INTEGRATED BILLING TECHNICAL MANUAL / SECURITY GUIDE

IB Version 2.0
Patch IB*2.0*432

September 2011

Veterans Affairs
Product Development (PD)

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Revision History

Date	Revision	Description of Change	Author Information
09/22/11	Patch IB*2.0*432	Initial Version	Berry Anderson

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PREFACE

This is the Technical Manual for Integrated Billing (IB) patch IB*2.0*432. It is designed to assist IRM personnel in the operation and maintenance of this patch.

For information regarding use of the software, please refer to the EDI Billing User Guide: EDI_USER_GUIDE_R0911.PDF.

For information on the installation of this interface, please refer to the Release Notes and Installation Guide for patch IB*2.0*432.

Note to Users with Qume Terminals

It is very important that you set up your Qume terminal properly. 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 <Enter> at this prompt for all subsequent logins. If any other terminal type configuration is set, options neither using the List Manager Utility will neither display nor function properly on your terminal. The reports and error messaging system in the interface makes extensive use of the List Manager functions.

Who Should Read this Manual?

This manual is intended for technical IRM personnel who may be called upon to install and support this software.

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Introduction

On January 16, 2009, CMS published the final rule to modify HIPAA Electronic Transaction Standards to include a transition to the 5010 version of X12 electronic transaction sets. The current version of the electronic claims software requires further development in order to fully comply with the HIPAA 5010 standards and ensure that third party payers properly adjudicate VHA claims. VHA must update the e-Claims software in order to meet this legislative mandate, while continuing to send and receive the 4010 version of the transaction for payers who are unable to transition to the 5010 version until January 1, 2012. This method will ensure VA has the ability to receive and process both the new and existing standards to maintain revenue and business efficiencies.

High level requirements include the following:

- Modify VistA fields, data sets and qualifiers to ensure full 5010 HIPAA compliance.
- Provide VistA the ability to determine when a non-MRA secondary claim should be generated, gather the correct required data, create the claim and transmit it to FSC.
- Enable the billing of additional claim types to the designated Medicare Administrative Contractor.
- Allow all services provided on the same day by two different VA divisions to be placed on a single UB-04 claim form or in an 837I transaction.
- Stop sending provider SSN as the default provider identifier on every transaction.
- Allow Medicare secondary claims for services excluded from the MRA adjudication process, such as Skilled Nursing Facility and Durable Medical Equipment services, to be transmitted electronically to a Secondary payer when no MRA COB data is included.

Implementation and Maintenance

Site Parameter Changes

There is no action needed at the time of installation.

IB SITE PARAMETERS			
350.9,8.14 CMS-1500 AUTO PRINTER 8;14 POINTER TO DEVICE FILE (#3.5)			
Name	Last Edited	Help Prompt	Description
CMS-1500 Auto Printer	OCT 12, 2010	Enter the name of the printer that will print automatically-processed secondary/tertiary CMS 1500 claims.	This is the printer that will be used to automatically print CMS-1500s when an electronic non-Medicare EOB is received and the subsequent insurance company requires printed claims.
350.9,8.15 UB-04 AUTO PRINTER 8;15 POINTER TO DEVICE FILE (#3.5)			
Name	Last Edited	Help Prompt	Description
UB-04 Auto Printer	OCT 12, 2010	Enter the name of the printer that will print automatically-processed secondary/tertiary	This is the printer that will be used to automatically print UB-04s when an electronic non-Medicare

