INTEGRATED BILLING

TECHNICAL MANUAL

Version 2.0

March 1994

Revised August 2011

Department of Veterans Affairs
Office of Information and Technology
Product Development

Revision History

Initiated on 12/29/04

Date	Description (Patch # if applic.)	Project Manager	Technical Writer
8/19.2011	Updated for patch IB*2.0*449, replaced Menu Diagram with statement. Technical writer review—formatting and convert to Section 508 compliant PDF.	Chris Minardi	Ed Zeigler (Oakland); Susan Strack (Oakland), technical writer review
June 2009	Updated for patch IB*2.0*399	Ashwani Suri/Timothy Holmes	Mary Ellen Gray
June 2008	Updated for patch IB*2.0*389	Ashwani Suri/Timothy Holmes	Mary Ellen Gray
12/29/04	Updated to comply with SOP 192-352 Displaying Sensitive Data.		Mary Ellen Gray
12/29/04	Pdf file checked for accessibility to readers with disabilities.		Mary Ellen Gray

Preface

This is the technical manual for the Integrated Billing (IB) software package. It is designed to assist IRM personnel in operation and maintenance of the package.

For information regarding use of this software, please refer to the Integrated Billing User Manual. For further information on installation and maintenance of this package, Release Notes and an Installation Guide are provided. A Package Security Guide is also provided which addresses security requirements for the package.

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Introduction

This release of Integrated Billing version 2.0 will introduce fundamental changes to the way MCCR-related tasks are performed. This software introduces three new modules.

- Claims Tracking
- Encounter Form Utilities
- Insurance Data Capture

There are also significant enhancements to the two previous modules, Patient Billing and Third Party Billing. IB has moved from a package with the sole purpose of identifying billable episodes of care and creating bills to a package which is responsible for the whole billing process through the passing of charges to Accounts Receivable (AR). IB v2.0 has added functionality to assist in

- Capturing patient data
- Tracking potentially billable episodes of care
- Completing utilization review (UR) tasks
- Capturing more complete insurance information.

IB v2.0 has been targeted for a much wider audience than previous versions.

- The Encounter Form Utilities module is used by MAS ADPACs or clinic supervisors to create and print clinic-specific forms. Physicians use the forms and consequently provide input into their creation.

- The Claims Tracking module will be used by UR personnel within MCCR and Quality Management (QM) to track episodes of care, do pre-certifications, do continued stay reviews, and complete other UR tasks.

- Insurance verifiers use the Insurance Data Capture module to collect and store patient and insurance carrier-specific data.

- The billing clerks see substantial changes to their jobs with the enhancements provided in the Patient Billing and Third Party Billing modules.

IB version 2.0 is highly integrated with other DHCP packages.

- PIMS is a feeder of patient demographic and eligibility data to IB. PIMS also provides information to Claims Tracking, Third Party Billing and Patient Billing on each billable episode of care, both inpatient and outpatient.

- IB passes bills and/or charges to Accounts Receivable for the purpose of follow-up and collection.

- Prescription information is passed from Outpatient Pharmacy to Patient Billing for the purpose of billing Pharmacy copayments.

- Prescription refills are passed through Claims Tracking to Third Party Billing to be billed using the Automated Biller.

- The Encounter Form Utilities print data on the forms from the Allergy, PIMS, and Problem List packages. The Print Manager, included with the Encounter Form Utilities, will also print out Health Summaries as well as documents from the Outpatient Pharmacy and PIMS packages.

- Means Test billing data may be transmitted between facilities using the PDX v1.5 package. This may assist sites with the preparation of bills for inpatients who transfer between facilities.

- Prosthetics information is passed to Claims Tracking and Third Party Billing.

The new functionality seen in this software is the direct result of input and feedback received from field users. Task groups made up of representatives from the field were created under the auspices of the MCCR Systems Committee and MCCR EP. These groups had meetings and/or conference calls with the developers and VACO Program Office (MCCR, MAS, and MIRMO) officials on a regular basis to develop the initial specifications and answer questions that arose during the development cycle. The field representatives in these groups included physicians, UR nurses, MAS ADPACs, MCCR coordinators, and billing clerks. An additional group of users was assembled prior to alpha testing to conduct full usability and functional testing of the software. The input from each of the individuals on these groups was invaluable to the software developers.

Orientation

The Integrated Billing Technical Manual is divided into major sections for general clarity and simplification of the material being presented. This manual is intended for use as a reference document by technical computer personnel.

The Implementation and Maintenance Section provides information on any aspect of the package that is site configurable. The file flow chart found in the Files Section shows the relationships between the IB files and files external to the IB package. This section also contains a listing of each IB input, print, and sort template with descriptions. There are also sections on archiving and purging, how to generate on-line documentation, and package-wide variables.

Information concerning package security may be found in the Integrated Billing v2.0 Package Security Guide.

Note to Users With Qume Terminals

It is very important that you set up your Qume terminal properly for this release of Integrated Billing. After entering your access and verify codes, you will see

Select TERMINAL TYPE NAME: {type}//

Please make sure that <C-QUME> is entered here. This entry will become the default. You can then press <RET> at this prompt for all subsequent log-ins. If any other terminal type configuration is set, options using the List Manager utility (such as the Insurance Company Entry/Edit option under the Patient Insurance Menu or the Clinic Setup/Edit Forms option under the Edit Encounter Forms Menu) will neither display nor function properly on your terminal.

Symbols

The following are explanations of the symbols used throughout this manual.

<RET>	Press the RETURN or ENTER key.
<SP>	Press the SPACEBAR.
<^>	Up-arrow, which you enter by pressing the SHIFT key and the numeric 6 key simultaneously.

<?> <??> <???> Enter single, double, or triple question marks to activate on-line help, depending on the level of help you need.

General Information

Namespace Conventions

The namespaces and file ranges assigned to the Integrated Billing package are DIC, File #36; IB, Files # 350 - 389; DGCR, Files # 399 - 399.5. Files #409.95 and 409.96, under namespace SD, are exported with version 2.0 of IB.

Integrity Checker

The IBNTEG routine checks integrity for other IB and DGCR routines. This was built using the KERNEL utility routine, XTSUMBLD.

SACC Exemptions/Non-Standard Code

One SACC exemption was granted for one time killing of the following DD nodes for IB v2.0.

^DD(399,.01,21)
^DD(399,2,21)
^DD(399,205,21)
^DD(399,213,23)
^DD(399,303,21)

Resource Requirements

Resource requirements for Integrated Billing version 1.0 were measured in great detail, and VA Medical Centers were distributed equipment for this package. The resource consumption of existing modules of Integrated Billing version 2.0 has not changed significantly. The three new modules in Integrated Billing have some additional resource requirements.

The installation of IB version 2.0 may require approximately 5-15 megabytes of additional disk capacity. This includes up to 2.5 megabytes in the global DPT, up to 2.5 megabytes in the global DGCR, up to 5 megabytes in the global IBA, and up to 5 megabytes in the new global IBT.

The Encounter Form Utilities require a small amount of additional capacity to edit and store the format of the encounter forms. Please note that the standard partition size has been increased to 40K. You will need to increase your partition size to the new standard in order to run the utilities. The printing of encounter forms will require at least one dedicated printer that most sites have already received. The printing will require additional CPU capacity; however, this job may be scheduled during non-peak workload hours.

The Insurance Data Capture module has been highly used during testing. This module will increase the disk utilization in the DPT global by approximately 1k per every 10 insurance policies and in the IBA global by 1k per every 3 insurance policies.

Based on the experience of our test sites, the Claims Tracking module will use approximately 5k of disk space for every pre-admission entry (one for every insurance case plus 5 per week for UR). In addition, approximately 1k of disk space for every 3 outpatient visits or prescription refills will be used.

Implementation and Maintenance

The Integrated Billing package may be tailored specifically to meet the needs of the various sites. Instructions may be found in the Integrated Billing User Manual under the MCCR System Definition Menu, that includes the MCCR Site Parameter Enter/Edit option and others that may be used by each site to define their own configuration. The Ambulatory Surgery Maintenance Menu contains all of the options necessary to transfer BASC procedures into the BILLABLE AMBULATORY SURGICAL CODE file (#350.4) annually, when new BASC procedures are provided. It also contains options to build and manage the use of CPT Check-off Sheets and an option to enter or edit locality modifiers. This functionality is currently obsolete but has been left in IB 2.0 pending possible future requirements. There are other options in the MCCR System Definition Menu to enter or edit billing rates, update rate types, activate revenue codes, enter/edit automated billing parameters, and edit insurance company information. The Enter/Edit IB Site Parameters option in the System Manager's Integrated Billing Menu is used to modify the parameters controlling the Integrated Billing background filer. All configurations may be modified at any time as the site's needs change.

Implementing Claims Tracking

Prior to installing IB v2.0, sites should review the Claims Tracking site parameters and determine how they plan to use this module. The recommended settings are shown in the User Manual. The Claims Tracking module has the ability to use a great deal of disk space and capacity if turned on to track all episodes.

Because this part of the package contains the data entry portion of the QM national roll up of data, and will determine the random sample cases for review, most sites will be compelled to run this part of the inpatient tracking. If you plan to use the Automated Biller to do bill preparation for outpatient and prescription refill billing, you will also want to turn on tracking of these portions of the Claims Tracking module. There are ways to automatically back load cases into Claims Tracking, so that if you don't currently have the capacity, or want to delay implementation, you can still take advantage of this module at a later date.

The option Claims Tracking Parameter Edit has a number of features that affect the operation of the software. There are parameters that may greatly affect the kind and frequency of records that are added to Claims Tracking and the amount of disk space utilized. Claims Tracking also contains a random sample generator for UR to randomly select which admissions are to be reviewed. Setting the parameters concerning the number of weekly admissions by service affects which cases, if any, are selected as the random case. If the numbers in these fields are set lower than the number of admissions per week, the random sample case will be selected early in the week. If the numbers in these fields are set higher than the number of admissions per week, depending on the random number selected for that week, there is a risk that no random sample will be selected.

Implementing Encounter Forms

There are steps that the local site should take before encounter forms can be used.

First, forms must be designed and assigned to the clinics. Forms can be shared between clinics, but it is important to control who has responsibility for editing the shared forms. One important aspect of designing encounter forms is determining what codes should go on the form. Many encounter forms will have lists of CPT codes, diagnosis codes, or problems. Because space on an encounter form is at a premium, careful analysis is required to determine the codes most commonly used by the clinic before entering codes on the form. For CPT codes, the option Most Commonly Used Outpatient CPT Codes can be used to determine a clinic's most commonly used codes.

Procedures for printing the encounter forms must be determined. The following are some of the questions that must be answered.

- What printers to use?
- Can the printers be loaded with enough paper?
- How many days in advance should the forms be printed?
- What time of day to run the print job?
- Should the printers be watched?
- What to do if there are printer problems?

It is expected that most printing of forms will be done in batch at night for entire divisions, and that forms will be printed several days in advance with only the additions printed the night before.

Then there are questions concerning what to do with the encounter forms.

- How will the completed encounter forms be routed?
- Who will input the data?

It is expected that much of the collected data will be input through checkout which is part of PIMS 5.3.

The Print Manager that comes with the Encounter Form Utilities is expected to be very useful to the local sites. Sites must decide which reports should be printed. The Print Manager allows these reports to be specified along with the encounter forms. The fastest way to define the reports is at the division level, rather than at the clinic level. Individual clinics can override reports defined to print at the division level.

Implementing Insurance Data Capture

There are a number of tools in the Insurance module to identify duplicate INSURANCE COMPANY file (#36) entries and to resolve these problems. It may also be helpful to review the process of how insurance information is collected at your facility. This module was designed so that as little information as possible would be collected during registration and that more complete information would be collected by a separate employee who would contact the insurance company.

Prior to installation

You may want to review how the GROUP NUMBER and GROUP NAME fields in the INSURANCE TYPE multiple of the PATIENT file (#2) are entered. These will be used to create the new GROUP INSURANCE PLAN file (#355.3). A new group plan will be created for every unique group plan entry for each insurance company. If possible, you may want to consolidate similar but unique names.

You may want to print a list of all active and inactive insurance companies along with their addresses. There are a number of new insurance company address fields. Determine which insurance company entries can be inactivated and merged into another (active) insurance company entry. (**Note:** Do not delete the old entries. They must be inactivated at this time.)

Determine which users should have access to the new Insurance options. There are options that allow for view-only access to both the insurance company information and patient insurance information as well as options for data entry. Limiting the ability of certain individuals to add/edit/delete information may improve the quality of your insurance information. Having accurate and detailed insurance information can improve your collections by focusing your efforts on cases that are potentially reimbursable.

Many sites enter Medicare and Medicaid policy information as an insurance policy. If the entry in the INSURANCE COMPANY file (#36) for Medicare and Medicaid exist, we recommend that the field WILL REIMBURSE? be answered "NO". This will prevent the software from treating this as a billable insurance company entry. If this is answered other than "NO", this could have a significant impact on the Claims Tracking module.

After Installation

First, run the option List Inactive Ins. Co. Covering Patients. This option will list companies that are currently covering patients who are non-billable due to the insurance company being inactive. In the Insurance Company Entry/Edit option, there is an action to activate and inactivate an insurance company. Use this action for the inactive insurance companies and it will allow you to print a list of the patients covered under these companies. If you wish to merge the patients to another company, you may do so at this or a later time.

If you found in your list of insurance companies that you have many similar entries to handle different inpatient, outpatient, or prescription address information, you may want to combine these entries into one. Choose the entry you wish to update and enter the complete information. Then go back and inactivate the companies you no longer wish to use and use the feature that lets you merge (repoint) the patients to the updated company entry. If you found many similar entries with the same name but entered slightly differently, you may want to consider entering those names as synonyms for the updated company.

The option List New not Verified Policies can be run periodically to list new policies that have been added since a specific date and have not been verified by your insurance staff. Updating this information can help you maintain the patient insurance information and allow your MCCR staff to concentrate on billing for covered care. This may foster good communication with your insurance carriers and ultimately improve your rates of collection.

Implementing Patient Billing

There is no preparation required by the facility to use the Patient Billing module of Integrated Billing version 2.0. However, the following guidelines are suggested.

Make a list of all stop codes, dispositions, and clinics where the billing of the Means Test outpatient copayment is not desired. These values may easily be entered into the system (utilizing the option Flag Stop Codes/Dispositions/Clinics) from the list.

Decide whether you would like to suppress the generation of mail messages for insured patients who have been billed Means Test copayments. If you wish to suppress these mail messages, update the parameter Suppress MT Ins Bulletin using the MCCR Site Parameter Enter/Edit option.

Implementing Third Party Billing

If your site wishes to use the Automated Biller, enter the values appropriate to your site to control the execution of the Automated Biller. Use the Enter/Edit Automated Billing Parameters [IB AUTO BILLER PARAMS] option.

AUTO BILLER FREQUENCY	Enter the number of days between each execution of the Automated Biller. (For example, enter "7" if you want bills created only once a week.)
INPATIENT STATUS (AB)	Enter the status in which the PTF record should be before the Auto Biller can create a bill. No auto bill will be created unless the PTF status is at least CLOSED, regardless of how this parameter is set.

The following parameters may be entered for inpatient admissions, outpatient visits, and prescription refills.

AUTOMATE BILLING	Enter "YES" if bills should be automatically created for possible billable events with no user interaction. Leave this blank if your site prefers each event to be manually checked before a bill is created by the Auto Biller.
BILLING CYCLE	For each type of event, enter the maximum date range of a bill. If this is left blank, the date range will default to the event date through the end of the month in which the event took place. For inpatient interim bills, this will be the next month after the last interim bill.
DAYS DELAY	Enter the number of days after the end of the BILLING CYCLE that the bill should be created.

The following parameters may be used by sites to control prescription refill billing data and charge calculation. If your site plans to implement prescription refill billing, enter the appropriate values using the MCCR Site Parameter Enter/Edit option [IB MCCR PARAMETER EDIT].

DEFAULT RX REFILL REV CODE — Enter the revenue code that should be used for most prescription refill bills. If this revenue code is defined, charges for every prescription refill will automatically be added to the bill with this Revenue Code. This site parameter may be overridden by the INSURANCE COMPANY file (#36) parameter PRESCRIPTION REFILL REV. CODE if left blank.

DEFAULT RX REFILL DX — If applicable, enter a diagnosis code that should be added to every prescription refill bill.

DEFAULT RX REFILL CPT — If applicable, enter a CPT code that should be added to every prescription refill bill.

The following are other new site parameters that may need to be set using the MCCR Site Parameter Enter/Edit option [IB MCCR PARAMETER EDIT].

HCFA-1500 ADDRESS COLUMN — For the HCFA-1500, enter the column number in which the mailing address should begin printing for it to show in the envelope window (if it does not already print in the appropriate place).

