFAI message Screen, users can take the following actions:

- Enter comments – user name and date/time will be automatically captured
- Change the Review Status – the entry will be marked by an asterisk
- Remove an entry from the list once it has been addressed – user name and date/time will be captured along with free text removal comment
- Jump to the claim in TPJI – comments from the RFAI Management Worklist will be viewable from within TPJI

9. IB Site Parameters

9.1. Define Printers for Automatically Processed Secondary/Tertiary Claims

New fields were added to the MCCR Site Parameter Display/Edit option so that users can define printers to which to print automatically processed secondary or tertiary claims and their associated EOB/MRAs to payers which cannot support electronic claim transmissions.

Step	Procedure
1	Access the MCCR System Definition Menu .
2	At the Select MCCR System Definition Menu Option: prompt, enter Site for MCCR Site Parameter Display/Edit.
3	At the Select Action: prompt, Enter IB to access the IB Site Parameters.

```
MCCR Site Parameters          Feb 01, 2011@15:04:47          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
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// IB Site Parameters
```



The following screen will display.

IB Site Parameters	Feb 01, 2011@16:22:02	Page: 1 of 5
Only authorized persons may edit this data.		
<p>[1] Copay Background Error Mg: IB ERROR Copay Exemption Mailgroup: IB ERROR Use Alerts for Exemption : NO</p>		
<p>[2] Hold MT Bills w/Ins : YES # of Days Charges Held: 90 Suppress MT Ins Bulletin : NO Means Test Mailgroup : IB MEANS TEST Per Diem Start Date : 11/05/90</p>		
<p>[3] Disapproval Mailgroup : MCCR - BUSINESS OFFICE Cancellation Mailgroup : UB-82 CANCEL Cancellation Remark : BILL CANCELLED IN BUSINESS OFFICE</p>		
<p>[4] New Insurance Mailgroup : IB NEW INSURANCE Unbilled Mailgroup : IB UNBILLED AMOUNTS Auto Print Unbilled List : NO</p>		
<p>+ Enter ?? for more actions EP Edit Set EX Exit Select Action: Next Screen//</p>		

Step	Procedure
4	At the Select Action: prompt, press the <Enter> key to accept the default of Next Screen until Section 7 is displayed.

IB Site Parameters	Feb 01, 2011@16:25:43	Page: 2 of 5
Only authorized persons may edit this data.		
<p>+ [5] Medical Center : CHEYENNE VAMC Default Division : CHEYENNE VAMR MAS Service : BUSINESS OFFICE Billing Supervisor : WAITHE,MOSES</p>		
<p>[6] Initiator Authorize: YES Xfer Proc to Sched : YES Ask HINQ in MCCR : YES Use Non-PTF Codes : YES Multiple Form Types: YES Use OP CPT screen : YES</p>		
<p>[7] UB-04 Print IDs : YES UB-04 Address Col : CMS-1500 Print IDs : YES CMS-1500 Addr Col : 40 CMS-1500 Auto Prter: RM340 UB-04 Auto Prter : RM340 EOB Auto Prter : RM340 MRA Auto Prter : RM340</p>		
<p>[8] Default RX DX Cd : V68.1 Default ASC Rev Cd : 490 Default RX CPT Cd : J8499 Default RX Rev Cd : 250</p>		
<p>[9] Bill Signer Name : <No longer used> Federal Tax # : 83-0168494 Bill Signer Title : <No longer used></p>		
<p>+ Enter ?? for more actions EP Edit Set EX Exit Select Action: Next Screen//</p>		

Step	Procedure
5	At the Select Action: prompt, enter EP=7 .
6	At the CMS-1500 Auto Printer: prompt, enter the name of the printer to which CMS secondary or tertiary claims will print.

7	At the UB04 Auto Printer : prompt, enter the name of the printer to which CMS secondary or tertiary claims will print.
8	At the EOB Auto Printer : prompt, enter the name of the printer to which CMS secondary or tertiary claims will print.
9	At the MRA Auto Printer : prompt, enter the name of the printer to which CMS secondary or tertiary claims will print.
	<i>Note: The same printer can be used to print more than one thing if your printers are setup to handle more than one form type.</i>
	<i>Remember: The MRA is a 132 column printout.</i>

```

UB-04 PRINT LEGACY ID: YES//
CMS-1500 PRINT LEGACY ID: YES//
UB-04 ADDRESS COLUMN:
CMS-1500 ADDRESS COLUMN: 40//
CMS-1500 Auto Printer:
UB-04 Auto Printer:
EOB Auto Printer:
MRA Auto Printer:

```

9.2. Enable Automatic Processing of Secondary/Tertiary Claims

A new field was added to the MCCR Site Parameter Display/Edit option so that users can enable/disable the automatic processing of secondary/tertiary non-MRA claims.

Step	Procedure
1	Access the MCCR System Definition Menu .
2	At the Select MCCR System Definition Menu Option : prompt, enter Site for MCCR Site Parameter Display/Edit.
3	At the Select Action : prompt, Enter IB to access the IB Site Parameters.

```

MCCR Site Parameters          Feb 01, 2011@15:04:47          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
  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// IB Site Parameters


```

The following screen will display.

IB Site Parameters	Feb 01, 2011@16:22:02	Page: 1 of 5
Only authorized persons may edit this data.		
[1] Copay Background Error Mg: IB ERROR Copay Exemption Mailgroup: IB ERROR Use Alerts for Exemption : NO		
[2] Hold MT Bills w/Ins : YES # of Days Charges Held: 90 Suppress MT Ins Bulletin : NO Means Test Mailgroup : IB MEANS TEST Per Diem Start Date : 11/05/90		
[3] Disapproval Mailgroup : MCCR - BUSINESS OFFICE Cancellation Mailgroup : UB-82 CANCEL Cancellation Remark : BILL CANCELLED IN BUSINESS OFFICE		
[4] New Insurance Mailgroup : IB NEW INSURANCE Unbilled Mailgroup : IB UNBILLED AMOUNTS Auto Print Unbilled List : NO		
+ Enter ?? for more actions		
EP Edit Set		EX Exit
Select Action: Next Screen//		

Step	Procedure
4	At the Select Action: prompt, press the <Enter> key to accept the default of Next Screen until Section 14 is displayed.

IB Site Parameters	Sep 16, 2011@14:32:21	Page: 3 of 5
Only authorized persons may edit this data.		
+ Enter ?? for more actions		
[10] Pay-To Providers : 1 defined, default - CHEYENNE TEST1 VAMC		
[11] Inpt Health Summary: INPATIENT HEALTH SUMMARY Opt Health Summary : OUTPATIENT HEALTH SUMMARY		
[12] HIPPA NCPDP Active Flag : Not Active Drug Non Covered Recheck Period : 0 days(s) Non Covered Reject Codes : 70 Product/Service Not Covered		
[13] Inpatient TP Active : YES Outpatient TP Active: YES Pharmacy TP Active : YES Prosthetic TP Active: YES		
[14] EDI/MRA Activated : BOTH EDI AND MRA		
+ Enter ?? for more actions		
EP Edit Set		EX Exit
Select Action: Next Screen//		

Step	Procedure
5	At the Select Action: prompt, enter EP=14 .
6	The Enable Auto Reg EOB Processing?: prompt will be set to YES.
	<i>This parameter should not be changed unless there is a compelling reason to stop the automatic processing of secondary/tertiary claims.</i>

```

Select Action: Next Screen// ep=14   Edit Set
SITE CONTACT PHONE NUMBER: 307-778-7581//
LIVE TRANSMIT 837 QUEUE: MCT//
TEST TRANSMIT 837 QUEUE: MCT//
AUTO TRANSMIT BILL FREQUENCY: 1//
HOURS TO TRANSMIT BILLS: 1130;1500;1700//
MAX # BILLS IN A BATCH: 10//
ONLY 1 INS CO PER CLAIM BATCH: YES//
DAYS TO WAIT TO PURGE MSGS: 15//
Allow MRA Processing?: YES//
Enable Automatic MRA Processing?: YES//
Enable Auto Reg EOB Processing?: YES//