IB SITE PARAMETERS			
		UB04 claims.	EOB is received and the subsequent insurance company requires printed claims
350.9,8.16 EOB AUTO PRINTER 8;16 POINTER TO DEVICE FILE (#3.5)			
Name	Last Edited	Help Prompt	Description
EOB Auto Printer	OCT 12, 2010	Enter the name of the printer that will print EOBs for automatically-processed secondary/tertiary claims.	This is the printer that will be used for automatically printing EOBs of automatically-processed claims when the subsequent insurance company requires printed secondary or tertiary claims.
350.9,8.17 AUTOMATIC REG EOB PROCESS? 8;17 SET			
Name	Last Edited	Help Prompt	Description
Enable Auto Reg EOB Processing '0' FOR NO; '1' FOR YES	DEC 22, 2010	Should Regular EOBs be automatically processed?	This field controls whether or not incoming Regular (Non-Medicare) EOBs can be automatically processed so that the subsequent bill is automatically generated and automatically authorized and sent to the next payer. If this field is NO, then all incoming Regular (Non-Medicare) EOBs will remain on the COB management worklist and manual processing of the EOBs will be necessary.
350.9,8.18 ALLOW REG EOB PROCESSING? 8;18 SET			
Name	Last Edited	Help Prompt	Description
Allow REG EOB Processing	NOV 18, 2010	Should the COB Management worklist be activated?	This field is used to turn the automated processing of EOBs completely off. If it is set to NO, REG secondary/tertiary claims will revert to a manual process. Nothing will be auto-processed, auto-printed, or placed on the COB management worklist. This is the master off switch
350.9,8.19 MRA AUTO PRINTER 8;19 POINTER TO DEVICE FILE (#3.5)			
Name	Last Edited	Help Prompt	Description
MRA Auto Printer	DEC 30, 2010	Enter the name of the printer that will print MRAs for automatically-processed	This is the printer that will be used for automatically printing MRAs of automatically-processed claims

IB SITE PARAMETERS			
		secondary/tertiary claims.	when the subsequent insurance company requires printed secondary or tertiary claims. MRAs need to have a device set up for 132 character printing

General Notes Regarding Changes to this Software

1. Integrated Billing files may only be updated through distributed options.
2. Per VHA Directive 2004-038 regarding security of software that affects financial systems, most of the IB routines and files may not be modified. Routines that may not be modified will be indicated by a comment on the third line. Files that may not be modified will have a note in the file description.
3. According to the same directive, most of the IB Data Dictionaries may not be modified.

Platform Requirements

VistA System:

A fully patched and complete VistA system is required, running Integrated Billing (IB) Version 2.0. In particular, the pre-requisite patches listed below must be installed prior to the installation of the EDI patch IB*2.0*432.

In addition, the VistA system must have a properly installed and functioning HL7 module.

Pre-Requisite Patch Requirements

VistA Package and Version	Associated Patch Designation(s)	Brief Patch Description
Integrated Billing (2.0)	IB*2*240	This patch changed all references of CHAMPUS to TRICARE in all IB files and all applicable IB namespaced routines and it will correct a problem in routine IBECEA3 which was causing an <UNDEFINED> error.
Integrated Billing (2.0)	IB*2*389	This patch updates the use of Prosthetics data within billing. It is primarily a maintenance patch with few functional changes.
Integrated Billing (2.0)	IB*2*402	There are three fixes in this patch: The first issue concerns an undefined error in the Enter/Edit Billing Information [IB EDIT BILLING INFO] option when site entered a number greater than the default procedure unit which is 1. The second issue is that user

VistA Package and Version	Associated Patch Designation(s)	Brief Patch Description
		cannot add charges for FEE LTC OPT RESPITE charge in the Cancel/Edit/Add Patient Charges [IB CANCEL/EDIT/ADDCHARGES] option. The last issue is when a provider was inactivated in the NEW PERSON (#200) file and his person class was no longer valid, IB sent an ATT/REND PROV SPECIALTY value of 99 for the provider causing the claim rejection.
Integrated Billing (2.0)	IB*2*405	This patch has enhancements which extend the capabilities of the Veterans Health Information Systems and Technology Architecture (VistA) electronic pharmacy (ePharmacy) billing system.
Integrated Billing (2.0)	IB*2*416	This patch contains electronic insurance verification (eIV) enhancements which are designed to improve the efficiency of the patient insurance verification process while reducing the workload of the insurance clerks.
Integrated Billing (2.0)	IB*2*417	This patch is to exclude the MRA's filing errors from the MRA patient responsibility calculation.
Integrated Billing (2.0)	IB*2*419	This patch changed the definition of the Billing Provider for claims in which care was provided at a non-VA facility (commonly referred to as Fee Basis claims).
Integrated Billing (2.0)	IB*2*431	ePayments
Integrated Billing (2.0)	IB*2*433	eBilling Preserve Claim number when cloned
Integrated Billing (2.0)	IB*2*436	Medicare Policy Types (MediGap plan (F&G)), functionality changes made to Dual Provider Status & Entity, Legal Claims and the National Provider Identifier (NPI)
Kernel	XU*8*549	This patch added the BILLING FACILITY NAME (#200) field to the INSTITUTION (#4) file and modified the Institution messaging handler