UB-92 ADDRESS COLUMN — For the UB-92, enter the column number in which the mailing address should begin printing for it to show in the envelope window (if it does not already print in the appropriate place).

If the Bill Addendum Sheet should automatically print for every HCFA-1500 with prescription refills or prosthetic items, set the DEFAULT PRINTER (BILLING) field for the BILL ADDENDUM form type to the appropriate device. (Use the Select Default Device for Forms option [IB SITE DEVICE SETUP].)

If certain insurance companies require a specific Revenue Code to be used for Rx refills that is different than the DEFAULT RX REFILL REV CODE field, use the option Insurance Company Entry/Edit [IBCN INSURANCE CO EDIT] to enter the required Revenue Code in the PRESCRIPTION REFILL REV. CODE field.

Routines

Per VHA Directive 10-93-142 regarding security of software that affects financial systems, most of the IB routines may not be modified. The third line of routines that may not be modified will be so noted. The following routines are exempt from this requirement.

IBD* - Encounter Form Utilities
IBO*, IBCO*, IBTO* - Non-critical Reports

Routines to Map

It is recommended that the following routines be mapped: IBA*, IBCNS, IBCNS1, IBCNSC*, IBCNSM*, IBCNSP*, IBCNSU*, IBEF*, IBR*, IBTRKR*, IBUTL*, and IBX*.

Obsolete Routines

The following routines are obsolete for IB in version 2.0 and may be deleted.

IBACKIN	IBEHCF1
IBOHCP	IBEHCFA
IBOHCTP	IBEP

Please note that the only routines in the DGCR namespace that are exported with IB 2.0 are DGCRAMS, DGCRNS, and DGCRP3. All other routines in the DGCR namespace may be deleted.

Callable Routines

$$INSURED^IBCNS1(dfn, date)	This extrinsic function will return a "1" if the patient is insured for the specified date or a "0" if the patient is not insured. Input of the date is optional. The default is "today". No other data is returned. For billing purposes, a patient is only considered insured if he has an entry in the INSUR-ANCE TYPE subfile that meets the following four conditions. 1. The insurance company is active. 2. The insurance company will reimburse the government. (If your site tracks Medicare coverage of patients, the entry in the INSURANCE COMPANY file (#36) should be set to not reimburse.)

Callable Routines, cont.

3. The effective date is before the date of care.
4. The expiration date is after the date of care. (Treat no entry in the EFFECTIVE DATE and EXPIRATION DATE fields as from the beginning of time to the end of time.)

You might find a reference something like the following.

```
I $$INSURED^IBCNS1(DFN,+$G(^DGPM(+DGPMCA,0))) D BILL...
```

ALL^IBCNS1(dfn, variable, active, date)

This function will return all insurance data in the array of your choice. Input the patient internal entry number and the variable in which you want the data returned. Optionally, you can ask for active insurance information by putting a "1" or "2" in the third parameter and a date for the insurance to be active on in the fourth parameter (the default is "today"). If the value of the third parameter is "2", then insurance companies that do not reimburse VA will be included. This is primarily to retrieve Medicare policies when it is desirable to include them in active policies, e.g., when printing insurance information on encounter forms.

It will return the 0, 1, and 2 nodes for each entry in the INSURANCE TYPE subfile and the 0 node from the GROUP INSURANCE PLAN file (#355.3) in a 2 dimensional array, Array(x, node). The array element Array(0) will be defined to the count of entries. In Array (x, node) x will be the internal entry in the INSURANCE TYPE subfile and node will be 0, 1, 2 or 355.3. The GROUP NAME and NUMBER fields have been moved to the GROUP INSURANCE PLAN file (#355.3), but since many programmers are used to looking for this data on the 0th node from the INSURANCE TYPE subfile, the current value from 355.3 is put back into the respective pieces of the 0th node. The code for this call looks something like the following.

```
K IBINS
D ALL^IBCNS1(DFN,"IBINS",1,IBDT) I $G(IBINS(0)) D LIST
```

Callable Routines, cont.

DGCRAMS	Supported call for AR to determine AMIS segments for insurance bills.
DGCRNS	IB v1.5 insurance retrieval call, to be replaced by ALL^IBCNS1.
DGCRP3	This call, available to Accounts Receivable, will print second and third notice UB-82s, UB-92s, and HCFA-1500s.
DISP^IBAPDX1(in, sptr, out, off)	This extrinsic function is also used by the PDX package. This call will transform the data in the array generated by the EXTR^IBAPDX call into an array which is in a display-ready format.
DISP^IBCNS	This tag can be called to do the standard insurance display. This display is used extensively in registration and billing. The variable DFN must be defined to the current patient. Using this tag will keep your displays current when the package developers update them or make other data dictionary changes.
DISP^IBARXEU(dfn, date, number of lines, unknown action)	This is a supported call for all developers. It will print the standard display of exemption status for the patient's current exemption on or before the specified date. If no date is specified, "today" is the default. It will print a maximum of three lines of text; the current exemption status, the exemption reason, and the date of the last exemption. All parameters are optional except for DFN. The display can be limited to a specified number of lines. In addition, if a medication copayment exemption status has never been determined for a patient, the display can be set to not display or display the unknown information.
EXTR^IBAPDX(tran, dfn, arr)	This extrinsic function is used by the Patient Data Exchange (PDX) version 1.5 package to transport Means Test billing data between facilities. For a given patient, this routine will build a global array containing Continuous Patient, Active Billing Clock, and Means Test Charge information from the transmitting facility.

Callable Routines, cont.

IB^IBRUTL	This call, available to Accounts Receivable, will determine if there are Means Test charges on hold associated with a given bill number. An optional parameter will return the held charges in an array.
IBAMTD	This routine is invoked by the MAS Movement Event Driver. It processes final Means Test charges for Category C veterans who are discharged.
IBAMTED	This routine is invoked by the MAS Means Test Event Driver. It sends a mail message to the IB CAT C mail group if a patient's Means Test "billable" status changes (i.e., from Category C to Category A or vice versa).
IBAMTS	This routine is invoked by the Scheduling Check-In Event Driver. It bills the Means Test outpatient copayment charge to Category C veterans who are checked in for a clinic visit.
IBARX	This routine has 4 calls supported for Outpatient Pharmacy only: XTYPE^IBARX (eligibility determination), NEW^IBARX (file new RX copayments), CANCEL^IBARX (cancel), and UPDATE^IBARX (update).
IBOLK	This routine has two supported entry points for the Accounts Receivable package to print a profile of an AR Transaction. The entry point ENF is used to print a full profile. The entry point ENB is used to print a brief profile.
IBRFN	This routine has supported calls to return the text of an error message.
IBRREL	This routine has one supported call, AR^IBRREL, for the Accounts Receivable package. If there are Means Test charges on hold that are associated with the input bill number, these charges will be displayed and available for selection to be "released" to AR.

Callable Routines, cont.

MENU^IBECK	This routine may be used on menu entry actions to display warnings.
RXST^IBARXEU(dfn, date)	This is a supported extrinsic variable for all developers that returns the current exemption on or before the specified date. If no date is specified, "today" is the default. This variable returns the following data in the respective piece position: exemption status, exemption status text, the exemption reason code, the exemption reason text, and the date of prior test.
STMT^IBRFN1(tran)	This routine call is used by the Accounts Receivable package during the printing of the patient statements. The input to this routine is the AR transaction number. The output is a global array which contains the pharmacy, inpatient, or outpatient clinical data which is incorporated into the patient statement.
THRES^IBARXEU1(date, type, dependents)	This supported call will return the threshold amount that a patient's income must not exceed to be exempt from the medication copayment requirement. Inputs are date of test, type of threshold (currently on type=2 is supported), and the number of dependents. The data is retrieved from the BILLING THRESHOLDS file (#354.3).

Routine List with Descriptions

DGCRAMS	Bridge routine to IBCAMS routine which determines Accounts Receivable AMIS category for insurance bills.
DGCRNS	Utility routine to determine if patient has active insurance and to do standard displays.
DGCRP3	Bridge routine to IBCF13 routine which is the call for Accounts Receivable to print bills.
IB20IN	IB version 2.0 initialization routine.
IB20PRE	IB version 2.0 pre-initialization routine.

Routine List with Descriptions, cont.

IB20PT, IB20PT1, IB20PT2, IB20PT3, IB20PT31, IB20PT32, IB20PT4, IB20PT41, IB20PT42, IB20PT43, IB20PT44, IB20PT45, IB20PT46, IB20PT47, IB20PT48, IB20PT5, IB20PT51, IB20PT6, IB20PT61, IB20PT62, IB20PT7, IB20PT8*	IB version 2.0 post initialization routines.
IBACVA, IBACVA1, IBACVA2	Routines for the mail message generation and automatic charge creation for the CHAMPVA subsistence charge.
IBAERR	Converts pharmacy copay error codes to text and sends a mail message if error occurs in a tasked job.
IBAERR1	Creates mail messages when errors occur during the compilation of Means Test charges.
IBAERR2	Processes error messages and sends mail messages for the Medication Copayment Exemption process.
IBAERR3	Sends and processes alerts for the Medication Copayment Exemption process if the site chooses to use alerts rather than mail messages for electronic notification.
IBAFIL	Posts tasks to the background filer. Starts filer if it is not running.
IBAMTBU	Creates mail messages when Category C patient movements change, and when continuous patients are discharged.
IBAMTBU1	Creates a mail message when charges are created in error for patients admitted for observation and examination.
IBAMTBU2	Generates a mail message if a change in the Means Test affects the patient's Means Test charges.
IBAMTC	Means Test Billing Nightly Compilation Job. Creates charges and updates billing clocks for all Category C inpatients.
IBAMTC1	Sends mail message when the Nightly Compilation Job has completed.
IBAMTC2, IBAMTC3	Ensures inpatient events are closed on discharge and Category C charges are passed. Sends mail message if not accomplished.

Routine List with Descriptions, cont.

IBAMTD	Means Test Billing Discharge Compilation Job. Calculates final Means Test charges when a Category C patient is discharged. Invoked by the MAS Movement Event Driver. the bundling and unbundling of Means Test billing data which is transmitted, received, and displayed by the PDX package.
IBAMTD1	Computes Means Test charges for single day admissions.
IBAMTD2	Determines whether a change in patient movements will affect a patient's Means Test charges.
IBAMTED	Invoked by the MAS Means Test Event Driver. Determines whether a change in the Means Test should result in the generation of a mail message.
IBAMTED1	Creates new or updated exemptions whenever a change occurs in a patient's demographic data, eligibility, Means Test, or Copay Test that would affect his/her exemption status.
IBAMTEDU	Determines whether a change in the Means Test will affect patient's Means Test charges. Creates a list of charges or patient care episodes which would be included in the mail message.
IBAMTEL	Contains the various locations where an error may occur in the processing of Means Test charges for inpatients.
IBAMTI, IBAMTI1, IBAMTI2	These routines handle all mail message generation, processing, and outputs for special inpatient billing cases.
IBAMTS, IBAMTS1, IBAMTS2	Bills/Credits Category C outpatient copayments via Scheduling Event Driver.
IBAPDX, IBAPDX0, IBAPDX1	These routines are invoked by the PDX package and handle the bundling and unbundling of Means Test billing data which is transmitted, received, and displayed by the PDX package.
IBAREP	Routine to repost IB Actions to Accounts Receivable.
IBARX, IBARX1	Routine has supported calls for Pharmacy Copay for eligibility, new charges, cancelled charges, and updated charges.

Routine List with Descriptions, cont.

IBARXDOC	Documentation of variable passing for IBARX.
IBARXEB	Sends electronic notification of changes in the patient's exemption status that require notification. Specifically, each time a patient either receives or loses a hardship exemption, a mail message or alert is generated.
IBARXEC, IBARXEC0, IBARXEC2, IBARXEC3	These routines are the main components of the Medication Copayment Exemption Conversion routines.
IBARXEC1, IBARXEC4, IBARXEC5	Print the report from the Medication Copayment Exemption Conversion and the related option.
IBARXECA	Contains the logic to cancel charges during the Medication Copayment Exemption process.
IBARXEI	Produces the full and brief inquiry options for the Medication Copayment Exemption process.
IBARXEP	Produces reports from the BILLING PATIENT file (#354) on the number and kinds of exemptions currently held by patients.
IBARXEPE	Edit pharmacy copay exemption letter.
IBARXEPL	Print pharmacy copay exemption letters.
IBARXEPV	Has the ability to test the accuracy of patient exemptions for a date range and to update the exemptions of incorrect entries.
IBARXET	Allows adding and editing of Billing Thresholds.
IBARXEU	Contains two supported calls to retrieve a patient's Medication Copayment Exemption status.
IBARXEU0	Routine used to retrieve and/or update a patient's Medication Copayment Exemption status. This routine should not be used by applications outside of IB.
IBARXEU1	Contains the logic to actually calculate a patient's Medication Copayment Exemption status.
IBARXEU3, IBARXEU4	Contain the logic to cancel past Medication Copayment charges in both IB and AR.
IBARXEU5	Contains the logic for dealing with net worth as part of income.

Routine List with Descriptions, cont.

IBARXEVT	Medication Copayment Exemption event driver. Invoked each time a Medication Copayment Exemption is created.
IBARXEX, IBARXEX1	Contain the logic for adding hardship exemptions for patients.
IBATER	Background job routine that searches for Transfer Pricing transactions in the Prosthetics file (#660).
IBATFILE	Utility calls for filing Transfer Pricing transactions.
IBATLM1, IBATLM1A, IBATLM1B	Routines used to create a listing of Transfer Pricing transactions.
IBATLM2, IBATLM2A, IBATLM2B	Routines used to display Transfer Pricing patient transactions.
IBATO, IBATO1	Routines used to produce various Transfer Pricing reports.
IBATUTL	Utility calls for various Transfer Pricing functions.
IBAUTL	Utility calls for IB application interface routines.
IBAUTL1	Utility routine to determine BASC billing rates.
IBAUTL2	Means Test billing utilities - retrieve billing rates; add/edit charges for a patient.
IBAUTL3	Means Test billing utilities - retrieve/update billing event and billing clock data.
IBAUTL4	Means Test billing utilities - calculate inpatient charges.
IBAUTL5	Means Test billing utilities - pass charges to Accounts Receivable; miscellaneous functions.
IBAUTL6, IBAUTL7	Contain the logic used to add entries to the BILLING PATIENT file (#354) and the BILLING EXEMPTIONS file (#354.1).
IBCA, IBCA0, IBCA1, IBCA2	MCCR add new billing record. (Routines formerly named DGCRA, DGCRA0, DGCRA1, DGCRA2.)
IBCA3	Displays all bills for episode of care. (Formerly named DGCRA3.)
IBCAMS	Determines Accounts Receivable AMIS category for insurance bills. (Routine formerly named DGCRAMS.)
IBCB, IBCB1, IBCB2	MCCR bill processing. (Routines formerly named DGCRB, DGCRB1, DGCRB2.)
IBCBB, IBCBB1, IBCBB2	Checks bills for completeness. (Routines formerly named DGCRBB, DGCRBB1, DGCRBB2.)
IBCBR	Enter/Edit Billing Rates. (Routine formerly named DGCRBR.)
IBCBULL	MCCR mail messages. (Routine formerly named DGCRBULL.)

Routine List with Descriptions, cont.

IBCC,IBCC1	Cancel a Third Party Bill. (Routine formerly named DGCRC.)
IBCCC, IBCCC1, IBCCC2	Cancel and copy bill. (Routines formerly named DGCRCC, DGCRCC1, DGCRCC2.)
IBCCC3	Continuation of Copy and Cancel.
IBCCPT	Display CPT codes from Ambulatory Surgeries screen. (Routine formerly named DGCRCPT)
IBCD, IBCD1, IBCD2, IBCD3, IBCD4, IBCD5	Automated Biller background job.
IBCDC	Automated Biller utility routine.
IBCDE	Automated Biller comments file management.
IBCEF, IBCEF1, IBCEF11, IBCEF2, IBCEF21, IBCEF22, IBCEF3, IBCEF31	Routines used for formatting UB-92/HCFA 1500 forms.
IBCF	Dispatch to print claim forms.
IBCF1, IBCF10, IBCF11, IBCF12, IBCF14	Print UB-82. (Routines formerly named DGCRP, DGCRP0, DGCRP1, DGCRP2, DGCRP4.)
IBCF13	Call for Accounts Receivable to print bills. (Routine formerly named DGCRP3.)
IBCF1TP	UB-82 Test Pattern Print. (Routine formerly named DGCRTP.)
IBCF2, IBCF21, IBCF22, IBCF23, IBCF2P	Print HCFA 1500.
IBCF2TP	Print HCFA 1500 Test Pattern Print.
IBCF3, IBCF31, IBCF32, IBCF33, IBCF331, IBCF34, IBCF3P	Print UB-92.
IBCF3TP	UB-92 Test Pattern Print.
IBCF4	Print Bill Addendum.
IBCFP	Print all authorized bills in order.
IBCMENU	Main menu driver. (Routine formerly named DGCRMENU.)
IBCNADD	Address Retrieval Engine for BILL/CLAIMS file (#399).
IBCNQ	Patient Billing Inquiry. (Routine formerly named DGCRNQ.)
IBCNQ1	Outpatient Visit Date Inquiry. (Routine formerly named DGCRNQ1.)