```

9.3. Printed Claims Rev Code Excl: 17 Activated Codes Defined

Patch IB*2*547 added Section 8, Printed Claims Rev Code Excl:, to the IB Site Parameters. When the Patch is installed, the following revenue codes, if active, will be pre-populated:

- 270-279
- 290-299

Users will be able to add and/or delete additional revenue codes. Revenue codes that are defined here will be used to screen out claims from the Printed Claims report.

```

IB Site Parameters          Nov 03, 2015@10:43:20          Page:      2 of      5
Only authorized persons may edit this data.
+
[5] Medical Center          : CHEYENNE VAMC                Default Division   : CHEYENNE VAMR
    MAS Service              : BUSINESS OFFICE            Billing Supervisor  : WAITHE,MOSES

[6] Initiator Authorize: YES                                Xfer Proc to Sched : YES
    Ask HINQ in MCCR        : YES                          Use Non-PTF Codes  : YES
    Multiple Form Types: YES                                Use OP CPT screen  : YES

[7] UB-04 Print IDs        : YES                            UB-04 Address Col  :
    CMS-1500 Print IDs      : YES                            CMS-1500 Addr Col  : 40
    CMS-1500 Auto Prter:   :                                UB-04 Auto Prter   :
    EOB Auto Prter         :                                MRA Auto Prter     :

[8] Printed Claims Rev Code Excl: 17 Activated Codes Defined

[9] Default RX DX Cd       : Z76.0 (ICD-10)                Default ASC Rev Cd : 490
    Default RX CPT Cd      : J8499                          Default RX Rev Cd  : 250

+          Enter ?? for more actions
EP  Edit Set                                EX  Exit
Select Action: Next Screen//

```

```

Excluded Revenue Codes      Nov 03, 2015@11:05:06          Page:      1 of      1

#    RCD    DESCRIPTION
1.   270    MED-SUR SUPPLIES
2.   271    NON-STER SUPPLY
3.   272    STERILE SUPPLY
4.   273    TAKEHOME SUPPLY
5.   274    PROSTH/ORTH DEV
6.   275    PACE MAKER
7.   276    INTRA OC LENS
8.   277    O2/TAKEHOME

```

9.	278	SUPPLY/IMPLANTS
10.	279	SUPPLY/OTHER
11.	290	MED EQUIP/DURAB
12.	291	MED EQUIP/RENT
13.	292	MED EQUIP/NEW
14.	293	MED EQUIP/USED
15.	294	MED EQUIP/SUPPLIES/DRUGS
16.	299	MED EQUIP/OTHER
Enter ?? for more actions		
AC	Add Revenue Code	DC Delete Revenue Code EX Exit
Select Item(s): Quit// ac Add Revenue Code		
Revenue Code: 118 REHAB/PVT REHABILITATION		
Revenue Code:		

Step	Procedure
1	Access the MCCR System Definition Menu .
2	At the Select MCCR System Definition Menu Option: prompt, enter Site for MCCR Site Parameter Display/Edit.
3	At the Select Action: prompt, Enter IB to access the IB Site Parameters.
4	At the Select Action: Next Screen// prompt, enter EP=8 to access Excluded Revenue Codes
5	At the Select Item(s): Quit// prompt, enter AC for Add Revenue Code
6	At the Revenue Code: prompt, enter a Revenue Code number
7	At the Revenue Code: prompt, press the Enter key when done adding codes

9.4. Alternate Primary Payer ID Types

Patch IB*2*547 added Sections 17 and 18, Alt Prim Payer ID Typ-Medicare and Alt Prim Payer ID Typ-Commercial. Users can define qualifiers to be used to define alternative professional and/or institutional primary payer IDs by type in Insurance Company Entry/Edit. These ID types provide the ability to direct 837 transactions to different processing entities depending on the type of claim.

IB Site Parameters	Nov 03, 2015@11:21:32	Page:	4 of 5
Only authorized persons may edit this data.			
+			
[16] EDI/MRA Activated : BOTH EDI AND MRA			
EDI Contact Phone : (307)778-7581			
EDI 837 Live Transmit Queue : MCT			
EDI 837 Test Transmit Queue : MCT			
Auto-Txmt Bill Frequency : Every Day			
Hours To Auto-Transmit : 1130;1500;1700			
Max # Bills Per Batch : 10			
Only Allow 1 Ins Co/Claim Batch?: NO			
Last Auto-Txmt Run Date : 03/08/11			
Days To Wait To Purge Msgs : 15			
Allow MRA Processing? : YES			
Enable Automatic MRA Processing?: YES			
Enable Auto Reg EOB Processing? : YES			
[17]Alt Prim Payer ID Typ-Medicare: 2 defined			
[18]Alt Prim Payer ID Typ-Commercial: 2 defined			
+ Enter ?? for more actions			
EP	Edit Set	EX	Exit
Select Action: Next Screen//			

Step	Procedure
1	Access the MCCR System Definition Menu .
2	At the Select MCCR System Definition Menu Option: prompt, enter Site for MCCR Site Parameter Display/Edit.
3	At the Select Action: prompt, Enter IB to access the IB Site Parameters.
4	At the Select Action: Next Screen// prompt, enter EP=17 to access Alt Prim Payer Typ-Medicare
5	At the Select Item(s): Quit// prompt, enter AT for Add ID Type
6	At the Enter a Primary ID Type: prompt, enter a Free Text ID Type
7	At the Are you adding 'HOSPICE' as a new IB ALTERNATE PRIMARY ID TYPES (the 2nd)? No// prompt, enter YES
8	At the Enter a Primary ID Type: prompt, press the Enter key when done adding types

```

Alt Primary Payer ID Types      Nov 03, 2015@11:32:18      Page:      1 of      1

1      DME

Enter ?? for more actions
AT  Add ID Type      DT  Delete ID Type      EX  Exit
Select Action: Quit//AT Add ID Type
Enter a Primary ID Type: HOSPICE
Are you adding 'HOSPICE' as
a new IB ALTERNATE PRIMARY ID TYPES (the 4TH)? No// y

```

9.5. ASC X12N Health Care Claim Request for Additional Information (277RFAI)

Patch IB*2*547 added Section 20 to the IB Site Parameters. When the Patch is installed, the following 277RFAI parameters will be pre-populated:

- Days to store 277RFAI Transactions
- Days to wait to purge entry on RFAI Management Worklist

```

IB Site Parameters      Nov 03, 2015@12:33:34      Page:      5 of      5
Only authorized persons may edit this data.
+

[19]Are we using ClaimsManager? : NO
Is ClaimsManager working OK? : NO
ClaimsManager TCP/IP Address : 10.152.21.145
ClaimsManager TCP/IP Ports : 10040
                             10050
                             10060
                             10070
                             10080
General Error MailGroup : IBCI GENERAL ERROR
Communication Error MailGroup: IBCI COMMUNICATION ERROR
MailMan Messages : PRIORITY

[20]Days to store 277RFAI Transactions: No Purge

```

Days to wait to purge entry on RFAI Management Worklist: 20

Enter ?? for more actions
EP Edit Set EX Exit
Select Action: Quit// ep=20 Edit Set
PURGE DAYS 277 RFAI: ??
Enter the number of days (between 365 and 3000) to
retain 277 RFAI transactions in VistA.
A null entry (the default) indicates the transactions
will be stored forever.
PURGE DAYS 277 RFAI:
WORKLIST PURGE DAYS 277 RFAI: 20//