Revenue Process

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

Revenue Cycle

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

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

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

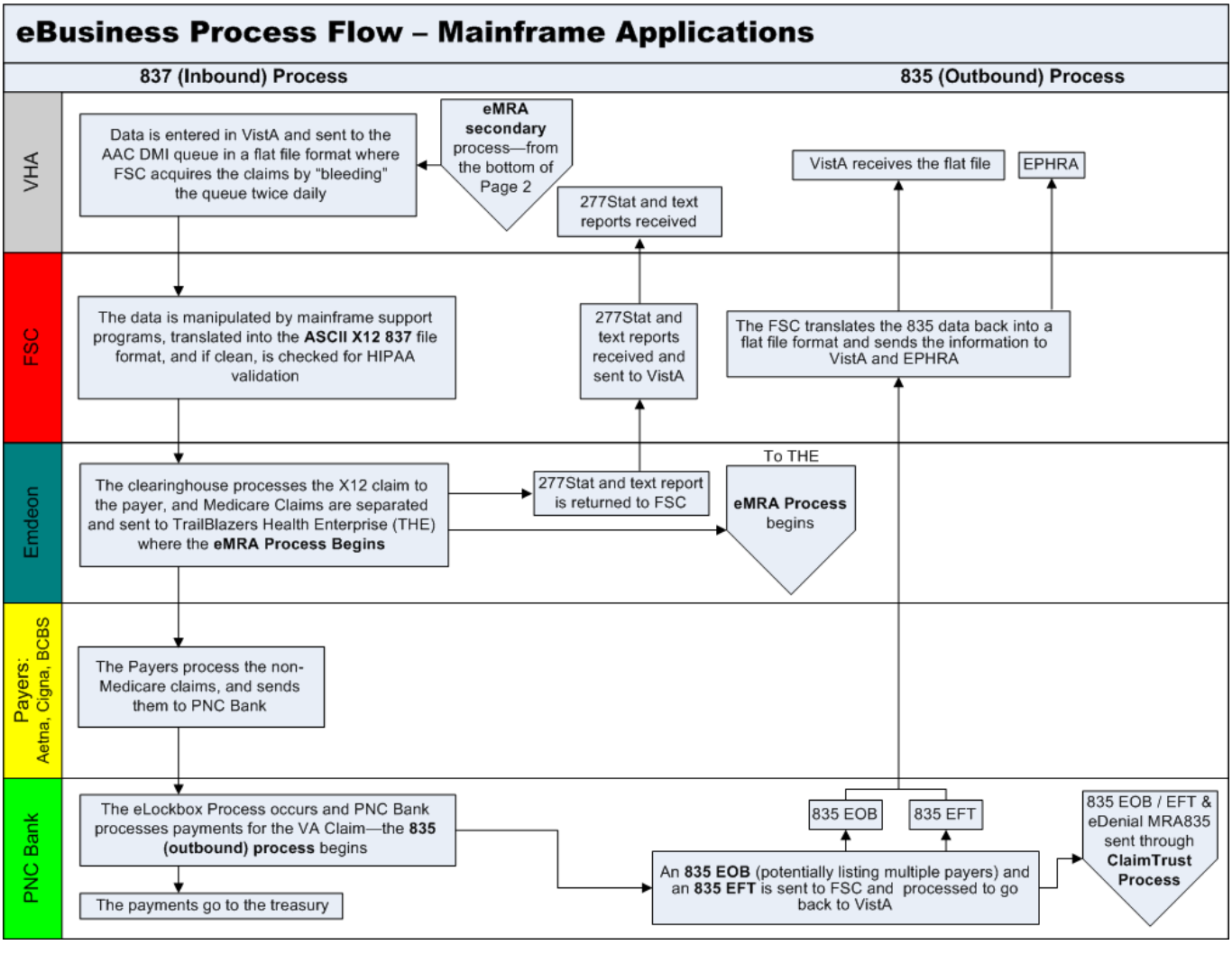
In the Billing phase, the patient encounter is documented and coded. An electronic data interchange (EDI) bill and/or Medicare Remittance Advice (MRA) request is generated and sent to the payer. Claim status messages include information that appears on the Claims Status Awaiting Resolution (CSA) report.