Routine List with Descriptions, cont.

IBCNS, IBCNS1	These routines contain the supported calls to determine if a patient has any insurance or active insurance, to retrieve the data, and to do standard displays.
IBCNS2	This routine contains a number of utilities called by data dictionary for the BILL/CLAIMS file (#399).
IBCNSA, IBCNSA0, IBCNSA1, IBCNSA2	These routines allow for the display and editing of the Annual Benefits available for an insurance plan.
IBCNSBL, IBCNSBL1	This routine creates the new insurance policy mail message. It is called by the event driver whenever a new insurance policy is added.
IBCNSC, IBCNSC0, IBCNSC01, IBCNSC1	These routines allow for the display and editing of insurance company data.
IBCNSD, IBCNSD1	These routines allow for the display and editing of the benefits a patient has used for a year for a specific plan.
IBCNSEH	This routine prints the extended help for insurance policy and plan information.
IBCNSEVT	This routine invokes the New Insurance Policy Added Event Driver every time a new insurance policy is added.

Routine List with Descriptions, cont.

IBCNSM, IBCNSM1, IBCNSM2, IBCNSM31, IBCNSM32, IBCNSM4	These routines display in list format one patient's policies, and allow for editing of these policies.
IBCNSM5, IBCNSM6, IBCNSM7, IBCNSM8, IBCNSM9	These routines print the insurance plan worksheets and policy coverage reports.
IBCNSOK, IBCNSOK1	These routines check, fix, and print reports on integrity of group plans in the PATIENT file [#2].
IBCNSP, IBCNSP0, IBCNSP01, IBCNSP11, IBCNSP3, IBCNSV	These routines display policy data for a patient in expanded format and allow for editing of the data.
IBCNSP2	This routine is the supported call to allow for editing of a patient's insurance policy and plan information from registration and billing.
IBCNSU, IBCNSU1	Insurance utility routines to add entries to the GROUP INSURANCE PLAN (#355.3), ANNUAL BENEFITS (#355.4), and INSURANCE CLAIMS YEAR TO DATE (#355.5) files.
IBCNSU2	This routine contains the new Plan Look-up Utility which is invoked from many points within the Insurance Data Capture module.
IBCNSU3	Functions for billing decisions to determine plan coverage limitations.
IBCNSU31	Functions for billing decisions to determine Insurance Filing Timeframe.
IBCOC	Prints a list of inactive insurance companies still listed as insuring patients.
IBCOC1	Prints a list of new but not verified insurance.
IBCONS1, IBCONS2, IBCONSC	Veterans with insurance outputs. (Routines formerly named DGCRONS1, DGCRONS2, DGCRONSC.)
IBCONS3	Veterans with insurance outputs interface with Claims Tracking.

Routine List with Descriptions, cont.

IBCOPV, IBCOPV1, IBCOPV2	Display outpatient visits screen. (Routines formerly named DGCROPV, DGCROPV1, DGCROPV2.)
IBCORC, IBCORC1, IBCORC2	Rank Insurance Carriers.
IBCRBG, IBCRBG1, IBCRBG2	Contains utility calls for various inpatient/PTF/outpatient/CPT functions.
IBCRTN	Edit bills returned from Accounts Receivable. (Routine formerly named DGCRTN.)
IBCSC1	Enter/Edit a Bill Screen 1 (Demographics). (Routine formerly named DGCRSC1.)
IBCSC2	Enter/Edit a Bill Screen 2 (Employment). (Routine formerly named DGCRSC2.)
IBCSC3	Enter/Edit a Bill Screen 3 (Payer/Mailing Address). (Routine formerly named DGCRSC3.)
IBCSC4	Enter/Edit a Bill Screen 4 (Inpt. EOC). (Routine formerly named DGCRSC4.)
IBCSC4A, IBCSC4B, IBCSC4C	Enter/Edit a Bill PTF Screens. (Routines formerly named DGCRSC4A, DGCRSC4B, DGCRSC4C.)
IBCSC4D, IBCSC4E	Enter/Edit a bill's diagnoses.
IBCSC5	Enter/Edit a Bill Screen 5 (Opt. EOC). (Routine formerly named DGCRSC5.)
IBCSC5A, IBCSC5C	Enter/Edit a bill's prescription refills.
IBCSC5B	Enter/Edit a bill's prosthetic items.
IBCSC6	Enter/Edit a Bill Screen 6 (Inpt. Billing Info). (Routine formerly named DGCRSC6.)
IBCSC61	Enter/Edit a Bill screen utility. (Routine formerly named DGCRSC61.)
IBCSC7	Enter/Edit a Bill Screen 7 (Opt. Billing Info). (Routine formerly named DGCRSC7.)
IBCSC8	Enter/Edit a Bill Screen 8 (Bill Specific Info). (Routine formerly named DGCRSC8.)

Routine List with Descriptions, cont.

IBCSC82	Enter/Edit a Bill Screen 8 for UB-92.
IBCSC8H	Enter/Edit a Bill Screen 8, if HCFA-1500. (Routine formerly named DGCRSC8H.)
IBCSCE, IBCSCE1	Enter/Edit a Bill screen edits. (Routines formerly named DGCRSCE, DGCRSCE1.)
IBCSCH, IBCSCH1	Enter/Edit a Bill help screens. (Routines formerly named DGCRSCH, DGCRSCH1.)
IBCSCP	Enter/Edit a Bill screen processor. (Routine formerly named DGCRSCP.)
IBCSCU	Enter/Edit a Bill screen utility. (Routine formerly named DGCRSCU.)
IBCU, IBCU1, IBCU2, IBCU3, IBCU4, IBCU5	Enter/Edit a Bill billing utility. (Routines formerly named DGCRU, DGCRU1, DGCRU2, DGCRU3, DGCRU4, DGCRU5.)
IBCU41, IBCU64	Third Party billing utilities.
IBCU6, IBCU61, IBCU62, IBCU63	Automatic calculation of charges utility routines. (Routines formerly named DGCRU6, DGCRU61, DGCRU62, DGCRU63.)
IBCU7, IBCU7	Procedure enter/edit utility routines. (Routines formerly named DGCRU7, DGCRU71.)
IBCU8, IBCU81, IBCU82	Third Party Billing Utilities.
IBCVA, IBCVA0, IBCVA1	Third Party Billing set variables. (Routines formerly named DGCRVA, DGCRVA0, DGCRVA1.)
IBDE, IBDE1, IBDE1A, IBDE1B, IBDE2, IBDE3, IBDEHELP	The import/export utility for the encounter form.
IBDF1A	Printing a single encounter form, along with other reports defined via the Print Manager.
IBDF1B, IBDF1B1, IBDF1B1A, IBDF1B1B, IBDF1B2, IBDF1B3, IBDF1B5, IBDF1BA	Printing batches of encounter forms for appointments, along with other reports defined via the Print Manager.
IBDF1C	Print a blank encounter form within the List Manager.
IBDF10, IBDF10A, IBDF10B	Shifting blocks and the contents of blocks.

Routine List with Descriptions, cont.

IBDF11, IBDF11A	Print Manager setup for the encounter form.
IBDF12	Editing Tool Kit forms.
IBDF13	Editing Tool Kit blocks.
IBDF14	Clinic Setups Report.
IBDF15	List Clinics Using Forms Report.
IBDF16	Edit package interfaces, marking areas.
IBDF17	Copy Check-off Sheets to encounter forms.
IBDF18	Utility for providing the Problem List package with a list of clinic common problems from an encounter form.
IBDF19	Routine for deleting garbage, compiling forms.
IBDF2A	Prints a form - device must be open, variables defined.
IBDF2B, IBDF2B1	Writes a data field to the form.
IBDF2D, IBDF2D1	Writes a selection list to the form.
IBDF2E	Writes lines and text areas to the form.
IBDF2F	Prints the form - the form image must be in an array.
IBDF3	Edit selection groups.
IBDF4, IBDF4A	Edit selections.
IBDF5, IBDF5A, IBDF5B, IBDF5C	Creating an array that contains the form for display via the List Manager; editing the form; creating new blocks on the form; moving and re-sizing blocks.
IBDF6, IBDF6A, IBDFC	Adding and deleting forms to a clinic setup; creating and deleting forms.
IBDF7	Creating a list of Tool Kit blocks for the List Manager; creating a new Tool Kit block.
IBDF8	Displaying a Tool Kit block.
IBDF9, IBDF9A, IBDF9A1, IBDF9B, IBDF9B1, IBDF9C, IBDF9D, IBDF9E	Displaying a block, resizing it, editing its attributes and contents.

Routine List with Descriptions, cont.

IBDFN, IBDFN1, IBDFN2, IBDFN3, IBDFN4, IBDFN5, IBDFN6	Entry points used by the PACKAGE INTERFACE file (#357.6) for interfacing with other packages.
IBDFU, IBDFU1, IBDFU10, IBDFU1A, IBDFU1B, IBDFU2, IBDFU2A, IBDFU2B, IBDFU2C, IBDFU3, IBDFU4, IBDFU5, IBDFU5A, IBDFU6, IBDFU7, IBDFU8, IBDFU9, IBDFUA	Utilities used for encounter forms.
IBEBR	Enter/Edit Billing Rates.
IBEBRH	Help routine for Enter/Edit Billing Rates.
IBECEA, IBECEA0	Cancel/Edit/Add Charges - build charges array for list processor.
IBECEA1	Cancel/Edit/Add Charges - logic for the Pass a Charge action.
IBECEA2, IBECEA21, IBECEA22	Cancel/Edit/Add Charges - logic for the Edit a Charge action.
IBECEA3, IBECEA31, IBECEA32, IBECEA33	Cancel/Edit/Add Charges - logic for the Add a Charge action.
IBECEA4	Cancel/Edit/Add Charges - logic for the Cancel a Charge action.
IBECEA5, IBECEA51	Cancel/Edit/Add Charges - logic for the Update Events action, and subsequent actions on the Update Events list.
IBECEAU, IBECEAU1, IBECEAU2, IBECEAU3, IBECEAU4	Cancel/Edit/Add Charges - utilities used by all actions.
IBECK	Checks status of filer.
IBECPF	Continuous Patient flag/unflag.
IBECPTE	Enter and/or edit BASC table reference data.
IBECPTT	Transfers BASC rate group and status updates from the UPDATE BILLABLE AMBULATORY SURGICAL CODE file (#350.41) to the BILLABLE AMBULATORY SURGICAL CODE file (#350.4).
IBECPTZ	BASC transfer utility.
IBEF	The Integrated Billing background filer.
IBEFCOP	Background filer, Rx copayment processor.

Routine List with Descriptions, cont.

IBEFUNC	Set of extrinsic functions.
IBEFUNC1, IBEFUNC2	Set of extrinsic functions used in BASC billing.
IBEFUTL	Utility program for filer options.
IBEFUTL1	Recompiles and cross references all IB templates.
IBEMTBC	Category C billing clock maintenance.
IBEMTF, IBEMTF1	Flag Stop Codes/Dispositions/Clinics.
IBEMTF2	List Non-Billable Stop Codes/Dispositions/Clinics.
IBEMTO	Bills all Means Test Outpatient copayment charges which are on hold awaiting the new copay rate.
IBEMTO1	Lists all Means Test Outpatient copayment charges which are on hold awaiting the new copay rate.
IBEPAR, IBEPAR1	IB Site Parameter entry and edit. (Routines formerly named DGCRPAR, DGCRPAR1.)
IBERS	User interface for the Appointment Check-off Sheet.
IBERS1	Search, sort, and print Appointment Check-off Sheets chosen by the user.
IBERS2	Gather and store individual patient data for a Check-off Sheet.
IBERS3	Gather and store individual patient PTF and billing diagnoses for a Check-off Sheet.
IBERSE	Build and edit the CPT lists for the Check-off Sheets.
IBERSI	List and/or delete procedures on Check-off Sheets that are AMA inactive and/or nationally, locally, and billing inactive.
IBERSP	Prints the formatted CPT list for the Check-off Sheets.
IBERSP1	Creates the formatted CPT list for the Check-off Sheets.

Routine List with Descriptions, cont.

IBESTAT	Status display of IB site parameters and filer status.
IBETIME	Capacity management utility.
IBJTBA, IBJTBA1	Used to display TPJI bill charge information.
IBJTRA, IBJTRA1	Used to display Claims Tracking insurance communications.
IBNTEG*	IB integrity routines.
IBOA31	List All Bills For a Patient Report. (Routine formerly named DGCRA31.)
IBOA32	Continuation of List All Bills For a Patient Report. Retrieves and displays Integrated Billing Actions. (Routine formerly named DGCRA32.)
IBOAMS	Revenue Code Totals by Rate Type Report. (Routine formerly named DGCRAMS1.)
IBOBCC, IBOBCC1	Search, sort, and print the Unbilled BASC for Insured Patient Appointment Report.
IBOBCR6	Continuous Pt. Report - displays a listing of patients who have been continuously hospitalized since July 1, 1986.
IBOBCRT	Billing Cycle Inquiry - displays 90 day billing clocks, primary eligibility code, status, etc.
IBOBL	List bills for an episode of care. (Routine formerly named DGCROBL.)
IBOCDRPT	Lists charges that may need to be cancelled because the patient is identified as Catastrophically Disabled.
IBOCHK	Verifies links from IB to Pharmacy.
IBOCNC	Determine Clinic CPT Usage Report search parameters from user input.
IBOCNC1	Search and sort the Clinic CPT Usage Report.
IBOCNC2	Print the Clinic CPT Usage Report.
IBOCOSI	Search, sort, and print the inactive CPT codes on Check-off Sheets Report.
IBOCPD	Option for printing the full or summary Clerk Productivity Report.
IBOCPDS	Search, sort, and print the Clerk Productivity Summary Report.
IBODISP	Brief and full inquiry to Integrated Billing Actions.

Routine List with Descriptions, cont.

IBODIV	Select division or clinic.
IBOEMP, IBOEMP1, IBOEMP2	List of employed patients with no insurance coverage.
IBOHLD1, IBOHLD2	Report of Category C Charges On Hold.
IBOLK	Patient Billing Inquiry - user interface, prints IB Actions.
IBOLK1	Address Inquiry.
IBOMBL	MCCR MAS Billing Log. (Routine formerly named DGCROMBL.)
IBOMTC	Category C Activity Listing - user interface.
IBOMTC1	Category C Activity Listing - compilation and output.
IBOMTE	Estimate Category C Charges - user interface.
IBOMTE1	Estimate Category C Charges - output.
IBOMTE2	Estimate Category C Charges - compile charges.
IBOMTP	Single Patient Cat C Profile - user interface.
IBOMTP1	Single Patient Cat C Profile - compilation and output.
IBORAT	Top level routine for Billing Rates Listing.
IBORAT1A	Builds a temp file of data from the IB ACTION CHARGE file (#350.2).
IBORAT1B	Parses the temp file built by IBORAT1A and calculates effective dates for IB ACTION CHARGES.
IBORAT1C	Writes the IB ACTION CHARGES to the selected device.
IBORAT2A	Filters the BILLING RATES file (#399.5) to build a temp file of billing rates.
IBORAT2B	Parses the temp file built by IBORAT2A and calculates effective dates for BILLING RATES.
IBORAT2C	Writes the BILLING RATES to the selected device.
IBORT, IBORT1	MCCR MAS Billing Totals Report. (Routines formerly named DGCRORT, DGCRORT1.)
IBOST	Statistics report routine.

Routine List with Descriptions, cont.

IBOSTUS, IBOSTUS1	Bill Status Report. (Routines formerly named DGCROST, DGCROST1.)
IBOTR, IBOTR1, IBOTR11	Insurance Payment Trend Report user interface. (Routines IBOTR and IBOTR1 were formerly named DGCROTR, DGCROTR1.)
IBOTR2	Insurance Payment Trend Report data compilation. (Routine formerly named DGCROTR2.)
IBOTR3, IBOTR4	Insurance Payment Trend Report output. (Routines formerly named DGCROTR3, DGCROTR4.)
IBOUNP1, IBOUNP2, IBOUNP3	Inpatients w/Unknown or Expired Insurance Report.
IBOUNP4, IBOUNP5, IBOUNP6	Outpatients w/Unknown or Expired Insurance Report.
IBOUTL	Utility program for output reports.
IBOVOP, IBOVOP1, IBOVOP2	Category C Outpatient/Events Report.
IBP	Archive/Purge - option driver.
IBPA	Archive/Purge - Archive billing data.
IBPEX	Contains the logic to purge entries from the BILLING EXEMPTIONS file (#354.1). This routine will not purge entries for approximately two years from its release date.
IBPF, IBPF1	Archive/Purge - Find Billing Data to Archive.
IBPFU	Archive/Purge - Find Billing Data to Archive utilities.
IBPO	Archive/Purge - Outputs - List Archive/Purge Log Entries; Archive/Purge Log Inquiry; List Search Template Entries.
IBPP	Archive/Purge - purge billing data.
IBPU, IBPU1, IBPU2	Archive/Purge - general utilities.
IBPUBUL	Archive/Purge - generate mail message after archive/purge operation.
IBPUDEL	Archive/Purge - delete entries from a search template.
IBR	Totals charges, passes to Accounts Receivable, subsequently updates IB actions.