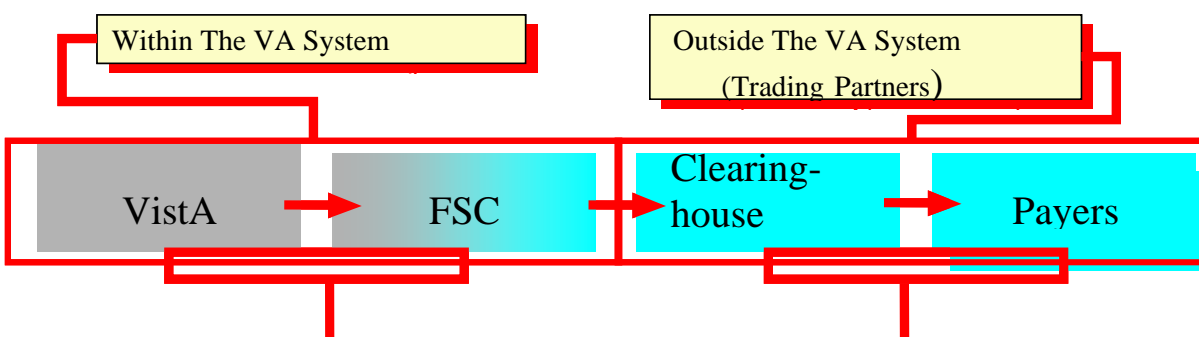
Step	Procedure
1	Access the MCCR System Definition Menu .
2	At the Select MCCR System Definition Menu Option: prompt, enter Site for MCCR Site Parameter Display/Edit.
3	At the Select Action: prompt, Enter IB to access the IB Site Parameters.
4	At the Select Action: Quit// prompt, enter EP=20 to access the 277RFAI parameters
5	At the PURGE DAYS 277 RFAI: prompt, press the Enter key to accept the default
6	At the WORKLIST PURGE DAYS 277 RFAI: prompt, enter a Number that represents the number of days a 277 RFAI entry will remain on the RFAI Worklist before being automatically removed

10. Reports

There are a number of reports available to monitor and manage electronic claims. The EDI menu option can be accessed from the Billing Clerk's Menu.

10.1. EDI Reports – Overview

TR reports provide the end-user with information to monitor and manage EDI claims still within the VA, that is, between the VAMC and the FSC in Austin, TX. The MM reports provide the end-user with information and feedback from parties external to the VA such as the clearinghouse and the various electronic payers.



TR- EDI Transmission Status Reports -

BAR	Bills Needing Resubmission Action
ECS	EDI Claim Status Report
MP	EDI Messages Not Yet Filed
PBT	Pending Batch Transmission Status Report
PND	EDI Batches Pending Receipt
REX	Ready for Extract Status Report
VPE	View/Print EDI Bill Extract Data

MM-EDI Return Message Management

EDI	Return Message Management Option Menu
CSA	Claim Status Awaiting Resolution
MCS	Multiple CSA Message Management
TCS	Test Claim EDI Transmission Report
	EDI Message Text to Screen Maint
	EDI Message Not Reviewed Report
	Electronic Error Report
	Electronic Report Disposition
	Return Message Filing Exceptions
	Status Message Management

10.2. Most Frequently Used Menus/Reports

10.2.1 Claims Status Awaiting Resolution – Synonym CSA

What is the purpose of this report?

Billing and Accounts Receivable (or Accounts Management) staff use CSA to review the most current status messages and to perform follow-up actions on the bills. Electronic status messages, which include information and rejection messages from the clearinghouse or the payers, are accessed using this option.

When is this option used?

This is an option that must be checked **Daily** to determine which claims have rejection or warning messages that were returned from the clearinghouse or from payers. The cause for rejections must be resolved. This option should be used in conjunction with supporting reports (e.g. R022, R0SS, R0SC).

The CSA report contains a Primary, Secondary and Tertiary sort capability and can be sorted by:

A	Authorizing Biller
B	Bill Number
C	Current Balance
S	Date of Service
D	Division
E	Error Code Text
N	Number of Days Pending
M	Patient Name
P	Payer
R	Review in Process
L	SSN Last 4

Once the CSA screen list is displayed, users can select new sort criteria and **re-sort** the list without exiting the option.

Reports can be run showing rejections only (R), or both informational and rejection messages (B). Users most often run the CSA report to show rejections only so they can focus on those claims that require corrective action.

These messages are automatically assigned a status of **Not Reviewed** and require users to review them and make corrections to update this status in IB. Users select a bill from the list to view the details and the entire message text. Messages are marked as **reviewed** or **review in process**. Users may document comments.



*With Patch IB*2.0*320, changes were made to suppress the display of 2Q Claim Status Messages and duplicate claim status messages.*

As messages are reviewed they can be marked as follows:

- **Not Reviewed** – No action has been taken on a bill that has been returned from the clearinghouse/payer
- **Review in Process** – While a claim is being reworked, the status can be changed to “Review in Process”
- **Review Complete** – The error has been resolved and the message from this report will be cleared

Actions such as Cancel Bill, Copy/Cancel Bill, TPJI and Print Bill are available to the user via this option and the user can make needed corrections and re-submit claims from within this option.

Other options available on the CSA include:

- CSA-EDI History Display – The EDI History display option shows all the status messages under the selected bill/message. This information is similar to information that can be viewed under the TPJI menu options.
- CSA-Enter/Edit Comments – The enter/edit comments option gives the user the ability to add a comment onto a bill (status message) in order to inform AR and billing why the issue hasn't been resolved or why the claim was printed to paper.
- CSA-Resubmit by Print – The Resubmit by Print action is used when the user reviews the status message or bill and determines the only way to correct the problem is to submit the claim on hard copy as it cannot pass the electronic edits. The user may “resubmit by print” to the payer instead of retransmitting electronically. If printed from this option, users will be asked if they wish to “review complete” the status message, which will automatically clear it from the report.
- CSA-Retransmit a Bill – Similar to the Resubmit by Print action, the Retransmit Bill is used when the user reviews the status message or bill and determines the reason for the rejection has been corrected elsewhere in the system and the claim just needs to be resent. The user may then retransmit to the payer.
- CSA-Review Status – A bill will continue to show up on the report until it is cancel/cloned, canceled or the status is changed to Review Complete.

Users also have access to the option Multiple CSA Message Management from within the CSA list if they hold the IB Message Management security key.



*Note: After Patch IB*2*547 is installed, the source of a claim status message will include the name of the clearinghouse when the clearinghouse is the source.*

10.2.2 Multiple CSA Message Management – Synonym: MCS

What is the purpose of this option?

This option is designed to allow users to take action on CSA messages when a problem arises during the processing of electronic claims that causes a large volume of erroneous status messages to be sent to the site. This option performs tasks similar to the CSA option.



*This option is locked by the **IB Message Management** security key.*

When is this option used?

This option is used when there are pages of erroneous messages in CSA that were caused by a processing problem. Use this option to take a similar action (such as retransmission of the associated claims) on multiple claims at the same time.

The initial search for claims and claims status messages is done automatically when the option is selected. The initial search results in the display of all claims that are **Not Cancelled** and for which the review status is **Not Reviewed** or **Review in Process**.



*If someone else is working on a claim in CSA, it will not display in MCS. Only one user can be in MCS at a time. The following message will be displayed: **Sorry, another user is currently using the MCS option. Please try again later.***

Once the initial list has been built, users may further refine their search or work from the default list.



The purpose of MCS is to select multiple claims and then apply the same action to all the selected claims. For example, users can enter a comment once and then apply the comment to 1-n claims.

Other actions available on the MCS include:

- Message Search – Allows the user to change the criteria upon which the list of claims will be built
- Change Review Status – Same as CSA
- Cancel Claims – Same as CSA
- Enter Comment – Same as CSA
- Resubmit by Print – Same as CSA
- Retransmit Bill – Same as CSA
- Select/Deselect Claims – Allows users to select the claims to which they want to apply an action



When using the Resubmit by Print action, the claims selected will not be removed from the list of claims until the claims have actually been printed.

10.2.3 Electronic Report Disposition

What is the purpose of this option?

This option allows the site to determine which clearinghouse generated electronic messages/reports are to be sent to the EDI mail group and which should be ignored.

When is this option used?

The default setting on this report will contain a disposition of “Mail Report to Mail Group”. It is up to the individual site’s supervisory staff to determine what reports should be ignored.



Further explanations of these reports are available in documents provided by the clearinghouse. They are entitled Claim Submitter Reports – Providers Reference Guide.

The following reports should be reviewed when they are received. They contain information that cannot be translated into claim status messages therefore, this information is not available in CSA.

R000 NETWORK NEWS

Provides news on system problems, updates and other pertinent information.

RPT-02 FILE STATUS REPORT

Provides an initial analysis of the file by displaying file status of accepted or rejected and a description of the status. It also indicates the total number of claims and the dollar value if the file contains valid claims.