Routine List with Descriptions, cont.

IBRBUL	Sends a mail message to the IB Category C mail group informing it that Category C charges have been determined for a veteran with insurance.
IBRCON1	Allows the user to do a lookup on a cross-reference of patients with converted charges and then select one for processing.
IBRCON2	Passes all outpatient converted charges prior to a user- selected date to Accounts Receivable by calling routine ^IBR.
IBRCON3	Top level routine for the IBRCON1 and IBRCON2.
IBRFN, IBRFN1, IBRFN2	Routine contains supported calls for Accounts Receivable.
IBRFN3	Passes bill/claims info to Accounts Receivable.
IBRFN4	Contains utility calls for IB/AR Extract.
IBRREL	Release Means Test charges placed on hold.
IBRUTL	Utilities for the IB/Accounts Receivable interface.
IBTOAT, IBTOAT1, IBTOAT2	These routines print the Admission Sheet.
IBTOBI, IBTOBI1, IBTOBI2, IBTOBI3, IBTOBI4	These routines print the Claims Tracking summary for billing.
IBTODD, IBTODD1	These routines print the Days Denied Report for Claims Tracking.
IBTOLR	This routine prints the list of cases in Claims Tracking requiring Random Sample.
IBTONB	This routine prints unbilled care that is billable in Claims Tracking.
IBTOPW	This routine prints the Pending Reviews Report.
IBTOSA	This routine prints the Scheduled Admissions with Insurance Report.
IBTOSUM, IBTOSUM1, IBTOSUM2	These routines print the MCCR/UR Summary Report.
IBTOTR	This routine prints the Claims Tracking Inquiry.
IBTOUA	This routine prints the Unscheduled Admissions with Insurance Report.
IBTOUR, IBTOUR1, IBTOUR2, IBTOUR3, IBTOUR4, IBTOUR5	These routines print the Claims Tracking UR Activity Report.

Routine List with Descriptions, cont.

IBTOVS	This routine prints a list of billable visits from Claims Tracking by visit type.
IBTRC, IBTRC1, IBTRC2, IBTRC3, IBTRC4	These routines display the list of Insurance Reviews for a visit and allow for editing of the data on one or more reviews, as well as adding or deleting reviews.
IBTRCD, IBTRCD0, IBTRCD1	These routines create the expanded display of a single Insurance Review and allow for editing of the review.
IBTRD, IBTRD1	These routines display the list of denials and appeals and allow for adding, editing, and deleting of the data on one or more of the listed items.
IBTRDD, IBTRDD1	These routines create the expanded display of a single denial or appeal and for editing of the entry.
IBTRE, IBTRE0, IBTRE1, IBTRE2, IBTRE20, IBTRE3	These routines display the list of Claims Tracking entries (inpatient visits, outpatient visits, prescription refills) for a patient, and allow for adding, editing, and deleting of visits on the list.
IBTRE4	This routine allows for editing of inpatient procedures in Claims Tracking.
IBTRE5	This routine allows for the editing of inpatient providers in Claims Tracking.
IBTRE6	This routine allows for the editing of inpatient procedures in Claims Tracking.
IBTRED, IBTRED0, IBTRED01, BTRED1, IBTRED2	These routines create the expanded display of a single entry in Claims Tracking and editing on the displayed data.
IBTRKR	Invoked by the inpatient event driver and automatically creates an inpatient Claims Tracking entry for specific admissions.
IBTRKR1	The random sample generator for determining which admissions will be part of the QM mandated random sample.
IBTRKR2	This routine is invoked by the nightly background job and adds scheduled admissions to Claims Tracking.
IBTRKR3, IBTRKR31	Adds prescription refill information to Claims Tracking.
IBTRKR4, IBTRKR41	Add outpatient encounters to Claims Tracking.

Routine List with Descriptions, cont.

IBTRKR5	This routine adds prosthetics to Claims Tracking.
IBTRP	Displays and allows editing of Claims Tracking parameters.
IBTRPR, IBTRPR0, IBTRPR01, IBTRPR1, IBTRPR2	These routines display pending hospital insurance reviews and perform necessary actions on these reviews.
IBTRV, IBTRV1, IBTRV2, IBTRV3, IBTRV31	These routines display the list of hospital reviews for a visit and allow for adding, editing, and deleting of the entries listed.
IBTRVD, IBTRVD0, IBTRVD1	These routines create the expanded display of a single hospital review and allow editing of the displayed data.
IBTUTL, IBTUTL1, IBTUTL2, IBTUTL3, IBTUTL4, IBTUTL5	These utility routines perform the creation of new entries in Claims Tracking, insurance reviews, and hospital reviews.

DGCR* to IB* Namespace Map

The following is a list of DGCR routines that changed to the IB namespace in this version.

DGCR Name	IB Name
DGCRA	IBCA
DGCRA0	IBCA0
DGCRA1	IBCA1
DGCRA2	IBCA2
DGCRA3	IBCA3
DGCRA31	IBOA31
DGCRA32	IBOA32
DGCRAMS1	IBOAMS
DGCRAMS2	OBSOLETE
DGCRB	IBCB
DGCRB1	IBCB1
DGCRB2	IBCB2
DGCRBB	IBCBB
DGCRBB1	IBCBB1
DGCRBB2	IBCBB2
DGCRBR	IBCBR
DGCRBULL	IBCBULL
DGCRC	IBCC
DGCRCC	IBCCC
DGCRCC1	IBCCC1
DGCRCC2	IBCCC2
DGCRCPT	IBCCPT
DGCRMENU	IBCMENU
DGCRNQ	IBCNQ
DGCRNQ1	IBCNQ1
DGCROBL	IBOBL
DGCROMBL	IBOMBL
DGCRONS1	IBCONS1
DGCRONS2	IBCONS2
DGCRONSC	IBCONSC
DGCROPV	IBCOPV
DGCROPV1	IBCOPV1
DGCROPV2	IBCOPV2
DGCRORT	IBORT
DGCRORT1	IBORT1
DGCROST	IBOSTUS
DGCROST1	IBOSTUS1
DGCROTR	IBOTR
DGCROTR1	IBOTR1
DGCROTR2	IBOTR2
DGCROTR3	IBOTR3
DGCROTR4	IBOTR4
DGCRP	IBCF1
DGCRP0	IBCF10
DGCRP1	IBCF11
DGCRP2	IBCF12
DGCRP4	IBCF14
DGCRPAR	IBEPAR
DGCRPAR1	IBEPAR1
DGCRSC1	IBCSC1
DGCRSC2	IBCSC2
DGCRSC3	IBCSC3
DGCRSC4	IBCSC4
DGCRSC4A	IBCSC4A
DGCRSC4B	IBCSC4B
DGCRSC4C	IBCSC4C
DGCRSC5	IBCSC5
DGCRSC6	IBCSC6
DGCRSC61	IBCSC61
DGCRSC7	IBCSC7
DGCRSC8	IBCSC8
DGCRSC8H	IBCSC8H
DGCRSCE	IBCSCE
DGCCRSCE1	IBCSCE1
DGCRSCH	IBCSCH
DGCRSCH1	IBCSCH1
DGCRSCP	IBCSCP
DGCRSCU	IBCSCU
DGCRTN	IBCRTN
DGCRTP	IBCF1TP
DGCRU	IBCU
DGCRU1	IBCU1
DGCRU2	IBCU2
DGGCRU3	IBCU3
DGCRU4	IBCU4
DGCRU5	IBCU5
DGCRU6	IBCU6
DGCRU61	IBCU61
DGCRU62	IBCU62
DGCRU63	IBCU63
DGCRU7	IBCU7
DGCRU71	IBCU71
DGCRVA	IBCVA
DGCRVA0	IBCVA0
DGCRVA1	IBCVA1

Files

Per VHA Directive 10-93-142 regarding security of software that affects financial systems, most of the IB Data Dictionaries may not be modified. The file descriptions of these files will be so noted. The files which **may** be modified are Encounter Form files #357 through #358.91.

Globals to Journal

The IB, IBA, IBAM, IBE, and IBT globals must be journalled. In a future release, we intend to move all dynamic files from IBE to IBA so that it will not be necessary to journal IBE. Journaling of the IBAT global is optional.

File List with Descriptions

File # File Name	Global File Description
36 INSURANCE COMPANY	^DIC(36, This file contains the names and addresses of insurance companies as needed by the local facility. **The data in this file is not editable using VA File Manager.**
350 INTEGRATED BILLING ACTION	^IB(350, Entries in this file are created by other applications calling approved interface routines.
350.1** IB ACTION TYPE	^IBE(350.1, This file contains the types of actions that a service can use with Integrated Billing and the related logic to tell IB how this entry is to be processed.
350.2** IB ACTION CHARGE	^IBE(350.2, This file contains the charge information for an IB ACTION TYPE by effective date of the charge.
350.21 IB ACTION STATUS	^IBE(350.21, The file holds new statuses which are introduced in v2.0, display and abbreviated names for the statuses, and classification-type fields for each status which are used for processing in the Integrated Billing module.

File List with Descriptions, cont.

File # File Name	Global File Description
350.3** IB CHARGE REMOVAL REASONS	^IBE(350.3, Data in this file comes pre-loaded with reasons why a charge may be cancelled or removed. **Sites are asked not to edit or add entries to this file.**
350.4 BILLABLE AMBULATORY SURGICAL CODES	^IBE(350.4, This file contains the CPT procedure and the associated HCFA rate groups for ambulatory surgeries that may be billed.
350.41 UPDATE BILLABLE AMBULATORY SURGICAL CODE	^IBE(350.41, This file contains updates to the ambulatory surgery procedures which can be billed.
350.5 BASC LOCALITY MODIFIER	^IBE(350.5, This file is used in the calculation of the charge for an ambulatory surgery performed on any given date.
350.6 IB ARCHIVE/PURGE LOG	^IBE(350.6, This file is used to track the archiving and purging operations of the following files used in Integrated Billing List Archive/Purge Log entries: INTEGRATED BILLING ACTION file (#350), CATEGORY C BILLING CLOCK file (#351), and BILL/CLAIMS file (#399).
350.7 AMBULATORY CHECK-OFF SHEET	^IBE(350.7, This file defines the Ambulatory Surgery Check-off Sheets used by outpatient clinics. It contains the CPT print format to be used on the Ambulatory Surgeries Check-off List.
350.71 AMBULATORY SURG. CHECK-OFF SHEET PRINT FIELDS	^IBE(350.71, This file contains the sub-headers and procedures associated with each check-off sheet defined for the CPT clinic list.
350.8* IB ERROR	^IBE(350.8, If a potential error is detected during a billing process, the full text description of the error will be reported from this file.
350.9 IB SITE PARAMETERS	^IBE(350.9, This file contains the necessary site-specific data to run and manage the Integrated Billing package and the IB Background Filer. **Only one entry per facility is allowed.**

File List with Descriptions, cont.

File # File Name	Global File Description
351 CATEGORY C BILLING CLOCK	^IBE(351, This file is used to create and maintain billing clocks in which Category C patients may be charged for copayment and per diem charges for hospital or nursing home care, as well as outpatient visits. It will initially be populated by the Means Test data conversion and subsequently created and updated by Integrated Billing. **Entries in this file should not be deleted or edited through VA FileMan.**
351.1 IB CONTINUOUS PATIENT	^IBE(351.1, This file contains a list of all hospital or nursing home care patients receiving continuous institutional care from prior to 7/1/86 who may be subject to Category C billing.
351.2 SPECIAL INPATIENT BILLING CASES	^IBE(351.2, This file is used to track inpatient episodes for Category C veterans who have claimed exposure to Agent Orange, Ionizing Radiation, and Environmental Contaminants.
351.6 TRANSFER PRICING PATIENT	^IBAT(351.6, This file is used to store Transfer Pricing patient specific information.
351.61 TRANSFER PRICING TRANSACTIONS	^IBAT(351.61, This file holds all transfer pricing transactions.
351.62 TRANSFER PRICING FIELD DEFINITION	^IBAT(351.62, This file comes populated with national entries. These entries should never be deleted or edited. It is not recommended that facilities add entries to this file. The entries are used to extract and format data for all the transfer pricing reports. DO NOT delete entries in this file. DO NOT edit data in this file with VA File Manager.
351.67 TRANSFER PRICING INPT PROSTHETIC ITEMS	^IBAT(351.67, This file stores the prosthetic devices that should be automatically billed for inpatient devices issued. Unless a device is in this file, it will only be billed for outpatient services (automatically).

File List with Descriptions, cont.

File # File Name	Global File Description
352.1** BILLABLE APPOINTMENT TYPE	^IBE(352.1, This is a time-sensitive file that maintains records for each appointment type with indicators for IGNORE MEANS TEST, PRINT ON INSURANCE REPORT, and DISPLAY ON INPUT SCREEN.
352.2 NON-BILLABLE DISPOSITIONS	^IBE(352.2, This file is used to flag dispositions in the DISPOSITION file (#37) as either billable or non-billable for Means Test billing.
352.3 NON-BILLABLE CLINIC STOP CODES	^IBE(352.3, This file is used to flag clinic stop codes in the CLINIC STOP file (#40.7) as either billable or non-billable for Means Test billing.
352.4 NON-BILLABLE CLINICS	^IBE(352.4, This file is used to flag clinics in the HOSPITAL LOCATION file (#44) as either billable or non-billable for Means Test billing.

File List with Descriptions, cont.

File # / File Name	Global / File Description
353** BILL FORM TYPE	^IBE(353, This is a reference file containing the types of health insurance claim forms used in billing. **Sites may add local forms to this file; however, the internal entry number for locally added forms should be in the stations number range of station number times 1000.**
353.1* PLACE OF SERVICE	^IBE(353.1, This file contains the Place of Service codes that may be associated with a procedure on the HCFA-1500. **These codes were developed specifically for the HCFA-1500 and should not be changed by the site.**
353.2* TYPE OF SERVICE	^IBE(353.2, This file contains the Type of Service codes that may be associated with a procedure on the HCFA-1500. **These codes were developed specifically for the HCFA-1500 and should not be changed by the site.**
354 BILLING PATIENT	^IBA(354, **Do not edit this file.** Under normal operation, it is not necessary to edit the fields in this file directly. The option Manual Change Copay Exemption (Hardships) can be used to update and correct this entry by creating a new exemption. If many patient records have problems, the option Print/Verify Patient Exemption Status can be used to correct the entries. The data in this file is updated each time a new (current) exemption is created for a patient. Exemptions are automatically created when changes in patient information change the exemption status or when an expired (older than one year) exemption is encountered when determining the exemption status for Pharmacy. This file will contain specific information related to billing about individual patients. Current status of the Medication Copayment Exemption will be kept in this file. Conceptually, this is different than the BILLING EXEMPTIONS file (#354.1), which maintains the audit log and historical data related to billing exemptions.

File List with Descriptions, cont.

File # File Name	Global File Description
354.1 BILLING EXEMPTIONS	^IBA(354.1, **Do not edit this file.** Under normal operation, it is not necessary to edit the fields in this file directly. The option Manual Change Copay Exemption (Hardships) can be used to update and correct entries by creating a new exemption. If many patient records have problems, the option Print/Verify Patient Exemption Status can be used to correct the entries.
354.2** EXEMPTION REASON	^IBE(354.2, This file contains the set of reasons that exemptions can be given and their associated status and description.
354.3** BILLING THRESHOLDS	^IBE(354.3, This file contains the income threshold amounts used by the Medication Copayment Exemption process.
354.4 BILLING ALERTS	^IBA(354.4, This file will only be populated if a site chooses to use the "Alert" functionality available in Kernel v7 instead of receiving mail messages. This is determined by the field USE ALERTS (#.14) in the IB SITE PARAMETERS file (#350.9).
354.5** BILLING ALERT DEFINITION	^IBE(354.5, This file contains the necessary information to process electronic notifications sent by the Medication Copayment Exemption process.
#354.6** IB FORM LETTER	^IBE(354.6, This file contains the header and main body of letters that are generated by the IB package. Each site should edit the header of the letter to reflect its own address. Sites may edit the main body of the letter to change the signer of the letter or add contact persons and phone numbers. The text of the letters has been approved by MCCR VACO.
#354.7 IB PATIENT COPAY ACCOUNT	^IBAM(354.7 This file stores summary information about a patient's copay account. The information will be used to determine if a patient has reached his copay cap for the month or year.