RPT-03 FILE SUMMARY REPORT

Provides summarized information on the quantity of accepted, rejected, and pending claims, as well as the total number of claims received by the clearinghouse for each submitted file.

RPT-08 PROVIDER MONTHLY SUMMARY

Displays the number and dollar value of claims accepted and forwarded by the clearinghouse for the month. Monthly and Y-T-D Totals for both accepted and rejected claims are included as well as the provider’s top 25 errors for the month.

The following reports contain information that is also translated into status messages and displayed on CSA.

RPT-04 FILE DETAIL SUMMARY REPORT

Contains a detail summary of the file submitted for processing. It provides a file roll-up listing of all accepted, rejected, and pending claims contained in each file submitted to the clearinghouse. It also contains payer name/id and status of claim.

RPT-04A AMENDED FILE DETAIL SUMMARY REPORT

Contains a detailed listing of all claims for which the status was amended during the previous processing day. Claims statuses are amended when a pending claim is processed and/or a claim is reprocessed at the clearinghouse.

RPT-05 BATCH & CLAIM LEVEL REJECTION REPORT

Contains rejected batches and claims listed with detailed error explanations. In order to prevent “lost” claims, the RPT-05 report must be reviewed and worked after each file transmission.

RPT-05A AMENDED BATCH & CLAIM LEVEL REJECTION REPORT

Contains rejected batches and claims listed with detailed error explanations. In order to prevent “lost” claims, the RPT-05A report must be reviewed and worked after each file transmission.

RPT-10 PROVIDER CLAIM STATUS

This report contains information provided from payers who are receiving claims for adjudication from the clearinghouse. Not all payers who process claims through the clearinghouse system provide information for this Provider Claim Status Report and the amount/frequency of information produced will vary from payer to payer.

RPT-11 SPECIAL HANDLING/UNPROCESSED CLAIMS REPORT

This report contains information provided from payers who are receiving claims for adjudication from the clearinghouse. Not all payers who process claims through the clearinghouse system provide information for this Provider Claim Status Report and the amount/frequency of information produced will vary from payer to payer. The RPT-11 returns Unprocessed, Request for Additional Information, and Rejected statuses only.

10.2.4 EDI Claim Status Report- Synonym: ECS

What is the purpose of this report?

View electronic transmission status to assure claims move through the system in a timely fashion.

When is this option used?

It is recommended that initially this report be viewed daily as it provides transmission status of all claims that were transmitted to FSC. Once a comfort zone is established and everything is flowing correctly, this report may only need to be run monthly.

Reports can be created based on:

- Specific Claim or Search Criteria
- Division
- Payer
- Transmission Date range
- EDI Status

Reports can be sorted by:

- Transmission Date
- Payer
- EDI Status
- Current Balance
- Division
- Claim Number
- AR Status
- Age

Possible EDI claim statuses include:

- Ready for Extract
- Pending Austin Receipt
- Accepted by Non-Payer
- Accepted Payer
- Error Condition
- Cancelled
- Corrected/Retransmitted
- Closed

10.3. Additional Reports and Options

10.3.1 Ready for Extract Status Report - Synonym: REX

What is the purpose of this report?

This report provides a list of claims held in a Ready for Extract status. These claims are held in a queue until batch processing occurs.

When is this option used?

Initially this option is used to assure claims are being transmitted at the times set in the MCCR Site Parameters. This option should be reviewed daily until there is a comfort level with the transmission timeframes and then less frequently based on local experience.

Claims that are trapped due to the EDI parameters being turned off can also be viewed. It is rare that EDI is turned off during processing. If this occurs, use EXT Extract Status Management to Cancel or Cancel/Clone/Auth the trapped claims.

Choices to view are:

- 1 All bills in Ready for Extract status
- 2 Bills trapped due to EDI parameter being turned off
(If EDI is on, no bills will be trapped in extract)

10.3.2 Transmit EDI Bills – Manual - Synonym: SEND

What is the purpose of this option?

This option is used to by-pass the normal daily/nightly transmission queues if the need arises to get the claim to the payer quickly.

When is this option used?

There are occasions when there is a need to transmit a claim(s) immediately instead of waiting for the batching frequency as scheduled in the MCCR Site Parameter. This option will allow sending individual claim(s) or all claims in a ready for extract status.

Select one of the following:

- A Transmit (A)LL bills in READY FOR EXTRACT status
- S Transmit only (S)ELECTED bills

10.3.3 EDI Return Message Management Menu – Synonym: MM

This menu contains the options needed to define the types of electronic reports from the clearinghouse that the site needs to see and defines the text that should/should not allow automatic review and filing for informational status messages. It also contains an option to purge old status messages, reports for maintaining the integrity of the return message subsystem and the option for reviewing electronically returned messages.

10.3.4 EDI Message Text to Screen Maintenance

What is the purpose of this option?

This option controls what status and/or error messages users may wish to review using special text words and/or phrases. This will either require the message to be reviewed or it will auto-file the message and flag it as not needing a review.

This option allows for the display of a list of words or phrases that, if found in the text of an informational status message, will either always require the message to be reviewed or will auto-file the message and flag it as not needing a review.

When is this option used?

Depending on what types of status messages users wish to review for follow-up on rejected claims and/or monitoring claims status, users may want to add or edit additional text as needed.

The words and phrases for “Requiring Review” and “Not Requiring Review” will initially populate as shown in the screen print below. This option is used to edit or add more words or phrases, as required, to manage and control the status messages.

10.3.5 EDI Messages Not Reviewed Report

What is the purpose of this report?

This option allows for the display of all EDI return messages that were filed without needing a review based on the text entries in the message screen text file.

When is this option used?

The report can be run for a user-selected date range, based on the date the message was received at the site, and may be sorted by the message text that caused the message to not need a review or by the bill number. Users may want to use this option for analysis or review of all EDI messages that they were not able to view initially.

10.3.6 Electronic Error Report

What is the purpose of this report?

This report provides a tool for billing supervisors and staff to identify the “who, what, and where” of errors in the electronic billing process. This is a report that will allow the supervisory staff to review “frequently received” errors. This is an informational management tool requiring no actions on the part of the billing staff.

When is this option used?

This option can be used at any time by a supervisor or other management staff when they want to determine the reason for various errors (i.e., the same error being made by one or more of the billing staff). The report can be sorted by:

A	AUTHORIZING BILLER
B	BILLED AMOUNT
E	EPISODE OF CARE
P	PATIENT NAME
S	PATIENT SSN
Y	PAYER NAME
C	ERROR CODE

10.3.7 Return Messages Filing Exceptions

What is the purpose of this option?

After users have transmitted claims and they have been received for EDI processing, a message will be sent to the mail groups shown in the set-up section of this manual.

When is this option used?

When a message is sent, it is temporarily stored in the “EDI MESSAGES” file. Normally, these messages are in and out of this file in a matter of seconds. If, however, a problem is detected and a message cannot be filed in the appropriate file (s) for its message type, the message will remain in this temporary file. There are two (2) *statuses* for messages in this file.

- **Pending:** The task to force a message to update the IB files has either not yet been created or has been created, but has not yet begun to run.
- **Updating:** The task to force a message to update the IB files has started. It may or may not still be running. If you try to file a message with this status, a check is made to see if it is currently running. If it is, the message will not be re-tasked.

Any message may be viewed or printed. This does not affect the message in any way, but looking at the message may help to indicate the next course of action needed.

There are two (2) *actions* available to get these messages out of the file.

- **File Message:** This action re-executes the tasked job to update the database with the contents of the message.
- **Delete Message:** This is a drastic action that should only be taken when it has been determined there is no other possible way to process a message. When a message is deleted using this action, a bulletin is sent to the IB EDI Mail Group with the text of the message and the name of the user who deleted the message. Users must hold the IB SUPERVISOR security key to perform this action.

10.3.8 Status Message Management

What is the purpose of this option?

This option allows users to print/purge electronically returned status messages that have been in a final review status for a user-selected number of days.

When is this option used?

There will be an accumulation of status messages in a final review status. This option will delete or purge status messages in one of the Final Review statuses prior to a selected date. Auto purging of messages can also be set in the IB Site Parameters.

This report can be sorted by:

- A ALL STATUS MESSAGES
- S SELECTED STATUS MESSAGES

Selected status message reports can be run showing:

- A Auto Filed/No Review Only
- B Bill Number
- S Message Severity
- T Specific Message Text

10.3.9 Bills Awaiting Resubmission – Synonym: BAR

What is the purpose of this report?

This report lists all batches that have been resubmitted but which did not include all of the bills from the original batch. These are batches that have at least one bill still not resubmitted or canceled.

When is this option used?

When a batch is identified to have a claim in error, the batch may be re-submitted with the claim in error removed. This option will track and report specific bills in this category. The report can sort data by:

- B BILL NUMBER
- L LAST SENT DATE
- A BILLED AMOUNT
- N BATCH NUMBER (LAST SENT IN)

The report also indicates the “Bill Transmission Status”.

10.3.10 EDI Messages Not Yet Filed –Synonym: MP

What is the purpose of this report?

This report allows you to select receipt, rejection or both message types and a minimum number of days these messages have been in a PENDING or UPDATING status before they will be included on the report. The report will then list all messages in the file that meet these criteria.

When is this option used?

This is a status report that allows for review of messages not yet filed.

10.3.11 Pending Batch Transmission Status Report – Synonym: PBT

What is the purpose of this report?

This report shows the current transmission status of a batch's mail message. It also includes the mail message number; the first and last date/time it was sent. Only batches in a pending transmission status will be on this report.

When is this option used?

This is another option to track the batch(s) of claims after authorizing and transmission to be sure all batches transmitted have been received in Austin. Users can omit both the station number prefix at the front of the batch number and the following zeroes and use only the final digits of the batch number for lookup.

10.3.12 EDI Batches Pending Receipt– Synonym: PND

What is the purpose of this report?

This report lists all batches by batch number that have been in a PENDING status and have not yet received confirmation of receipt from Austin for more than one (1) day. The report includes individual claims if the users choose to include them.

The report includes:

- Batch Number
- Transmission Date
- Mail Message #

Claims display the following:

- Claim Number
- Payer Sequence
- Balance Due
- EDI Status
- IB Status
- AR Status

EDI Batches Pending Austin Receipt After 1 Day					Page: 2
Run Date: 01/07/2008@14:44:28					
Batch #	Transmission Date		Mail Message #		

Claim	Seq	Bal Due	EDI Stat	IB Status	AR Status
K600KQD	P	198.54	P	PRNT/TX	NEW BILL
K600NEU	P	76.36	P	PRNT/TX	NEW BILL
K600QR2	P	305.11	P	PRNT/TX	NEW BILL
K600WS7	P	76.36	P	PRNT/TX	NEW BILL
K600WSF	P	880.71	P	PRNT/TX	NEW BILL
4420029590	03/29/2006@21:05:33		1321		
Claim	Seq	Bal Due	EDI Stat	IB Status	AR Status
K600FN7	P	76.36	P	REQUEST MRA	BILL INCOMPLETE
K600IPF	P	73.01	P	REQUEST MRA	BILL INCOMPLETE
K600WSA	P	4390.06	P	REQUEST MRA	BILL INCOMPLETE
K600WSK	P	73.01	P	REQUEST MRA	BILL INCOMPLETE
Enter ENTER to continue or '^' to exit:					



Members of the G.IB EDI mail group will receive an email message when there are batches of claims that have not received a confirmation message from Austin after 1 day.

```

Subj: EDI BATCHES WAITING AUSTIN RECEIPT FOR OVER 1 DAY  [#21387]
06/19/04@19:02  6 lines
From: XXXXXXXXXXXX,XXXX X  In 'IN' basket.  Page 1  *New*
-----
There are 30 EDI batch(es) still pending Austin receipt
for more than 1 day.  Please investigate why they have not yet been confirmed
as being received by Austin.




Since there were more than 10 batches found, please run the
EDI BATCHES WAITING FOR AUSTIN RECEIPT OVER 1-DAY report to get a list of the
se batches.

Enter message action (in IN basket): Delete//

```

When is this option used?

Users may use this option to obtain Batch or Messages numbers when a problem arises or to monitor the status of batches recently transmitted. Batches should not be in a “Pending Austin Receipt” status for more than a day.

	<i>Contact IRM for assistance in finding out why a confirmation message has not been received from Austin.</i>
	<i>Before contacting IRM, note the Message Numbers for the batches that you need investigated. These numbers can be found in the PND option.</i>
	<i>If IRM needs assistance, log a REMEDY ticket or call the National Help Desk at 1-888-596-4357.</i>

10.3.13 View/Print EDI Bill Extract Data – Synonym: VPE

What is the purpose of this option?

This option displays the EDI extract data for a bill.

When is this option used?

This option is used only if there is a need to determine what data was transmitted for a specific bill. The detailed extract data will contain all the elements in the flat file that is transmitted to FSC. FSC, in turn, translates the data to a HIPAA-compliant format for transmission to the clearinghouse.

10.3.14 Insurance Company EDI Parameter Report – Synonym: EPR

What is the purpose of this option?

This option will display the EDI Parameters of the Active Insurance Companies defined in Vista.

The contents of the following parameters will be included in this report:

- Insurance Company Name
- Street Address and City of Insurance Company
- Electronic Transmit?
- Institutional Electronic Bill ID
- Professional Electronic Bill ID
- HPID/OEID
- Electronic Type
- Type of Coverage
- Always Use main VAMC as Billing Provider

```

All Companies                               Insurance Company EDI Parameter Report                               Page: 1
Sorted By Ins Company Name                                                         Mar 02, 2015@10:30:28
Only Blank or 'PRNT' Bill ID's = NO
'*' indicates the HPID/OEID failed validation checks
                                           Electron Inst Prof HPID/ Electronic
Insurance Company Name Street Address City Transmit ID ID OEID Type Coverage Type
=====
INSURANCE COMPANY ONE PO BOX 141159 XXX,OH YES-L 8XXXX 8XXXX 7999999999 GROUP PLAN HEALTH INS...
INSURANCE COMPANY TWO PO BOX 30101 XXX,UT YES-L                               6999999999* OTHER HEALTH INS...

```

When is this option used?

This option can be used whenever there is a need to confirm that the Insurance Company parameters are correctly defined to support the electronic transmission of claims. This option will be of value when the eClaims Plus patches are loaded and sites gain the ability to transmit secondary claims to the payers (electronic, end-to-end processing). **Example:** Sites can use this option to make sure the payers' Electronic Bill IDs are defined.

10.3.15 Test Claim EDI Transmission Report – Synonym: TCS

What is the purpose of this option?

The Claim Status Messages for claim(s) and batch(es) submitted via the RCB option as Test claims will not appear in CSA. No action will be required in response to these messages. For informational purposes, these messages will be available through the Test Claim EDI Transmission Report. This option can be used to investigate the status of test claims to see, for example, whether the transmission was accepted/rejected by FSC or accepted/rejected by the clearinghouse.



The messages in this option will be automatically purged after 60 days.

When is this option used?

This option can be used whenever a user needs to investigate the current status of a claim or batch of claims. The messages in this report will be like the messages in TPJI.

```

Test Claim EDI Transmission Report                               Page: 1
Selected Batches                                                         Mar 22, 2005@12:14:38
=====
Batch#: 6050011719
Claim#: K404XXX IB,Patient7 (1500, Prof, Outpat)
-----
Transmission Information
03/17/2005@11:11:25 Bch#11719 IB,Clerk2 CIGNA HEALTHCARE (S)

```

10.3.16 Third Party Joint Inquiry – Synonym: TPJI

What is the purpose of this option?







This option provides a convenient location for both claim, AR, Insurance and EDI data related to a claim.

When is this option used?

This option is used by both Integrated Billing and Accounts Receivable personnel who require information about a claim. Both AR and IB users can also add comments to an MRA Request or non-MRA Request claim using this option.