File List with Descriptions, cont.

File # File Name	Global File Description
#354.71 IB COPAY TRANSACTIONS	^IBAM(354.71 This file stores individual transactions for outpatient medication copayments. The transactions in this file will be used to store detailed information about a patient's rx copayments, including amounts billed and not billed. There should be transactions stored in this file for both this facility and other treating facilities throughout the VA system.
#354.75 IB COPAY CAPS	^IBAM(354.75 This file comes populated with data. The data in this file should not be edited, added, or deleted locally. The information stored here is the cap amounts for outpatient medication copayment. Once a patient has reached his cap, billing will stop for the remainder of the period indicated.
#355.1* TYPE OF PLAN	^IBE(355.1, This file contains the standard types of plans that an insurance company may provide. The type of plan may be dependent on the type of coverage provided by the insurance company and may affect the type of benefits that are available for the plan.

File List with Descriptions, cont.

File # File Name	Global File Description
#355.2* TYPE OF INSURANCE COVERAGE	^IBE(355.2, This file contains the types of coverage with which an insurance company is generally associated. If an insurer is identified with more than one type of coverage, it should be identified as HEALTH INSURANCE as this encompasses all.
#355.3 GROUP INSURANCE PLAN	^IBA(355.3, This file contains the relevant data for group insurance plans. The data in this file is specific to the plan itself. This is in contrast to the PATIENT file (#2) which contains data about patients' policies and where the policy may be for a group or health insurance plan.
#355.31 INSURANCE FILING TIME FRAME	^IBE(355.13, This file contains the list of valid Standard Insurance Filing Time Frames that may be automatically applied. This file comes populated with the standard entries and should not be modified locally.
#355.4 ANNUAL BENEFITS	^IBA(355.4, This file contains the fields to maintain the annual benefits by year for an insurance policy.
#355.5 INSURANCE CLAIMS YEAR TO DATE	^IBA(355.5, This file contains the CLAIM TO DATE information about a patient's health insurance claims to a specific carrier for a specific year. This will allow estimate receivables based on whether claims exceed deductibles or other maximum benefits.
#355.6** INSURANCE RIDERS	IN ^IBE(355.6, This file contains a listing of insurance riders that can be purchased as add-on coverage to a group plan. The software does nothing special with these riders. The listing may be added to locally and be assigned to patients as policy riders. This information is strictly for display and tracking purposes only.
#355.7 PERSONAL POLICY	^IBA(355.7, This file contains the insurance riders that have been purchased as add-on coverage to a group plan. This information is used internally for display purposes only.
#356 CLAIMS TRACKING	^IBT(356, This file may contain entries of all types of billable events that need to be tracked by MCCR. The information in this file is used for MCCR and/or UR purposes. It is information about the event itself not otherwise stored or pertinent for MCCR purposes.

File List with Descriptions, cont.

File # / File Name	Global / File Description
#356.1 HOSPITAL REVIEW	^IBT(356.1, This file contains Utilization Review information about appropriateness of admission and continued stay in an acute medical setting. It uses the Interqual criteria for appropriateness. An entry for each day of care for cases being tracked is required by the QM office in VACO. The information in this file will be rolled up into a national database. Only reviews that have a status of COMPLETE should be rolled up. The information in this file is clinical in nature and should be treated with the same confidentiality as required of all clinical data.
#356.11** CLAIMS TRACKING REVIEW TYPE	^IBE(356.11, This is the type of review that is being performed by MCCR or UR. This file may contain the logic to determine which questions and/or screens can be presented to the user in the future. **Do not add, edit, or delete entries in this file without instructions from your ISC.**
#356.2 INSURANCE REVIEW	^IBT(356.2, This file contains information about the MCCR/UR portion of Utilization Review and the associated contacts with insurance carriers. Appropriateness of care is inferred from the approval and denial of billing days by the insurance carriers UR section. While this information appears to be primarily administrative in nature, it may contain sensitive clinical information and should be treated with the same confidentiality as required of all clinical data.
#356.21** CLAIMS TRACKING DENIAL REASONS	^IBE(356.21, This file is a list of the standard reasons for denial of a claim. Editing this file may have significant impact on the results of the MCCR NDB roll up of Claims Tracking information. **Do not add, edit, or delete entries in this file without instructions from your ISC.**

File List with Descriptions, cont.

File # / File Name	Global / File Description
#356.3** CLAIMS TRACKING SI/IS CATEGORIES	^IBE(356.3, This file contains the major categories that are used to address the severity of illness and intensity of service. Specific criteria for each category must be met to address appropriateness of admission to continued stay in and discharge from specialized units and general units. Editing this file may have significant impact on the QM national roll up of Utilization Review information. The contents of this file are the general categories for Intensity of Service and Severity of Illness from Interqual. **Do not add, edit, or delete entries in this file without instructions from your ISC.**
#356.399 CLAIMS TRACKING/BILL	^IBT(356.399, This file serves as a bridge between Claims Tracking and the BILL/CLAIMS file (#399). An entry is created automatically by the billing module to link the events being billed to the Claims Tracking entry. It serves as a cross-reference in a many to many relationship for the entries in these two files. It should be maintained by the Billing module.
#356.4** CLAIMS TRACKING NON-ACUTE CLASSIFICATIONS	^IBE(356.4, This file contains the list of approved non-acute classifications provided by the UM office in VACO. The codes are used in roll up of national data **Do not add, edit, or delete entries in this file without instructions from your ISC.**
#356.5** CLAIMS TRACKING ALOS	^IBE(356.5, This file contains the DRGs and average length of stays (ALOS) year that is the most common ALOS approved by insurance companies. This generally is much shorter than the ALOS for VA.
#356.6** CLAIMS TRACKING TYPE	^IBE(356.6, This file contains the types of events that can be stored in Claims Tracking. It also contains data on how the Automated Biller is to handle each type of event. **Do not add, edit, or delete entries in this file without instructions from your ISC.**

File List with Descriptions, cont.

File # File Name	Global File Description
#356.7** CLAIMS TRACKING ACTION	^IBE(356.7, This file contains a list of the types of actions that may be taken on a review or a contact by an insurance company. **Do not add, edit, or delete entries in this file without instructions from your ISC.**
#356.8** CLAIMS TRACKING NON-BILLABLE REASONS	^IBE(356.8, This is a file of reasons that may be entered into the Claims Tracking module to specify why a potential claim is not billable. **Do not add, edit, or delete entries in this file without instructions from your ISC.**
#356.9 INPATIENT DIAGNOSIS	^IBT(356.9, This file is designed to hold all inpatient diagnoses.
#356.91 INPATIENT PROCEDURE	^IBT(356.91, This file is designed to hold all inpatient procedures.
#356.93 INPATIENT INTERIM DRG	^IBT(356.93, This file holds interim DRGs computed by the Claims Tracking module for display in Claims Tracking and on reports. The computed ALOS is based upon 1992 HCFA average lengths of stay (ALOS), not VA averages. The purpose is to help utilization review personnel determine if the ALOS approved by an insurance company is within industry standards.
#356.94 INPATIENT PROVIDERS	^IBT(356.94, This file allows the Claims Tracking module to store the admitting physician. In addition, the attending and resident providers can be identified in this file. If attending and resident providers are entered, they are assumed to be entered completely for an episode of care being tracked. If no provider other than admitting physician is entered, the providers and attending from MAS will be considered to be the correct providers. Because QM data may be extracting this data on the national roll up, it is necessary to correctly identify the attending physician.
#357 ENCOUNTER FORM	^IBE(357, This file contains encounter form descriptions used by the Encounter Form utilities to print encounter forms.

File List with Descriptions, cont.

File # File Name	Global File Description
#357.1 ENCOUNTER FORM BLOCK	^IBE(357.1, This file contains descriptions of blocks, which are rectangular areas on an encounter form.
#357.2 SELECTION LIST	^IBE(357.2, A selection list is composed of one or more rectangular area(s) in a block, called columns, which contain a list. The column(s) will have one or more subcolumns, each subcolumn containing either text or an input symbol. The input symbols are for the user to mark to indicate a choice from the list.
#357.3 SELECTION	^IBE(357.3, This file contains the items appearing on the SELECTION LISTS. A selection can be composed of several fields; therefore, they can occupy several subcolumns. Only the text is stored here, not the MARKING SYMBOLS.
#357.4 SELECTION GROUP	^IBE(357.4, A Selection Group is a set of items on a list and the header under which those items should appear.
#357.5 DATA FIELD	^IBE(357.5, A data field can be composed of a label (determined at the time the form description is created) and data, coming from the DHCP database (determined at the time the form prints). The label and data are printed to the encounter form. A data field can be composed of subfields, each subfield containing possibly its own label and data.
#357.6* PACKAGE INTERFACE	^IBE(357.6, This file is used in the form design process and to print data to the form. It contains a description of all of the interfaces with other packages.
#357.7 FORM LINE	^IBE(357.7, This file contains either a horizontal or vertical line appearing on the form.
#357.8 TEXT AREA	^IBE(357.8, A TEXT AREA is a rectangular area on the form that displays a word processing field. The text is automatically formatted to fit within this area.

File List with Descriptions, cont.

File # File Name	Global File Description
#357.91** MARKING AREA TYPE	^IBE(357.91, This file contains the different types of marking areas in which the user can write that can be printed to a form. The following are examples: ( ), __,. These are for the person completing the form to enter a mark to indicate a choice.
#357.92** PRINT CONDITIONS	^IBE(357.92, This file contains a table containing a list of conditions recognized by the Print Manager. They are used to specify the conditions under which reports should be printed. The Print Manager is a program that scans the appointments for selected clinics for a selected date and prints specified reports under specified conditions.
#358 IMP/EXP ENCOUNTER FORM	^IBE(358, This file is nearly identical to File #357. It is used by the Import/Export Utility as a workspace for importing or exporting forms.
#358.1 IMP/EXP ENCOUNTER FORM BLOCK	^IBE(358.1, This file is nearly identical to File #357.1. It is used by the Import/Export Utility as a workspace for importing or exporting forms.
#358.2 IMP/EXP SELECTION LIST	^IBE(358.2, This file is nearly identical to File #357.2. It is used by the Import/Export Utility as a workspace for importing or exporting forms.
#358.3 IMP/EXP SELECTION	^IBE(358.3, This file is nearly identical to File #357.3. It is used by the Import/Export Utility as a workspace for importing or exporting forms.
#358.4 IMP/EXP SELECTION GROUP	^IBE(358.4, Nearly identical to File #357.4. It is used by the Import/Export Utility as a workspace to import/export forms.
#358.5 IMP/EXP DATA FIELD	^IBE(358.5, This file is nearly identical to File #357.5. It is used by the Import/Export Utility as a workspace for importing or exporting forms.

File List with Descriptions, cont.

File # File Name	Global File Description
#358.6 IMP/EXP PACKAGE INTERFACE	^IBE(358.6, This file is nearly identical to File #357.6. It is used by the Import/Export Utility as a workspace for importing or exporting forms.
#358.7 IMP/EXP FORM LINE	^IBE(358.7, This file is nearly identical to File #357.7. It is used by the Import/Export Utility as a workspace for importing or exporting forms.
#358.8 IMP/EXP TEXT AREA	^IBE(358.8, This file is nearly identical to File #357.8. It is used by the Import/Export Utility as a workspace for importing or exporting forms.
#358.91 IMP/EXP MARKING AREA	^IBE(358.91, This file is nearly identical to File #357.91. It is used by the Import/Export Utility as a workspace for importing or exporting forms.
#362.1 IB AUTOMATED BILLING COMMENTS	^IBA(362.1, This file contains entries created by the Third Party Automated Biller. As the Auto Biller attempts to create bills based on events in Claims Tracking, it sets entries in this file indicating the action taken by the Auto Biller for the event. The only way entries are added to this file is by the Auto Biller. There is no user entry.
#362.3 IB BILL/CLAIMS DIAGNOSIS	^IBA(362.3, This file contains all diagnoses for bills in the BILL/CLAIMS file (#399).
362.4 IB BILL/CLAIMS PRESCRIPTION REFILL	^IBA(362.4, This file contains all prescription refills for bills in the BILL/CLAIMS file (#399).
362.5 IB BILL/CLAIMS PROSTHETICS	^IBA(362.5, This file contains all prosthetic items associated with bills in the BILL/CLAIMS file (#399).
399 BILLS/CLAIMS	^DGCR(399, This file contains all the information necessary to complete a Third Party billing claim form.

File List with Descriptions, cont.

File # / File Name	Global / File Description
399.1** MCCR UTILITY	^DGCR(399.1, This file contains all of the Occurrence Codes, Discharge Statuses, Discharge Bedsections, and Value Codes which may be used on a Third Party Claim form.
399.2** REVENUE CODE	^DGCR(399.2, This file contains all of the Revenue Codes which may be used on the Third Party Claim forms.
399.3** RATE TYPE	^DGCR(399.3, This file contains all of the Rate Types which may be used on the Third Party Claim forms.
399.4** MCCR INCONSISTENT DATA ELEMENTS	^DGCR(399.4, Contains a list of all possible reasons a bill may be disapproved during the authorization phase of the billing process.
399.5** BILLING RATES	^DGCR(399.5, Contains the historical billing rates associated with revenue codes and specialties for which the DVA has legislative authority to bill third parties for reimbursement. It is used to automatically associate revenue codes, bedsections, and amounts on bills.
409.95 PRINT MANAGER CLINIC SETUP	^SD(409.95, This file defines which encounter forms to use for a particular clinic. It can also be used to define other forms or reports to print, along with the new encounter forms. For each appointment, a packet of forms can be printed, saving the effort of collating the forms manually.
409.96 PRINT MANAGER DIVISION SETUP	^SD(409.96, This file allows the user to specify reports or forms that should print in addition to the encounter forms for the entire division. Only reports contained in the PACKAGE INTERFACE file (#357.6) can be specified. The user can ALOS specify the conditions under which the report should print. The intent is to print packets of forms so that they do not have to be manually collated.

*File contains data which will overwrite existing data.
**File contains data which will merge with existing data.

Templates

Input Templates

FILE#	TEMPLATE	DESCRIPTION
36	IBEDIT INS CO1	Edits INSURANCE COMPANY file from Insurance Company Edit option.
350.9	IB EDIT CLEAR	Clear Integrated Billing Filer Parameters.
	IB EDIT MCCR PARM	Enter/edit MCCR Site Parameters.
	IB EDIT SITE PARAM	Enter/edit Integrated Billing Site Parameters.
351	IB BILLING CYCLE ADD	Patient Billing Clock Maintenance, new entry.
	IB BILLING CYCLE ADJUST	Patient Billing Clock Maintenance, edit existing entry.
353	IB DEVICE	Bill Form Print Device Setup.
354	IB CURRENT STATUS	Updates the current status in the BILLING PATIENT file whenever a new exemption is created.
354.1	IB INACTIVATE EXEMPTION	Inactivates exemptions. Only one exemption for a date may be active.
	IB NEW EXEMPTION	Updates new exemptions in the BILLING EXEMPTIONS file.
354.3	IB ENTER THRESHOLD	Enter new income thresholds.
355.4	IBCN AB ADD COM	Allows editing of ANNUAL BENEFITS comments.
	IBCN AB EDIT ALL	Allows editing of all ANNUAL BENEFITS fields.
	IBCN AB HOME HEA	Allows editing of the Home Health section of ANNUAL BENEFITS.
	IBCN AB HOSPC	Allows editing of the Hospice section of ANNUAL BENEFITS.

Input Templates, cont.

FILE#	TEMPLATE	DESCRIPTION
355.4 cont.	IBCN AB INPT	Allows editing of the Inpatient section of ANNUAL BENEFITS.
	IBCN AB IV MGMT	Allows editing of the IV Mgmt section of ANNUAL BENEFITS.
	IBCN AB MEN H	Allows editing of the Mental Health section of ANNUAL BENEFITS.
	IBCN AB OPT	Allows editing of the Outpatient section of ANNUAL BENEFITS.
	IBCN AB POL INF	Allows editing of the Policy Information section of ANNUAL BENEFITS.
	IBCN AB REHAB	Allows editing of the Rehab section of ANNUAL BENEFITS.
355.5	IBCN BU ADD COM	Allows editing of the Comments in BENEFITS USED.
	IBCN BU ED AL	Allows editing of all BENEFITS USED fields.
	IBCN BU INPT	Allows editing of the Inpatient section of BENEFITS USED.
	IBCN BU OPT	Allows editing of the Outpatient section of BENEFITS USED.
	IBCN BU POL	Allows editing of the Policy section of BENEFITS USED.
356	IBT ASSIGN CASE	Allows assigning a case to a reviewer.
	IBT BILLLING INFO	Allows editing of billing information in Claims Tracking.
	IBT PRECERT INFO	Allows editing of pre-certification information in Claims Tracking.
	IBT QUICK EDIT	Allows editing of necessary fields for a visit in Claims Tracking.
	IBT STATUS CHANGE	Allows changing status of a visit in Claims Tracking.

Input Templates, cont.

FILE#	TEMPLATE	DESCRIPTION
356 cont.	IBT UR INFO	Edit field used to determine which cases require which types of reviews.
356.1	IBT ADD COMMENTS	Edits COMMENTS field of HOSPITAL REVIEW file (#356.1).
	IBT REMOVE NEXT REVIEW	Deletes next review date.
	IBT REVIEW INFO	Edits REVIEW INFORMATION field.
	IBT SPECIAL UNIT	Edits SPECIAL UNITS SI/IS fields.
	IBT STATUS CHANGE	Edits STATUS field.
356.2	IBT ACTION INFO	Allows editing of specific field relative to an Action.
	IBT ADD APPEAL	Edits Appeal information.
	IBT APPEAL INFO	Allows editing of Appeal Address in File #36.
	IBT COMMENT INFO	Edits COMMENTS fields.
	IBT CONTACT INFO	Edits Contact information.
	IBT FINAL OUTCOME	Allows specifying final outcome of an appeal.
	IBT INS VERIFICATION	Allows insurance verifiers to edit specific contact information from Insurance Mgmt.
	IBT INSURANCE INFO	Edits the Appeals Address in the INSURANCE COMPANY file (#36).
	IBT QUICK EDIT	Used to add/edit a new review.
	IBT REMOVE NEXT REVIEW	Deletes next review data.
	IBT STATUS CHANGE	Edits INSURANCE REVIEW STATUS field.
357	IBDF EDIT NEW FORM	Used to edit a new form.
	IBDF EDIT OLD OR COPIED FORM	Used to edit an existing form.

Input Templates, cont.

FILE#	TEMPLATE	DESCRIPTION
357.1	IBDF EDIT HEADER BLOCK	Used to edit the header block of a form.
	IBDF EDIT HEADER & OUTLINE	Used to edit a block's header and outline.
	IBDF NEW EMPTY BLOCK	Used to edit the header, position, outline, and other characteristics of a new block.
	IBDF POSITION COPIED BLOCK	Used to position a copied block onto a form.
357.2	IBDF EDIT SELECTION LIST	Used to edit a selection list, except for the position and size of the columns.
	IBDF POSITION/SIZE COLUMNS	Used to edit the size and position of a selection list's columns.
357.3	IBDF EDIT SELECTION	Used to edit a selection.
357.5	IBDF EDIT DATA FIELD	Used to edit a data field.
	IBDF EDIT FORM HEADER	Used to edit the form header data field.
357.6	IBDF EDIT AVAILABLE HLTH SMRY	Used to define a package interface that prints a Health Summary.
	IBDF EDIT AVAILABLE REPORT	Used to define a package interface that prints a report other than a Health Summary.
	IBDF EDIT OUTPUT/SELECTION RTN	Used to define a package interface of the type output routine or selection routine.
357.7	IBDF FORM LINE	Used to edit a line.
357.8	IBDF EDIT TEXT AREA	Used to edit a text area.
357.91	IBDF EDIT MARKING AREA	Used to edit a marking area.

Input Templates, cont.

FILE#	TEMPLATE	DESCRIPTION
399	IB MAIL	Enter/edit a bill's mailing address.
	IB REVCODE EDIT	Enter/Edit a bill's revenue code information.
	IB SCREEN1	Enter/Edit billing screen 1, demographic information.
	IB SCREEN2	Enter/edit billing screen 2, employment information.
	IB SCREEN3	Enter/edit billing screen 3, payer information.
	IB SCREEN4	Enter/edit billing screen 4, inpatient event information.
	IB SCREEN5	Enter/edit billing screen 5, outpatient event information.
	IB SCREEN6	Enter/Edit billing screen 6, inpatient general billing information.
	IB SCREEN7	Enter/edit billing screen 7, outpatient general billing information.
	IB SCREEN8	Enter/Edit UB-82 billing screen 8, billing specific information.
	IB SCREEN82	Enter/edit UB-92 billing screen 8, bill specific information.
	IB SCREEN8H	Enter/Edit HCFA 1500 billing screen 8, billing specific information.
	IB STATUS	Edit a bill's status.
399.2	IB ACTIVATE	Activate/inactivate revenue codes.
399.3	IB RATE EDIT	Update RATE TYPE file (#399.3).
409.95	IBDF PRINT MANAGER	Defines reports and encounter forms to clinic.
409.96	IBDF PRINT MANAGER	Defines reports and encounter forms to division.

Sort Templates

FILE#	TEMPLATE	DESCRIPTION
2	IBNOTVER, IBNOTVER1	Lists new, not verified insurance entries.
36	IB INACTIVE INS CO	List of inactive insurance companies covering patients.
350	IB INCOMPLETE	Integrated Billing Action List of entries with a status of INCOMPLETE.
354	IB BILLING PATIENT BY STATUS	List of currently exempt patients by status.
	IB BILLING PATIENT BY REASON	List of currently exempt patients by reason.
	IB EXEMPT PATIENTS	List of exempt patients.
	IB BILLING PAT W/INCOME	List of patients with a "No Income Data" exemption.
	IB EXEMPTION LETTER	Stores results of search when printing exemption letters.
354.3	IB PRINT THRESHOLD	List of thresholds.
356	IBT LIST VISITS	Lists visits in Claims Tracking by date and type. Primarily list random sample cases.
362.1	IB AB COMMENTS	Automated Biller Error/Comments Report.
399	IB CLK PROD	Clerk Productivity Report.
399.5	IB BILLING RATES	Billing Rates List.

Print Templates

FILE#	TEMPLATE	DESCRIPTION
2	IB NOTVER	Lists new, not verified insurance entries.

Print Templates, cont.

FILE#	TEMPLATE	DESCRIPTION
36	IB INACTIVE INS CO	List of inactive insurance companies shown in the system as still providing patient coverage.
40.8	IB DIVISION DISPLAY	Displays wage rates and locality modifier data for a division.
350	IB INCOMPLETE	Integrated Billing Action List of entries with status of INCOMPLETE.
	IB LIST	Integrated Billing Action List.
350.41	IB CPT UPDATE ERROR	Update Billable Amb. Surg. Transfer Error List Report.
350.6	IB PURGE LIST LOG ENTRIES	Displays log entries from the IB Archive Purge Log.
350.7	IB CPT PG DISPLAY	Displays a Check-off Sheet's line format and associated subheaders.
350.71	IB CPT CP DISPLAY	Displays procedures associated with a particular Check-off Sheet subheader.
351	IB BILLING CLOCK HEADER	Displays the header for the Patient Billing Clock Inquiry.
	IB BILLING CLOCK INQ	Displays the Patient Billing Clock Inquiry data.
352.1	IB APPOINTMENT TYPE	Billable Appointment Type List.
354	IB BILLING PATIENT	Prints the exemption reason reports with the detailed patient listing.
	IB BILLING PATIENT SUMMARY	Prints the exemption reason reports that do not include the detailed patient listing.
	IB BILLING PAT W/INCOME	Used when producing a list of non exempt patients with no income data.

Print Templates, cont.

FILE#	TEMPLATE	DESCRIPTION
354 cont.	IB PATIENT ADDRESSES	For local use, contains patient names and addresses.
	IB DO NOT USE	Creates results of IB EXEMPTION LETTER sort template.
354.3	IB PRINT THRESHOLD	Prints a list of entries from the BILLING THRESHOLDS file (#354.3).
356	IB LIST VISITS	Lists visits in Claims Tracking. Primarily to list random sample cases.
362.1	IB AB COMMENTS	Automated Biller Error/Comments Report.
399	IB CLK PROD	Clerk Productivity Report.
399.5	IB BILLING RATES	List billing rates.
409.71	IB CPT RG DISPLAY	Displays billing Medicare rate group data for a procedure.

File Flow Chart

FILE # AND NAME	POINTS TO		POINTED TO BY	
36 INSURANCE COMPANY	5	STATE	2	PATIENT
	36	INSURANCE COMPANY	36	INSURANCE COMPANY
	353	BILL FORM TYPE	350.9	IB SITE PARAMETERS
	355.2	TYPE OF INSURANCE COVERAGE	355.3	GROUP INSURANCE PLAN
	399.2	REVENUE CODE	356.2	INSURANCE REVIEW
			399	BILL/CLAIMS
			412	AR DEBTOR
			430	ACCOUNTS RECEIVABLE
			453	APPLICANT
			513.85	UTILIZATION REVIEW CONFIGURATION
350 INTEGRATED BILLING ACTION	2	PATIENT	52	PRESCRIPTION
	4	INSTITUTION	350	INTEGRATED BILLING ACTION
	200	NEW PERSON	351.2	SPECIAL INPATIENT BILLING CASES
	350	INTEGRATED BILLING ACTION		
	350.1	IB ACTION TYPE		
	350.21	IB ACTION STATUS		
	350.3	IB CHARGE REMOVE REASONS		
350.1 IB ACTION TYPE	49	SERVICE/SECTION	52	PRESCRIPTION
	350.1	IB ACTION TYPE	350	INTEGRATED BILLING ACTION
	430.2	ACCOUNTS RECEIVABLE CATEGORY	350.1	IB ACTION TYPE
			350.2	IB ACTION CHARGE
			350.4	BILLABLE AMBULATORY SURGICAL CODE
			350.41	UPDATE BILLABLE AMBULATORY SURGICAL CODE
			399.1	MCCR UTILITY
350.2 IB ACTION CHARGE	350.1	IB ACTION TYPE		
350.21 IB ACTION STATUS			350	INTEGRATED BILLING ACTION
350.3 IB CHARGE REMOVE REASONS			350	INTEGRATED BILLING ACTION

File Flow Chart, cont.

FILE # AND NAME	POINTS TO		POINTED TO BY	
350.4 BILLABLE AMBULATORY SURGICAL CODE	350.1 409.71	IB ACTION TYPE AMBULATORY PROCEDURE		
350.41 UPDATE BILLABLE AMBULATORY SURGICAL CODE	81 350.1	CPT IB ACTION TYPE		
350.5 BASC LOCALITY MODIFIER	40.8	MEDICAL CENTER DIVISION		
350.6 IB ARCHIVE/PURGE LOG	1 200	FILE NEW PERSON		
350.7 AMBULATORY CHECK-OFF SHEET			44 350.71	HOSPITAL LOCATION AMBULATORY SURG CHECK-OFF SHEET PRINT FIELDS
350.71 AMBULATORY SURG. CHECK-OFF SHEET PRINT FIELDS	350.7 350.71 409.71	AMBULATORY CHECK-OFF SHEET AMBULATORY SURG. CHECK-OFF SHEET PRINT FIELDS AMBULATORY PROCEDURE	350.71	AMBULATORY SURG. CHECK-OFF SHEET PRINT FIELDS
350.8 IB ERROR	354.5	BILLING ALERT DEFINITION		
350.9 IB SITE PARAMETERS	2 3.8 4 5 36 40.8 49 80 81 200 353 399.2	PATIENT MAIL GROUP INSTITUTION STATE INSURANCE COMPANY MEDICAL CENTER DIVISION SERVICE/SECTION ICD DIAGNOSIS CPT NEW PERSON BILL FORM TYPE REVENUE CODE		
351 CATEGORY C BILLING CLOCK	2 200	PATIENT NEW PERSON		

File Flow Chart, cont.

FILE # AND NAME	POINTS TO		POINTED TO BY	
351.1 IB CONTINUOUS PATIENT	2 200	PATIENT NEW PERSON		
351.2 SPECIAL INPATIENT BILLING CASES	2 200 350 405	PATIENT NEW PERSON INTEGRATED BILLING ACTION PATIENT MOVEMENT		
351.61 TRANSFER PRICING TRANSACTIONS	81 80.2 50 80 4 405 45 351.6 351.61	CPT DRG DRUG ICD DIAGNOSIS INSTITUTION PATIENT MOVEMENT PTF TRANSFER PRICING PATIENT TRANSFER PRICING TRASACTIONS		
351.67 TRANSFER PRICING INPT PROSTHETIC ITEMS	661.1	PROSTHETIC HCPCS		
352.1 BILLABLE APPOINTMENT TYPE	409.1	APPOINTMENT TYPE		
352.2 NON-BILLABLE DISPOSITIONS	37	DISPOSITION		
352.3 NON-BILLABLE CLINIC STOP CODES	40.7	CLINIC STOP		
352.4 NON-BILLABLE CLINICS	44	HOSPITAL LOCATION		
353 BILL FORM TYPE			36 350.9 399	INSURANCE COMPANY IB SITE PARAMETERS BILL/CLAIMS
353.1 PLACE OF SERVICE			162 399	FEE BASIS PAYMENT BILL/CLAIMS
353.2 TYPE OF SERVICE			162 399	FEE BASIS PAYMENT BILL/CLAIMS

File Flow Chart, cont.

FILE # AND NAME	POINTS TO		POINTED TO BY	
354 BILLING PATIENT	2 354.2	PATIENT EXEMPTION REASON	354.1	BILLING EXEMPTIONS
354.1 BILLING EXEMPTIONS	200 354 354.2 354.4	NEW PERSON BILLING PATIENT EXEMPTION REASON BILLING ALERTS		
354.2 EXEMPTION REASON			354 354.1	BILLING PATIENT BILLING EXEMPTIONS
354.3 BILLING THRESHOLDS				
354.4 BILLING ALERTS	200 354.5	NEW PERSON BILLING ALERT DEFINITION	354.1	BILLING EXEMPTIONS
354.5 BILLING ALERT DEFINITION	3.8 200	MAIL GROUP NEW PERSON	354.4	BILLING ALERTS
354.6 IB FORM LETTER				
355.1 TYPE OF PLAN			355.3	GROUP INSURANCE PLAN
355.2 TYPE OF INSURANCE COVERAGE			36	INSURANCE COMPANY
355.3 GROUP INSURANCE PLAN	2 36 200	PATIENT INSURANCE COMPANY NEW PERSON	355.4 355.5	ANNUAL BENEFITS INSURANCE CLAIMS YEAR TO DATE
355.4 ANNUAL BENEFITS	200 355.3	NEW PERSON GROUP INSURANCE PLAN		
355.5 INSURANCE CLAIMS YEAR TO DATE	2 200 355.3	PATIENT NEW PERSON GROUP INSURANCE PLAN		

File Flow Chart, cont.

FILE # AND NAME	POINTS TO		POINTED TO BY	
355.6 INSURANCE RIDERS			355.7	PERSONAL POLICY RIDERS
355.7 PERSONAL POLICY RIDERS	2 355.6	PATIENT INSURANCE RIDERS		
356 CLAIMS TRACKING	2 41.1 52 200 356.6 356.8 356.9 399 405 409.68 660 9000010	PATIENT SCHEDULED ADMISSION PRESCRIPTION NEW PERSON CLAIMS TRACKING TYPE CLAIMS TRACKING NON-BILLABLE REASONS INPATIENT DIAGNOSIS BILL/CLAIMS PATIENT MOVEMENT OUTPATIENT ENCOUNTER RECORD OF PROSTHETIC APPLIANCE/REPAIR VISIT	356.1 356.2 356.399 362.1	HOSPITAL REVIEW INSURANCE REVIEW CLAIMS TRACKING/BILL IB AUTOMATED BILLING COMMENTS
356.1 HOSPITAL REVIEW	45.7 80.2 200 356 356.1 356.11 356.3 356.4	FACILITY TREATING SPECIALTY DRG NEW PERSON CLAIMS TRACKING HOSPITAL REVIEW CLAIMS TRACKING REVIEW TYPE CLAIMS TRACKING SI/IS CATEGORIES CLAIMS TRACKING NON-ACUTE CLASSIFICATIONS	356.1 356.2	HOSPITAL REVIEW INSURANCE REVIEW
356.11 CLAIMS TRACKING REVIEW TYPE			356.1 356.2	HOSPITAL REVIEW INSURANCE REVIEW

File Flow Chart, cont.

FILE # AND NAME	POINTS TO		POINTED TO BY	
356.2 INSURANCE REVIEW	2	PATIENT	356.2	INSURANCE REVIEW
	36	INSURANCE COMPANY		
	80	ICD DIAGNOSIS		
	200	NEW PERSON		
	356	CLAIMS TRACKING		
	356.1	HOSPITAL REVIEW		
	356.11	CLAIMS TRACKING REVIEW TYPE		
	356.2	INSURANCE REVIEW		
	356.21	CLAIMS TRACKING DENIAL REASONS		
	356.7	CLAIMS TRACKING ACTION		

File Flow Chart, cont.