The following actions are available from TPJI:

BC	Bill Charges
DX	Bill Diagnosis
PR	Bill Procedures
CB	Change Bill
ED	EDI Status
AR	Account Profile
CM	Comment History
IR	Insurance Reviews
HS	Health Summary
AL	Active List
VI	Insurance Company
VP	Policy
AB	Annual Benefits
EL	Patient Eligibility

	<i>Patch IB*2*377 included changes to allow the addition of and the viewing of MRA Request claim comments using TPJI. Comment History now pertains to MRA Request claims as well as regular claims. MRA Request claim comments are not stored as AR comments though.</i>
	<i>Note: Patch IB*2*516 changed the lists of Active and Inactive claims to display the claim type of either Institutional or Professional in addition to Inpatient, Inpatient Humanitarian, Outpatient, or Outpatient Humanitarian.</i>
	<i>Note: Patch IB*2*516 also added the ability for users to view related claims for which the patient is responsible, when reviewing Claim Information for a selected claim.</i>
	<i>Note: After Patch IB*2*547 is installed, the source of a claim status message will include the name of the clearinghouse when the clearinghouse is the source.</i>
	<i>Note: After Patch IB*2*547 is installed, users will be able to view the comments that were added to an entry on the new RFAI Management Worklist in the comment section of the TPJI.</i>
	<i>Note: After Patch IB*2*547 is installed, users will be able to view the complete and current textual description associated with the Claims Adjustment Reason Codes/Remittance Advice Remark Codes (CARC/RARC) received in an electronic EOB.</i>

Patch IB*2*488 modified the way message storage errors (created when an EEOB or MRA is received and all the line items cannot be matched correctly) are displayed in TPJI. Internal MUMPS code will no longer be displayed to the users.

The Following types of errors will be displayed:

- Procedure Code mismatch
- Procedure Modifier mismatch
- Revenue Code mismatch

- Charge Amount mismatch
- Number of Units mismatch

```

Claim Information                      Nov 25, 2013@14:56:02          Page: 1 of 2
%K101XXX  IB,PATIENT 123              IXXXXX              DOB: XX/XX/XX      Subsc ID: XXXXXXXXXX

Insurance Demographics                Subscriber Demographics
  Bill Payer: IB INSURANCE CO          Group Number: GRP PLN XXXXX
Claim Address: PO BOX XXXXX           Group Name: STATE OF WY
              CHEYENNE, WY 820031234   Subscriber ID: XXXXXXXXXX
Claim Phone: 800/XXX-XXXX             Employer: STATE OF WYO
                                      Insured's Name: IB,PATIENT 123
                                      Relationship: PATIENT

                                Claim Information
  Bill Type: OUTPATIENT                Charge Type: INSTITUTIONAL
Time Frame: ADMIT THRU DISCHARGE       Service Dates: XX/XX/XX - XX/XX/XX
Rate Type: REIMBURSABLE INS.          Orig Claim: 145.49
AR Status: ACTIVE                     Balance Due: 145.49
+      |% EEOB | Enter ?? for more actions|
BC Bill Charges                      AR Account Profile          VI Insurance Company
DX Bill Diagnosis                   CM Comment History          VP Policy
PR Bill Procedures                  IR Insurance Reviews        AB Annual Benefits
CB Change Bill                     HS Health Summary           EL Patient Eligibility
ED EDI Status                      AL Go to Active List         EB Expand Benefits
RX ECME Information                EX Exit
Select Action: Next Screen// BC Bill Charges
DO YOU WANT ALL EEOB DETAILS?: NO// Y

```

The type of mismatch error and the values that were in the outbound 837 transaction will be displayed along with the values that were received in the inbound 835 transaction.

```

Bill Charges                          Apr 14, 2014@16:27:18          Page: 7 of 8
K101EVT  IB,PATIENT MRA  I4321        DOB: 12/01/66      Subsc ID: 011871234A
04/10/14 - 04/10/14          ADMIT THRU DISCHARGE      Orig Amt: 0.00
+
-----
VistA could not match all of the Line Level data received in the EEOB
(835 Record 40) to the claim in VistA.

Mismatched Procedure Code:

Payer reported the following was billed via the Claim (837):
  Proc:71010  Mods:59  Rev Cd:324  Chg:227.40  Units:1
Payer reported adjudication via the EOB (835) as follows:
  Proc:71015  Mods:59  Rev Cd:324  Chg:227.40  Units:1
  Amt:100.00

-----
Service line adjustment (EEOB Record 41) has no matching service line
  Allowed Amt: 114.80  Per Diem Amt: 0.00
-----
Service line adjustment (EEOB Record 45) has no matching service line
+      |% EEOB | Enter ?? for more actions|
PR Bill Procedures                   CM Comment History          AB Annual Benefitslity
CI Go to Claim Screen               IR Insurance Reviews        EL Patient Eligibility
                                   HS Health Summary           EX Exit
ED EDI Status                       AL Go to Active List
                                   VI Insurance Company
Select Action: Next Screen//

```


10.3.17 Re-generate Unbilled Amounts Report

What is the purpose of this option?

This option provides some basic information about billable events that have not yet been billed to a payer and dollar amounts associated with billable events in a specified time-frame.

When is this option used?

This option can be used to view the number of inpatient or outpatient care events and/or prescriptions that have not been billed and the dollar amounts attributed to the events.

```
Subj: UNBILLED AMOUNTS SUMMARY REPORT [#197848] 06/23/14@12:41 34 lines
From: INTEGRATED BILLING PACKAGE In 'IN' basket. Page 1 *New*
-----
SUMMARY UNBILLED AMOUNTS FOR CHEYENNE VAMC (442).
PERIOD: FROM 09/01/04 TO 09/30/06
DETAILED REPORT PRINTED TO '/dev/pts/5'

Inpatient Care:
Number of Unbilled Inpatient Admissions :          0
Number of MRA Unbilled Inpt Admissions  :          2
Number of Inpt. Institutional Cases     :          0
Average Inpt. Institutional Bill Amount :    15321.18
Number of Inpt. Professional Cases      :          0
Average Inpt. Professional Bill Amount  :    1036.36
Total Unbilled Inpatient Care           :          0.00
Total MRA Unbilled Inpatient Care       :          0.00
```



*Note: Patch IB*2*547 provided the ability for users to run this report by division (one or more) or not and to sort the report by division or by patient name in alphabetical order. If users do search by division, the Re-generate Unbilled Amount Summary will display the summary totals before the division data. The display of CPT codes and monetary amounts for outpatient claims has also been restored.*

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

Search by Division?? NO//

Start with DATE: 08/23/1966// t-1000 (FEB 07, 2013)

Go to DATE: 11/04/2015// (NOV 04, 2015)

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

10.3.18 Patient Billing Inquiry – Synonym: INQU

What is the purpose of this option?

This option provides some basic information about a particular claim. It is a simple inquiry option.

When is this option used?

This option can be used to view the following type of information related to a bill:

- Bill Status
- Rate Type
- Form Type
- Visit Date(s)
- Charges
- AR Status
- Statement Dates
- Dates related to actions such as Entered, Cancelled or Printed
- Bill Number copied from or to
- Patient, Mailing and Insurance Company address

The data available varies based upon when the inquiry is made and what actions have been carried out regarding the claim

10.3.19 Printed Claims Report



What is the purpose of this option?

This option provides information about claims that are printed locally but which had the potential to be transmitted electronically. The report can be generated for either the Consolidated Patient Account Centers (CPACs) or the sites which process TRICARE claims.

When is this option used?

This report is used by billing personnel to monitor the printing of potentially transmittable claims and displays the following information:

- Biller
- Outpatient/Inpatient and Institutional/Professional
- Rate Type
- Plan Type
- Division
- Revenue Codes
- Insurance Company

	<i>Note: The revenue codes that determine whether or not a printed claim will be included in this report are defined in the IB Site Parameters.</i>
	<i>Note: Claims to the payer – Department of Labor and certain types of rate types and types of plans are not included in this report because they do not have the potential to be transmitted electronically.</i>

10.3.20 HCCH Payer ID Report

What is the purpose of this option?

When the VHA sends a claim to the clearing house with no defined Primary Payer ID (EDI - Inst Payer Primary ID and/or EDI - Prof Payer Primary ID) and the clearinghouse has an electronic ID for the payer, they return the payer ID to the site. VistA automatically takes the ID and populates the field in the Insurance Company file. This option provides information about the updates or attempted updates to the Insurance Company file.



If a value already exists in VistA for the Payer ID, no update will be made but the attempt will be reported.

When is this option used?

This report is used by billing personnel to monitor the automated updates or update attempts to the Insurance Company file when the 277STAT reports are received from the clearinghouse. The report provides the following data:

- Insurance Company Name
- Insurance Company Address
- Date
- Type of ID (Professional or Institutional)
- Old Value
- New Value
- Update Made (Yes/No)

HCCH Payer ID Report

Jan 11, 2017@09:53:18

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Timeframe: 12/17/16 thru 01/11/17

Insurance Co	Address	Date	EDI-PayerID	OldValue	NewValue	Updated
AETNA	PO BOX 2295 FT. WAYNE INDI	12/28/16	Prof		XXXXX	Yes
AETNA HEALTH PLANS	PO BOX 12340 FRESNO CALIFO	01/02/16	Prof		XXXXX	Yes
BANKERS FIDELITY	PO BOX 105652 ATLANTA GEOR	12/19/16	Prof	XYZ123	123456	No
MEDICARE (WNR)	PO BOX 660159 DALLAS	01/01/17	Inst	XXXXX1	XXXXX2	No

11. APPENDIX A – BATCH PROCESSING SETUP

BATCH PROCESSING SETUP

The following example shows you how to define batch processing for a payer:


Step	Procedure
1	Under the IB Site Parameters , go to field [15] EDI/MRA Activated .
2	Edit fields as necessary (fields are highlighted in yellow for this example).
	<i>Details on each field follow the screen example.</i>
	<i>When the MRA software was loaded (Patch IB*2.0*155), the EDI/MRA Activated field was removed from this screen. Only an IRM is able to access this field via FileMan. The reason for this is to prevent MRA from being activated before the FSC is ready to accept MRA transmissions from a particular site.</i>

IB Site Parameters	Aug 13, 2003@10:22:46	Page: 5 of 6
Only authorized persons may edit this data.		
+-----		
[15] EDI/MRA Activated	:	EDI
EDI Contact Phone	:	
EDI 837 Live Transmit Queue	:	MCH
EDI 837 Test Transmit Queue	:	MCT
Auto-Txmt Bill Frequency	:	Every Day
Hours To Auto-Transmit	:	1300;1600
Max # Bills Per Batch	:	50
Only Allow 1 Ins Co/Claim Batch?	:	NO
Last Auto-Txmt Run Date	:	08/13/03
Days To Wait To Purge Msgs	:	120

EDI/MRA Activated: Controls whether EDI is available for the site.

Choose from:

- 0 - NOT EDI OR MRA;
- 1 - EDI ONLY;
- 2 - MRA ONLY; or
- 3 - BOTH EDI AND MRA

	This prompt is no longer accessible to anyone except an IRM.
---	--

IB Site Parameters	May 27, 2004@14:14:24	Page: 5 of 6
Only authorized persons may edit this data.		
+		
HMO NUMBER	:	
STATE INDUSTRIAL ACCIDENT PROV:	:	
LOCATION NUMBER	:	
[15] EDI/MRA Activated	:	BOTH EDI AND MRA
EDI Contact Phone	:	217-554-3135
EDI 837 Live Transmit Queue	:	MCH
EDI 837 Test Transmit Queue	:	MCT
Auto-Txmt Bill Frequency	:	Every Day
Hours To Auto-Transmit	:	1000;1400;2000
Max # Bills Per Batch	:	10

Only Allow 1 Ins Co/Claim Batch?: NO	
Last Auto-Txmt Run Date	: 05/26/04
Days To Wait To Purge Msgs	: 45
Allow MRA Processing?	: YES
Enable Automatic MRA Processing?	: YES
+ Enter ?? for more actions	
EP Edit Set	EX Exit Action

EDI Contact Phone: The phone number of the person at the site contact to whom EDI inquiries will be directed. The Pay-to Provider telephone number that is defined in Section 10 for each Pay-to Provider, will be printed on the UB04 and CMS-1500 form starting with Patch IB*2.0*400.

EDI 837 Live Transmit Queue: The name of the Austin data queue that will receive claims to be processed via a live connection to the clearinghouse. These data are populated at the time of installation and would not normally be edited by the site.

EDI 837 Test Transmit Queue: The name of the Austin data queue that will receive test claims. These data are populated at the time of installation and would not normally be edited by the site.

Auto Txmt Bill Frequency: The desired number of days between each execution of the automated bill transmitter. For example, if the automated bill transmitter should run only once a week, this number would be 7. If the automated bill transmitter should run every night, then the number should be 1. If this is left blank or zero then the automated bill transmitter background job will never run.

Hours To Transmit Bills: Contains the times of the day when EDI transmission of bills should occur. A maximum of 4 daily times daily may be entered and the times must be separated by a semi-colon. Times must be entered in 4-digit military format, without punctuation (HHMM;HHMM;HHMM;HHMM). If no times are entered, EDI transmission will take place as a normal part of the nightly job.

Max # Of Bills Per Batch: The maximum number of bills allowed in a single batch. With a new payer, it is suggested that you begin with fairly small batches (10-20 claims).

Only Allow 1 Ins Co/Claim Batch: Indicates whether or not the site wishes to limit batches to claims for a single insurance company.

Last Auto-Txmt Run Date: The last date the auto transmit of bills was run at the site. These data are display only and cannot be edited.

Days To Wait To Purge Msgs: This is the number of days after an electronic status message has been marked reviewed, that the purge message option can delete it from the system.

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12. APPENDIX B – GLOSSARY

GLOSSARY OF TERMS

Acronym or Term	Definition/Explanation
835	<p>HIPAA Standard Electronic Transaction ASC X12 835, Health Care Claim:</p> <p>The HIPAA-adopted standard for electronic remittance advice to report the processing of all claim types (including retail pharmacy). The 835 is sent from health plans to healthcare providers and contains detailed information about the processing of the claim. This includes payment information and reduction or rejection reasons. The 835 transactions generally contain information about multiple claims. All health plans are required to use the same explanation of benefit codes (adjustment reason codes) and adhere to very specific reporting requirements. The term “835” is used interchangeably with <i>Electronic Remittance Advice (ERA)</i> and <i>Medicare Remittance Advice (MRA)</i>.</p>
837	<p>HIPAA Standard Electronic Transaction ASC X12 837, Health Care Claim Payment/Remittance Advice:</p> <p>The HIPAA-adopted standard for electronic submission of hospital, professional and dental claims or encounters. The 837 is sent from healthcare providers to health plans (payers). The 837 transactions are generally multiple claims (batches). The 837 standard includes the information for coordination of benefits and is also used for secondary payer claims submission. The term “837” is used interchangeably with <i>electronic claim</i>.</p>
277 RFAI	<p>Hipaa Standard Electronic Transaction ASC X12 277, Health Care Claim Request for Additional Information</p> <p>The HIPAA adopted standard for requesting additional information for health care claims submitted. Payers utilize this transaction for requesting additional information or missing information from providers on previously submitted health care claims.</p>
Billing Provider Secondary ID Number	This is either the facility tax ID # (default) or an ID assigned to the facility by the insurance company.
Care Unit	Specific data related to patient care (pre-defined by an insurance company) that provides the insurance company with a finer breakdown of the care being billed. The data that comprises the breakdown are insurance company specific and are not required by all payers. (For example, Orthopedics, Dermatology, Urology, etc.).
Claims Status Awaiting Resolution (CSA)	Used to reference the option used by billing staff to review the most current status messages received for a bill(s) and do follow-up on the bills. Users will be able to select a bill from the list to view the details and the entire message text as well as to mark the message as reviewed or under review and document user comments.
Claim Status Message	Electronic messages returned to the VAMC providing status information on a claim from the Financial Service Center (FSC), Clearinghouse or a payer
Clearinghouse	A company that provides batch and real-time transaction processing services. Transactions include insurance eligibility verification, claims submission process and electronic remittance information and payment posting for electronic claims.