FILE # AND NAME	POINTS TO		POINTED TO BY	
356.21 CLAIMS TRACKING DENIAL REASONS			356.2	INSURANCE REVIEW
356.3 CLAIMS TRACKING SI/IS CATEGORIES	356.31	CLAIMS TRACKING SI/IS CRITERIA	356.1 356.31	HOSPITAL REVIEW CLAIMS TRACKING SI/IS CRITERIA
356.399 CLAIMS TRACKING/ BILLING	356 399	CLAIMS TRACKING BILL/CLAIMS		
356.4 CLAIMS TRACKING NON-ACUTE CLASSIFICATIONS			356.1	HOSPITAL REVIEW
356.5 CLAIMS TRACKING ALOS	80.2	DRG		
356.6 CLAIMS TRACKING TYPE			356	CLAIMS TRACKING
356.7 CLAIMS TRACKING ACTION			356.2	INSURANCE REVIEW
356.8 CLAIMS TRACKING NON-BILLABLE REASONS			356	CLAIMS TRACKING
356.9 INPATIENT DIAGNOSIS	80 405	ICD DIAGNOSIS PATIENT MOVEMENT	356	CLAIMS TRACKING
356.91 INPATIENT PROCEDURE	80.1 405	ICD OPERATION/PROCEDURE PATIENT MOVEMENT		
356.93 INPATIENT INTERIM DRG	80.2 405	DRG PATIENT MOVEMENT		
356.94 INPATIENT PROVIDERS	200 405	NEW PERSON PATIENT MOVEMENT		

File Flow Chart, cont.

FILE # AND NAME	POINTS TO		POINTED TO BY	
357 ENCOUNTER FORM			357.1 409.95	ENCOUNTER FORM BLOCK PRINT MANAGER CLINIC SETUP
357.1 ENCOUNTER FORM BLOCK	357	ENCOUNTER FORM	357.2 357.5 357.7 357.8	SELECTION LIST DATA FIELD FORM LINE EXT AREA
357.2 SELECTION LIST	357.1 357.6 357.91	ENCOUNTER FORM BLOCK PACKAGE INTERFACE MARKING AREA TYPE	357.3 357.4	SELECTION SELECTION GROUP
357.3 SELECTION	357.2 357.4	SELECTION LIST SELECTION GROUP		
357.4 SELECTION GROUP	357.2	SELECTION LIST	357.3	SELECTION
357.5 DATA FIELD	357.1 357.6	ENCOUNTER FORM BLOCK PACKAGE INTERFACE		
357.6 PACKAGE INTERFACE	142	HEALTH SUMMARY TYPE	357.2 357.5 409.95 409.96	SELECTION LIST DATA FIELD PRINT MANAGER CLINIC SETUP PRINT MANAGER DIVISION SETUP
357.7 FORM LINE	357.1	ENCOUNTER FORM BLOCK		
357.8 TEXT AREA	357.1	ENCOUNTER FORM BLOCK		
357.91 MARKING AREA TYPE			357.2	SELECTION LIST

File Flow Chart, cont.

FILE # AND NAME	POINTS TO		POINTED TO BY	
357.92 PRINT CONDITIONS			409.95 409.96	PRINT MANAGER CLINIC SETUP PRINT MANAGER DIVISION SETUP
358 IMP/EXP ENCOUNTER FORM			358.1	IMP/EXP ENCOUNTER FORM BLOCK
358.1 IMP/EXP ENCOUNTER FORM BLOCK	358	IMP/EXP ENCOUNTER FORM	358.2 358.5 358.7 358.8	IMP/EXP SELECTION LIST IMP/EXP DATA FIELD IMP/EXP FORM LINE IMP/EXP TEXT AREA
358.2 IMP/EXP SELECTION LIST	358.1 358.6 358.91	IMP/EXP ENCOUNTER FORM BLOCK IMP/EXP PACKAGE INTERFACE IMP/EXP MARKING AREA	358.3 358.4	IMP/EXP SELECTION IMP/EXP SELECTION GROUP
358.3 IMP/EXP SELECTION	358.2 358.4	IMP/EXP SELECTION LIST IMP/EXP SELECTION GROUP		
358.4 IMP/EXP SELECTION GROUP	358.2	IMP/EXP SELECTION LIST	358.3	IMP/EXP SELECTION
358.5 IMP/EXP DATA FIELD	358.1 358.6	IMP/EXP ENCOUNTER FORM BLOCK IMP/EXP PACKAGE INTERFACE		
358.6 IMP/EXP PACKAGE INTERFACE	142	HEALTH SUMMARY TYPE	358.2 358.5	IMP/EXP SELECTION LIST IMP/EXP DATA FIELD
358.7 IMP/EXP FORM LINE	358.1	IMP/EXP ENCOUNTER FORM		
358.8 IMP/EXP TEXT AREA	358.1	IMP/EXP ENCOUNTER FORM		
358.91 IMP/EXP MARKING AREA			358.2	IMP/EXP SELECTION LIST

File Flow Chart, cont.

FILE # AND NAME	POINTS TO		POINTED TO BY	
362.1 IB AUTOMATED BILLING COMMENTS	356 399	CLAIMS TRACKING BILL/CLAIMS		
362.3 IB BILL/CLAIMS DIAGNOSIS	80 399	ICD DIAGNOSIS BILL/CLAIMS	399	BILL/CLAIMS
362.4 IB BILL/CLAIMS PRESCRIPTION REFILL	50 52 399	DRUG PRESCRIPTION BILL/CLAIMS		
362.5 IB BILL/CLAIMS PROSTHETICS	399 660	BILL/CLAIMS RECORD OF PROS APPLIANCE/ REPAIR		
399 BILL/CLAIMS	2 4 5 36 40.8 44 45 80 80.1 81 200 353 353.1 353.2 362.3 399 399.1 399.2 399.3 399.4	PATIENT INSTITUTION STATE INSURANCE COMPANY MEDICAL CENTER DIVISION HOSPITAL LOCATION PTF ICD DIAGNOSIS ICD OPERATION/PROCEDURE CPT NEW PERSON BILL FORM TYPE PLACE OF SERVICE TYPE OF SERVICE IB BILL/CLAIMS DIAGNOSIS BILL/CLAIMS MCCR UTILITY REVENUE CODE RATE TYPE MCCR INCONSISTENT DATA ELEMENTS	356 356.399 362.1 362.3 362.4 362.5 399	CLAIMS TRACKING CLAIMS TRACKING/BILL IB AUTOMATED BILLING COMMENTS IB BILL/CLAIMS DIAGNOSIS IB BILL/CLAIMS PRESCRIPTION REFILL IB BILL/CLAIMS PROSTHETICS BILL CLAIMS
399.1 MCCR UTILITY	350.1	IB ACTION TYPE	42.4 399 399.5 11500.61	SPECIALTY BILL/CLAIMS BILLING RATES ODS BILLING SPECIALTY

File Flow Chart, cont.

FILE # AND NAME	POINTS TO		POINTED TO BY	
399.2 REVENUE CODE			36 350.9 399 399.5	INSURANCE COMPANY IB SITE PARAMETERS BILL/CLAIMS BILLING RATES
399.3 RATE TYPE	430.2	ACCOUNTS RECEIVABLE CATEGORY	399	BILL/CLAIMS
399.4 MCCR INCONSISTENT DATA ELEMENTS			399	BILL/CLAIMS
399.5 BILLING RATES	399.1 399.2	MCCR UTILITY REVENUE CODE		
409.95 PRINT MANAGER CLINIC SETUP	44 357 357.6 357.92	HOSPITAL LOCATION ENCOUNTER FORM PACKAGE INTERFACE PRINT CONDITIONS		
409.96 PRINT MANAGER DIVISION SETUP	40.8 357.6 357.92	MEDICAL CENTER DIVISION PACKAGE INTERFACE PRINT CONDITIONS		

Exported Options

Menu Diagram

The Diagram Menu Options feature of the Kernel package may be used to generate printouts of full menus provided by IB.

Options without Parents

Background Vet. Patients with Discharges and Ins [IB BACKGRND VET DISCHS W/INS] Background Vet. Patients with Admissions and Ins [IB BACKGRND VETS INPT W/INS] Background Vet. Patients with Opt. Visits and Ins [IB BACKGRND VETS OPT W/INS]	These report options may be queued to run regularly at the discretion of the facility.
Clear Integrated Billing Filer Parameters [IB FILER CLEAR PARAMETERS]	This option clears the IB site parameters which control the IB Background Filer. It is set up as a Start Up job which is executed when the CPU is rebooted.
Queue Means Test/Category C Compilation of Charges [IB MT NIGHT COMP]	This option executes jobs for Claims Tracking, the Auto Biller, and Means Test billing. It should be queued to run each evening after the G&L recalculation has been completed.
Output IB Menu [IB OUTPUT MENU]	This menu option is designed to be assigned to users outside of IB.
View Insurance Management Menu [IBCN VIEW INSURANCE DATA]	This menu contains view options to patient insurance and insurance company information. It was designed to be assigned to users outside of IB.
Auto-Build Average Bill Amounts (IBT MONTHLY AUTO GEN AVE BILL)	This option should be scheduled to run automatically once a month. No device is necessary. It will build and store the number of inpatient and outpatient bills authorized and the total dollar amounts of the bills. A mail message is generated when the job has successfully completed.
Auto-Generate Unbilled Amounts Report (IBT MONTHLY AUTO GEN UNBILLED)	This option should be scheduled to run automatically once a month on or about the first of the month. No device is

necessary. It will build and store the unbilled amounts data and send a mail message with the necessary results. The new site parameter, AUTO PRINT UNBILLED LIST, will allow for sites to pre-determine if a detailed listing should be printed each month.

Archiving and Purging

The Purge Menu (under the System Manager's Integrated Billing Menu) provides archiving and purging capabilities for certain Integrated Billing files.

The Purge Update File option is used to delete all CPT entries from the temporary file, UPDATE BILLABLE AMBULATORY SURGICAL CODE (#350.41), after they have been transferred to the permanent file, BILLABLE AMBULATORY SURGICAL CODES (#350.4). At this time, these files are obsolete as the regulation implementing billing of ambulatory surgery CPT codes uses HCFA rates was never passed.

The remainder of the options in the Purge Menu are used to archive and purge billing data. The files which may be archived and subsequently purged are the INTEGRATED BILLING ACTION file (#350) (pharmacy copayment transactions only), the CATEGORY C BILLING CLOCK file (#351), and the BILL/CLAIMS file (#399).

At a minimum, billing data from the current and one previous fiscal year must be maintained on-line. With this version of Integrated Billing, data may be purged up through any date prior to the beginning of the previous fiscal year.

A separate routine is provided to purge entries from the BILLING EXEMPTIONS file (#354.1) with the Medication Copayment Exemption patch. There is no output from this routine. It is provided for maintenance of this file until a more robust archiving and purging option can be written.

The following criteria must be met to purge billing data.

INTEGRATED BILLING ACTION file (#350) (pharmacy copayment actions)	The prescription which caused the action to be created must have been purged from the pharmacy database before the action may be archived. In addition, the bill must be closed in Accounts Receivable. The date the bill was closed is the date used to determine whether it will be included.
CATEGORY C BILLING CLOCK file (#351)	Only clocks with a status of CLOSED or CANCELLED and a clock end date prior to the to the selected time frame are included.

BILL/CLAIMS file (#399)	The bill must be closed in Accounts Receivable. The date the bill was closed is the date used to determine whether it will be included.
BILLING EXEMPTIONS file (#354.1)	Billing Exemptions may be purged using the new routine, IBPEX, if they are at least 1 year old, not the patient's current exemption, do not contain dates of canceled charges in AR, and if active, must be one year older than the purge date for inactive exemptions.

There are three steps involved in the archiving and purging of these files.

1. A search is conducted to find all entries which may be archived through the Find Billing Data to Archive option. You choose which of the three files you wish to include in the search. The entries found are temporarily stored in a sort (search) template in the SORT TEMPLATE file (#.401). An entry is also made to the IB ARCHIVE/ PURGE LOG file (#350.6). This log may be viewed through the Archive/Purge Log Inquiry and List Archive/Purge Log Entries options.

   The List Search Template Entries option allows you to view the contents of a search template. You may delete entries from the search template using the Delete Entry from Search Template option.

2. The entries are archived using the Archive Billing Data option. It is highly recommended that you archive the entries to paper (print to a non-slave printer), as there is currently no functionality to retrieve or restore data that has been archived.

3. The data is purged from the database using the Purge Billing Data option. The search template containing the purged entries is also deleted. An electronic signature code and the XUMGR security key are required to archive and purge data.

Expected Disk Space Recovery from Purging

Because of data retention requirements, it has not been possible to measure actual space recovered in a production environment with the use of the purge options. The following list shows the average record size of entries as measured at a test site (at approximately 70% efficiency).

Record type	File	1k blocks per record
Pharmacy Copay	350	.38
Billing Clocks	351	.14
Third Party Bills	399	.75

From testing of the software, we have determined that purging small numbers of entries (less than 200) will not yield measurable disk space. However, when large numbers of entries (over 1000) are purged, nearly 97% of the space is recovered. The actual percentage of the space recovered is relative to the number of consecutive entries purged. The number of consecutive records purged is relative to whether the site has closed the bills either by collecting the amount due or cancelling the bills.

External Relations

1. The following packages need to be installed on your system prior to installing Integrated Billing V. 2.0.

   Accounts Receivable V. 3.7
   Kernel V. 7.1
   Outpatient Pharmacy V. 5.6
   VA FileMan V. 20.0
   IFCAP V. 4.0
   OE/RR V. 1.96
   PIMS V. 5.3

2. IB V. 2.0 has custodial integration agreements with the following packages.

   A. Accounts Receivable (DBIA#s 126, 300, 301, 304, 306 - 310)
   IB provides AR with the following:
   - brief and full profiles of prescription entries which cause an AR transaction
   - returns service dates for a specific bill
   - passes clinical data to AR to appear on the patient statement
   - prints 2nd and 3rd notices for third party bills
   - determines AMIS segment for reimbursable insurance bills
   - identifies any IB Actions on hold for a bill
   - prints Revenue Code totals by Rate Type
   - passes an error message from File #350.8

   B. Fee Basis (DBIA#s 228, 396)
   IB allows Fee Basis to use the PLACE OF SERVICE (#353.1) and TYPE OF SERVICE (#353.2) files and to add insurance information.

   C. Income Verification Match (DBIA#s 257, 324)
   IB provides IVM with a call to determine whether a patient has insurance and whether a patient may be billed the Means Test outpatient copayment.

D. Outpatient Pharmacy (DBIA# 125)
IB provides Outpatient Pharmacy with the following:
- a call to determine eligibility for pharmacy copayment and correct IB Action Type
- ability to process charges for new, renew or refilled prescriptions
- ability to remove charges for new, renew or refilled prescriptions
- updates charges when the days supply has been edited
- determines the IB CHARGE REMOVAL REASON when a prescription is deleted
- look-up to the IB CHARGE REMOVE REASONS file (#350.3)

E. Patient Data Exchange (DBIA# 271)
IB provides PDX with routines to build and extract Means Test billing data.

F. Problem List (DBIA# 336)
IB provides Problem List with function calls to collect common problem lists defined under the Encounter Form Utilities.

3. IB V. 2.0 has requested integration agreements with the following packages, and they have been approved.

A. Accounts Receivable (DBIA#s 127, 380-389)
AR provides IB with the following:
- a routine used for setting up a new charge for a debtor
- allows the IB ACTION TYPE file (#350.1) to point to the ACCOUNTS RECEIVABLE CATEGORY file (#430.2)
- look-up to the ACCOUNTS RECEIVABLE file (#430)
- set the STATEMENT DAY field
- reference to determine the internal number of decrease and increase adjustment types

B. DRG Grouper (DBIA#s 368, 369, 370, 371)
DRG Grouper provides IB with the following:
- direct reference to specific fields within the ICD DIAGNOSIS file (#80)
- direct reference to specific fields within the ICD OPERATION/PROCEDURE file (#80.1)
- store pointers to the DRG file (#80.2) to retrieve data at the time claims are generated
- a call to calculate interim DRGs to determine the expected length of stay for a visit

C. Health Summary (DBIA# 253)
Health Summary allows IB to do look-ups to the HEALTH SUMMARY TYPE file (#142) and to print health summaries.

D. HINQ (DBIA# 379)

HINQ provides IB a call to allow billing clerks to replace requests for HINQ inquires for potentially billable patients with unverified eligibility.

E. IFCAP (DBIA# 353)
IFCAP provides IB with the short description describing the name of a prosthetic device which is being billed on a claim to a third party carrier.

F. Kernel (DBIA# 372)
Kernel gives permission to IB to add entries to the INSTITUTION file (#4) when creating bills.

G. List Manager (DBIA# 367)
List Manager provides IB with calls used to refresh the screen and reset the scrolling area while program control remains with an action.

H. Outpatient Pharmacy (DBIA#s 124, 237)
Outpatient Pharmacy provides IB with the following:
- a call to display information from the PRESCRIPTION file (#52)
- reference to determine prescription number and drug name
- printing of the Action Profile and Information Profile
- stores pointers to the PRESCRIPTION (#52) and DRUG (#50) files to retrieve data at the time claims are generated
- directly reference selected fields in the PRESCRIPTION (#52) and DRUG (#50) files
- directly reference the OUTPATIENT VERSION field (#49.99) of the PHARMACY SYSTEM file (#59.7)

I. Patient Data Exchange (DBIA# 272)
PDX allows IB to directly reference fields in the VAQ-TRANSACTION (#394.61) and VAQ-DATA SEGMENT (#394.71) files.

J. Patient File (DBIA# 187)
The PATIENT file (#2) provides direct references to IB for the purpose of sorting and printing on a patient's Ambulatory Surgery Check-off Sheet.

K. Problem List (DBIA# 354)
Problem List provides IB with a call to obtain a list of a patient's active problems. It also provides a call for IB to access the EXPRESSIONS file (#757.01) to create lists of common problems by clinic.

L. Prosthetics (DBIA#s 373, 374)
Prosthetics provides IB with the following:
- stores pointers to the RECORD OF PROS APPLIANCE/REPAIR (#660) and PROS ITEM MASTER (#661) files to retrieve data at the time claims are generated
- print item name on screens and bills
- call to find potentially billable prosthetic items
- call to find prosthetic items which may have been delivered to a patient within a specific date range
- direct reference to specific fields in the RECORD OF PROS APPLIANCE/REPAIR file (#660)

M. Registration (DBIA# 186, 414-434)
Registration provides IB with the following:
- multiple calls to obtain Means Test data
- medical center division by which to sort and print various reports
- patient eligibility data to print on various documents

N. Scheduling (DBIA# 188, 397-411)
Scheduling provides IB with the following:
- multiple calls to get patient appointment data for check-off sheets and encounter forms
- calls to get clinic and division information for various reports

Internal Relations

All of the IB V. 2.0 package options have been designed to stand alone.

Package-wide Variables

Though there are no variables that can always be assumed to be present in Integrated Billing, the following is a list of common variables and their meanings.

IBAFY
The current fiscal year.

IBARTYP
The Accounts Receivable Category pointer value stored in the IB ACTION TYPE file (#350.1) for the current entry.

IBATYP
The pointer value to the IB ACTION TYPE file (#350.1) for the current entry.

IBCHCDA
Pointer to IB Action - Inpt IB Action Charge for copayments.

IBCHPDA
Pointer to IB Action - Inpt IB Action Charge for per diems.

IBCLDA
Pointer to Cat C Billing Clock record (File #351).

IBCLDAY
Cat C Billing Clock Inpatient Days within one clock.

IBCLDOL
Cat C Billing Clock Inpatient dollars for current 90 days of care.

IBCLDT
Cat C Billing Clock Start Date.

IBDESC
The brief description to/from the INTEGRATED BILLING ACTION file (#350).

IBDUZ
The user DUZ as passed from an application. In the background filer, the user who caused the filer to be queued will be reflected in the DUZ variable; however, IBDUZ should equal the user causing the current transaction.

IBEVCAL
IB Action Event last calculated date.

IBEVDA
Pointer to IB Action - Inpt IB Action Event.

IBEVDT
IB Action Event event date.

IBFAC
Institution from File #350.9 (points to File #4).

IBHANG
The number of seconds the background filer should hang after finishing posting all transactions and waiting to look for more transactions to post.

IBIL
The AR bill number or Charge ID.

IBJOB
Identifies IB job (1-Inpt BGJ, 2-Inpt Disch job, etc.).

IBLAST
The most recent transaction for a given new transaction. If there have been no subsequent transactions to a new transaction, it will equal the new transaction. However, if a transaction has been cancelled or updated, this will be the pointer to the most recent (last) cancellation or update.

IBLINE
Used to draw lines (79 or 80 dashes).

IBN
The pointer to the INTEGRATED BILLING ACTION file (#350) for the current action.

IBND
The zeroth node from the INTEGRATED BILLING ACTION file (#350) (e.g., IBND=^IB(IBN,O)).

IBNOS
The list of pointer values to the INTEGRATED BILLING ACTION file (#350) that are to be combined and passed to AR as one transaction.

IBNOW
Contains the current date/time.

IBOP
Identifies IB Archive/Purge operation (1-Search, 2-Archive, 3-Purge).

IBPARNT
The original NEW Integrated Billing Action for any action. This will be the pointer value. For NEW Actions, this will point to itself.

IBSEQNO
IB Action sequence number (1-New, 2-Cancel, 3-Update).

IBSERV
Service associated with billing application (points to File #49).

IBSITE
Institution site number.

IBSL
IB Action softlink.

IBTOTL
Dollar amount passed to Accounts Receivable, must be greater than zero to pass charges.

IBTRAN
The AR Transaction number for a NEW IB Action, the value returned after passing a transaction to AR. More than one IB Action may have the same AR Transaction.

IBWHER
Codes to denote processing point in case of error.

IBY
Error processing (equals 1 or -1^error code).

How to Generate On-Line Documentation

This section describes some of the various methods by which users may secure Integrated Billing technical documentation. On-line technical documentation pertaining to the Integrated Billing software, in addition to that which is located in the help prompts and on the help screens which are found throughout the Integrated Billing package, may be generated through utilization of several Kernel options. These include but are not limited to %INDEX; Menu Management, Inquire (Option File) and Print Option File; VA FileMan Data Dictionary Utilities, List File Attributes.

Entering question marks at the "Select ... Option:" prompt may also provide users with valuable technical information. For example, a single question mark (?) lists all options which can be accessed from the current option. Entering two question marks (??) lists all options accessible from the current one, showing the formal name and lock for each. Three question marks (???) displays a brief description for each option in a menu while an option name preceded by a question mark (?OPTION) shows extended help, if available, for that option.

For a more exhaustive option listing and further information about other utilities which supply on-line technical information, please consult the DHCP Kernel Reference Manual.

%Index
This option analyzes the structure of a routine(s) to determine in part if the routine(s) adhere(s) to DHCP Programming Standards. The %INDEX output may include the following components: compiled list of Errors and Warnings, Routine Listing, Local Variables, Global Variables, Naked Globals, Label References, and External References. By running %INDEX for a specified set of routines, the user is afforded the opportunity to discover any deviations from DHCP Programming Standards which exist in the selected routine(s) and to see how routines interact with one another, that is, which routines call or are called by other routines.

To run %INDEX for the Integrated Billing package, specify the following namespace(s) at the "routine(s) ?>" prompt: IB.

Integrated Billing initialization routines which reside in the UCI in which %INDEX is being run, as well as local routines found within the Integrated Billing namespace, should be omitted at the "routine(s) ?>" prompt. To omit routines from selection, preface the namespace with a minus sign (-).

Inquire (Option File)

This Menu Management option provides the following information about a specified option(s): option name, menu text, option description, type of option and lock, if any. In addition, all items on the menu are listed for each menu option.

To secure information about Integrated Billing options, the user must specify the name or namespace of the option(s) desired. The namespace associated with the Integrated Billing package is IB.

Print Option File

This utility generates a listing of options from the OPTION file. The user may choose to print all of the entries in this file or may elect to specify a single option or range of options. To obtain a list of Integrated Billing options, the following option namespace should be specified: IB.

List File Attributes

This VA FileMan option allows the user to generate documentation pertaining to files and file structure. Utilization of this option via the "Standard" format will yield the following data dictionary information for a specified file(s).

- File name and description
- Identifiers
- Cross-references
- Files pointed to by the file specified
- Files which point to the file specified
- Input, print, and sort templates

In addition, the following applicable data is supplied for each field in the file: field name, number, title, global location, description, help prompt, cross-reference(s), input transform, date last edited, and notes.

Using the "Global Map" format of this option generates an output which lists all cross-references for the file selected, global location of each field in the file, input templates, print templates, and sort templates. For a comprehensive listing of Integrated Billing files, please refer to the Files Section of this manual.

Glossary

Action Type	The type of event that an application passes to Integrated Billing.
Admission Sheet	(a.k.a. Attestation Sheet) This is a worksheet commonly used in the front of inpatient charts with a workspace available for concurrent reviews.
ADPAC	Automated Data Processing Applications Coordinator
ALOS	Average Length of Stay
AMIS	Automated Management Information System
Annual Benefits	The amount or percentages of coverage for specific types of care under an insurance plan.
AR	Accounts Receivable This is a system of bookkeeping necessary to track VAMC debt collection.
Automated Biller	This is a new utility introduced in IB v2.0 for the purpose of establishing third party bills with no user intervention.
Background Filer	A background job that accumulates charges and causes adjustment transactions to a bill.
BASC	Billable Ambulatory Surgical Code
Benefits Used	The amounts or portions of a patient's insurance policy that have been used (i.e., deductibles, annual or lifetime maximums).
Billing Clock	A 365 day period, usually beginning when a patient is Means Tested and is placed in Category C, through which a patient's Means Test charges are tracked. An inpatient's Medicare deductible copayment entitles the patient to 90 days of hospital/nursing home care. These 90 days must fall within the 365 day billing clock.

Block	A rectangular region on an encounter form. Attributes include position, size, outline type, and header. All other form components are contained within a particular block, and their position is relative to the block's position.
Category C	Category C patients are responsible for making copayments as a result of Means Test legislation.
Check-off Sheet	A site configurable printed form containing CPT codes, descriptions, and dollar amounts (optional). Each check-off sheet may be assigned to an individual clinic or multiple clinics.
Claims Tracking	This is a new module in Integrated Billing that allows for the tracking of an episode of care from scheduling through final disposition of a bill.
Collateral Visit	A visit by a non-veteran patient whose appointment is related to or associated with a service-connected patient's treatment.
Column	A selection list contains one or more columns, a column being a rectangular area that contains a portion of the entries on a selection list. Attributes include position and height.
Concurrent Reviews	Review of patients by the hospital Utilization Review performed during the patient's hospital stay.
Consistency Checker	Provides a method of assuring the accuracy of data contained in a patient file.
Continuous Patient	Patients continuously hospitalized at the same level of care since July 1, 1986.
Converted Charges	During the conversion, the BILLS/CLAIMS file (#399) is checked to insure that each outpatient visit has been billed. For each visit without an established bill, one is established and given a status of CONVERTED.
Copayment	The charges, required by legislation, that a patient is billed for services or supplies.

CPT	Current Procedural Terminology A coding method developed by the American Hospital Association to assign code numbers to procedures which are used for research, statistical, and reimbursement purposes.
Data Field	A block component that is the means by which data from DHCP is printed to the form. The data is obtained at the time the form is printed (i.e., it is not stored with the form) and can be particular to the patient. A data field can have subfields, which are conceptually a collection of related data fields. Attributes include label, label type (underlined, bold, invisible), position, data area, data length and position (area on the form allocated to the data), item number, and package interface (the routine used to get the data).
DHCP	Decentralized Hospital Computer Program
Diagnosis Code	A numeric or alpha-numeric classification of the terms describing medical conditions, causes, or diseases.
Discharge Summary	An admission summary usually completed by the clinician upon the patient's discharge from the hospital.
Encounter Form	A paper form used to display data pertaining to an outpatient visit and to collect additional data pertaining to that visit.
Entry Action	An attribute of a package interface. It is MUMPS code that is executed before the interface's entry point is executed.
EP	Expert Panel
Exit Action	An attribute of a package interface. It is MUMPS code that is executed after the interface's entry point is executed.
Form Line	A block component. A straight line that will be printed to the form. Attributes include orientation (horizontal, vertical), position, and length.
Form Locator	A block on the UB or HCFA bill form.
Group Plan	A specific health insurance plan that an insurance company offers.
HCFA	Health Care Finance Administration
HCFA-1500	AMA approved health insurance claim form used for outpatient third party billings.

HINQ	Hospital Inquiry
Hospital Review	The application of Utilization Review criteria to determine if admissions or continued stay in the hospital meets certain guidelines. Refers to QM mandated reviews.
IB	Integrated Billing
ICD-9	International Classification of Diseases, the Ninth Modification A coding system designed by the World Health Organization to assign code numbers to diagnoses and procedures for statistical, research, and reimbursement purposes.
Insurance Data Capture	This is a new module in Integrated Billing that is used to capture and store insurance company and patient insurance information.
Insurance Review	The input of UR information about insurance company contact and insurance company action.
Integrated Billing Action	The billing record created when an application passes an event to Integrated Billing that may cause a charge adjustment (increase or decrease) in the amount a debtor may owe; or a supporting event to document an event that causes a charge adjustment to a debtor.
Interqual Criteria	A method of evaluating appropriateness of care.
Item Number	An attribute that must be specified when defining a data field if the data field's package interface returns a list. The item number is used to specify which item on the list should be printed to the data field. For example, there is a package interface for returning service-connected conditions. The first data field created for a form for displaying a service-connected condition would specify item number one.
Locality Rate Modifier	The Geographic Wage Index that is used to account for wage differences in different localities when calculating the ambulatory surgery charge. It is multiplied by the wage component to get the final geographic wage component of the charge.
MAS	Medical Administration Service
MCCR	Medical Care Cost Recovery

	The collection of monies by the Department of Veterans Affairs (VA).
Marking Area	The areas on a selection list that the user marks to indicate selections from the list (e.g., ( ), [ ], { }).
Means Test	A financial report used to determine if a patient may be required to make copayments for care.
MIRMO	Medical Information Resources Management Office
Options	The different functions within menus.
Package Interface	A table that is the method by which the Encounter Form Utilities interface with other packages. Presently there are three types of package interfaces: for printing reports via the Print Manager, printing data to data fields, and for entering data to selection lists. Attributes include entry point, routine, entry action, exit action, protected variables, required variables, data type, data description, and custodial package.
PDX	Patient Data Exchange
Per Diem	The daily copay charge for hospital or nursing home care.
PIMS	Patient Information Management System
Policy	The specific patient information about a health insurance policy. A policy may reference a group plan.
Principal Diagnosis	Condition established after study to be chiefly responsible for the patient's admission.
Print Manager	A utility used to define the reports and encounter forms that should be printed for clinics. It will then print the reports and forms in packets for each appointment specified.
Problem List	This is a clinical software package used to track a patient's problems across clinical specialties.
Provider	A person, facility, organization, or supplier which furnishes health care services.
Protected Variable	An attribute of a package interface. It is a variable that should be "newed" before calling the interface's entry point.
Reimbursable	Health insurance that will reimburse VA for the cost of

Insurance	medical care provided to its subscribers.
Required Variable	An attribute of a package interface. It is a variable that must exist in order for the interface's entry point to be called.
Revenue Code	A code identifying the type of care provided on a third party bill.
Security Code	A code assigned to each user identifying him/her specifically to the system and allowing him/her access to the functions/ options assigned to him/her.
Security Key	Used in conjunction with locked options or functions. Only holders of this key may perform these options/functions. Used for options which perform a sensitive task.
Selection	A component of a selection list. It is a single entry on the list. It is stored with the form and is usually data taken from a file in DHCP such as a CPT code with its description.
Selection Group	A component of a selection list. It is a named group of selections on the list. Attributes include a header and the print order.
Selection List	A block component whose purpose is to contain a list (e.g., a list of CPT codes). The list contains subcolumns for marking areas, which are areas meant to be marked to indicate selections being made from the list. Attributes include headers, subcolumns, subcolumn width, subcolumn type, package interface (the routine used to fill the list), and many attributes for the appearance of the list.
Stop Code	A three-digit number corresponding to an additional stop/service a patient received in conjunction with a clinic visit. Stop code entries are used so that medical facilities may receive credit for the services rendered during a patient visit.
Subcolumn	A component of a selection list. It can contain either text, such as a CPT code, or a marking area.
Subfield	A component of a data field. It can display a single value, whereas a data field can be used to display a collection of related values. Attributes include those for the label and the area on the form to print the data. Also, for package interfaces that return records that have multiple values, the particular data must be specified.

Text Area	A rectangular area in a block that is used to display a word-processing field. The text is automatically formatted to fit within the block. Attributes include the word-processing field, the position, and size of the text area. The text is stored with the form.
Third Party Billings	Billings where a party other than the patient is billed.
Tool Kit	A set of pre-configured encounter forms and blocks to facilitate sites' use of the Encounter Forms package.
UB-82	AMA approved health insurance claim form used for Third Party billings.
UB-92	AMA approved health insurance claim form used for Third Party billings.
UR	Utilization Review A review carried out by allied health personnel at pre-determined times during the hospital stay to assess the appropriateness of care.
Wage Percentage	The percentage of the rate group unit charge that is the wage component to be used in calculating the HCFA charge for ambulatory surgical procedures.

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