Acronym or Term	Definition/Explanation
CPAC	Consolidated Patient Account Center
CSA	<i>See</i> Claims Status Awaiting Resolution
eClaim	A claim that is submitted electronically from the VA
EDI	<i>See</i> Electronic Data Interchange
Electronic Data Interchange (EDI)	EDI is the process of transacting business electronically. It includes submitting claims electronically (paperless claims processing), as well as electronic funds transfer and electronic inquiry for claim status and patient eligibility.
Electronic Payer	A payer that has an electronic connection with the clearinghouse
ePayer	Payer that accepts electronic claim from the clearinghouse pays electronically. <i>See</i> Payer.
Facility Fed Tax ID #	This is the number that will be the default for all providers for the ID type at the facility if the payer does not have specific requirements
Fiscal Intermediary	A fiscal intermediary performs services on behalf of healthcare payers. These services include claim adjudication, reimbursement and collections. Trailblazer is an example of a fiscal intermediary that acts on behalf of Medicare. Trailblazer receives claims from the VA in the form of an 837 file and then adjudicates the claims to create a MRA/EOB 835 file.
Form Types	The UB-04 or CMS-1500 billing form on which services will be billed
FSC	The VA Financial Services Center in Austin. The Financial Service Center translates claims into an industry-standard format (HIPAA 837) and forwards claims to the clearinghouse. The FSC is the single point for the exchange of data between VistA and the clearinghouse.
Healthcare Company	<i>See</i> Payer
Health Insurance Portability and Accountability Act (HIPAA)	In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain healthcare data between healthcare payers, plans, and providers. This will enable the entire healthcare industry to communicate electronic data using a single set of standards thus eliminating all non-standard formats currently in use. Once these standards are in place, a healthcare provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.
HPID	Health Plan Identifier
Insurance Company	<i>See</i> Payer
Legacy IDs	This term refers to those payer-provided or users own IDs (individual and organizational) which will eventually be made obsolete by the use of National

Acronym or Term	Definition/Explanation
	Provider Identifiers
Non-VA Facility	Any facility that provides services to a VA patient and subsequently bills the VA for those services
Non-VA Provider	Any individual provider who provides services to a VA patient and subsequently bills the VA for these services
National Provider Identifier	A standard, unique health identifier for healthcare providers, both individuals and organizations
OEID	Other Entity Identifier
Parent	The top facility in a hierarchical domain
Payer	The insured's insurance company. Other terms that are used to denote Payer include ePayer, insurance company, healthcare company, etc.
Payer Code	A code used for enrollment that uniquely identifies the payer.
Payer List	List of payers that consist of the payer category, claim type, payer code, and payer name
Provider	Provider of healthcare services
Provider ID	A provider ID can represent a facility or an individual physician/provider.
Taxonomy Code	<p>The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization.</p> <p>The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category.</p>
UPIN	Unique Provider Identification Number
URL	Uniform Resource Locator
VAMC	Veterans Affairs Medical Center
VISN	Veterans Integrated Service Network

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13. APPENDIX C – HIPAA Provider ID – Reference Guide

This table displays the HIPAA qualifiers and associated ID types. This table can be used to help identify what type of Provider ID is being used in the electronic format.

Institutional										
Qualifier	Definition	Billing Provider	Attending		Operating		Other		Service	
		2010AA	2310A	2330D	2310B	2330E	2310C	2330F	2310E	2330H
	Payer Type:		C	O	C	O	C	O	C	O
	VPE Segment:	PRV1	OPR2	OP1	OPR3	OP2	OPR4	OP9	SUB2	OP3
OB	State License Number	-	OB		OB		OB		OB	
1A	Blue Cross Provider Number	1A	1A	1A	1A	1A	1A	1A	1A	-
1B	Blue Shield Provider Number	-	1B	1B	1B	1B	1B	1B	1B	1B
1C	Medicare Provider Number	1C	1C	1C	1C	1C	1C	1C	1C	1C
1D	Medicare Provider Number	1D	1D	1D	1D	1D	1D	1D	1D	1D
1G	Provider UPIN Number	1G	1G	1G	1G	1G	1G	1G	1G	-
1H	TRICARE ID Number	1H	1H	1H	1H	1H	1H	1H	1H	-
1J	Facility ID Number	1J	-	-	-	-	-	-	1J	-
B3	PPO Number	B3	-	-	-	-	-	-	-	-
BQ	HMO Code Number	BQ	-	-	-	-	-	-	-	-
EI	Employer's ID Number	EI	EI	EI	EI	EI	EI	EI	EI	EI
FH	Clinic Number	FH	-	-	-	-	-	-	FH	-
G2	Provider Commercial Number	G2	G2	G2	G2	G2	G2	G2	G2	G2
G5	Provider Site Number	G5	-	-	-	-	-	-	G5	-
LU	Location Number	LU	LU	LU	LU	LU	LU	LU	LU	LU
N5	Provider Plan Network ID Number	-	N5	N5	N5	N5	N5	N5	N5	N5
TJ	Federal Taxpayer's ID Number	-		-	-	-	-	-	-	-
X4	Clinical Lab Improvement Amendment (CLIA #)	-	-	-	-	-	-	-	-	-
U3	Unique Supplier ID Number (USIN)	-	-	-	-	-	-	-	-	-
SY	Social Security Number	SY	SY	-	SY	-	SY	-	-	-
X5	State Industrial Accident Provider Number	X5	X5	-	X5	-	X5	-	X5	-
C = Current Payer O = Other Payer										

Professional												
Qualifier	Definition	Billing Provider	Referring		Rendering		Purchased		Service Facility		Supervising	
	HIPAA Loop	2010AA	2310A	2330D	2310B	2330E	2310C	2330F	2310D	2330G	2310E	2330H
	Payer Type: VPE Record		C	O	C	O	C	O	C	O	C	O
		PRV1	OPR5	OP4	OPR2	OP1	SUB1	OP6	SUB2	OP7	OPR8	OP8
OB	State License Number	-	OB	-	OB	-	OB	-	OB	-	OB	-
1A	Blue Cross Provider Number	-	-	-	-	-	1A	-	1A	-	-	-
1B	Blue Shield Provider Number	1B	1B	1B	1B	1B	1B	1B	1B	1B	1B	1B
1C	Medicare Provider Number	1C	1C	1C	1C	1C	1C	1C	1C	1C	1C	1C
1D	Medicare Provider Number	1D	1D	-	1D	-	1D	1D	1D	1D	1D	1D
1G	Provider UPIN Number	1G	1G	-	1G	-	1G	-	1G	-	1G	-
1H	TRICARE ID Number	1H	1H	-	1H	-	1H	-	1H	-	1H	-
1J	Facility ID Number	1J	-	-	-	-	-	-	-	-	-	-
B3	PPO Number	B3	-	-	-	-	-	-	-	-	-	-
BQ	HMO Code Number	BQ	-	-	-	-	-	-	-	-	-	-
EI	Employer's ID Number	EI	EI	EI	EI	EI	EI	EI	-	-	EI	EI
FH	Clinic Number	FH	-	-	-	-	-	-	-	-	-	-
G2	Provider Commercial Number	G2	G2	G2	G2	G2	G2	G2	G2	G2	G2	G2
G5	Provider Site Number	G5	-	-	-	-	-	-	-	-	-	-
LU	Location Number	LU	LU	LU	LU	LU	LU	LU	LU	LU	LU	-
N5	Provider Plan Network ID Number	-	N5	N5	N5	N5	N5	N5	-	N5	N5	N5
TJ	Federal Taxpayer's ID Number	-	-	-	-	-	-	-	TJ	-	-	-
X4	Clinical Lab Improvement Amendment (CLIA #)	-	-	-	-	-	-	-	X4	-	-	-
U3	Unique Supplier ID Number (USIN)	U3	-	-	-	-	U3	-	-	-	-	-
SY	Social Security Number	SY	SY		SY		SY	-	-	-	SY	-
X5	State Industrial Accident Provider Number	X5	X5	-	X5	-	X5	-	X5	-	X5	-
C = Current Payer O = Other Payer												