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

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

EDI Billing provides the VHA with the capability to submit electronic Institutional & Professional claims, rather than printing and mailing claims from each facility.

EDI Process Flow



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

From the user's desktop, the claim goes to the FSC in Austin, TX as a VistA MailMan message. The FSC translates the claim into the HIPAA 837 format and forwards it to the clearinghouse.

The clearinghouse processes the claims. Medicare claims are separated and sent to TrailBlazers Health Enterprise. Other claims are sent to the Payer. If the clearinghouse does not have an electronic connection with a payer or if specific claims must be submitted on paper, the claim is printed at Express Bill and mailed to the payers.

The payer adjudicates the claim and determines payment. The payment may be sent electronically to PNC Bank as an EFT or the payer may mail a paper check.

PNC Bank will send: EFT dollars directly to the U.S. Treasury, .EFT 835 transactions, containing daily total deposit information by payer to the FSC, and ERA 835 transactions, containing electronic EOBs (EEOBs) to the FSC.

The FSC will pass EFT and ERA information on to each VAMC in flat file format via VistA MailMan messages. Additionally, the FSC will transmit the EFT and ERA flat file information to the EPHRA database, maintained by the Austin Information Technology Center (AITC), but managed by the FSC 224-Unit staff. The FSC will also transmit unroutable EEOB data to EPHRA. Unroutable EEOB data does not contain the appropriate Tax ID information to allow the FSC to route it to the proper VistA AR system. FSC 224-Unit staff will monitor EPHRA for unroutable EEOB data and use other data identifiers, such as the bill number, to determine appropriate routing and transmit to the correct VistA AR system.

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

Files

Namespace

Routines that are modified as a result of patch IB*2.0*432 are in the "IB" namespace.

File List

WARNING: It is not recommended that you use VA FileManager to edit any of the files directly! Furthermore, editing any of the new files without direction from the interface programmers may cause the interface to become non-functional!

File #	File Name	Data Dictionary	Patch
36	INSURANCE COMPANY	This file contains the names and addresses of insurance companies as needed by the local facility.	IB*2.0*432
350.8	IB ERROR	This file contains errors for billing functions.	IB*2.0*432
350.9	IB SITE PARAMETERS	This file contains the data necessary to run the IB package, and to manage the IB background filer.	IB*2.0*432
353.3	IB ATTACHMENT REPORT TYPE	This file contains entries that describe the type of supplemental information available to support a claim for reimbursement for health care services. Attachment Report Type Code is at both the claim level and line level.	IB*2.0*432
355.3	GROUP INSURANCE PLAN	This file contains the relevant data for Group insurance plans. The data in this file is specific to the plan itself.	IB*2.0*432

File #	File Name	Data Dictionary	Patch
355.93	IB NON/OTHER VA BILLING PROVIDER	This file contains data for non-VA facilities that provide services for VA patients who have reimbursable insurance for these services.	IB*2.0*432
362.4	IB BILL/CLAIMS PRESCRIPTION REFILL	This file contains all prescription refills for bills in the Bill/Claims file.	IB*2.0*432
364.5	IB DATA ELEMENT DEFINITION	This file contains the definition of all data elements that are needed for various forms throughout the MCCR DHCP system. It contains the 'blueprint' for how to extract the data for each data element entry.	IB*2.0*432
364.6	IB FORM SKELETON DEFINITION	This file contains records that define the skeleton makeup of forms for the IB system. This definition includes the absolute position of every field that can be output on the form, the length each field must be limited to, and some descriptive information. This includes printed forms, transmittable output files, and special local billing screens.	IB*2.0*432
364.7	IB FORM FIELD CONTENT	This is the file that contains the specific fields to be used to produce the associated form or screen. If there is no insurance company or bill type specified for an entry, this is assumed to be the default definition of the field.	IB*2.0*432
399	BILL/CLAIMS	This file contains all of the information necessary to complete a Third Party billing form.	IB*2.0*432

Input Templates

Input Template	File	Patch
IB SCREEN10	#399	IB*2.0*432
IB SCREEN102	#399	IB*2.0*432
IB SCREEN10H	#399	IB*2.0*432
IB SCREEN6	#399	IB*2.0*432
IB SCREEN7	#399	IB*2.0*432
IB SCREEN8	#399	IB*2.0*432
IB SCREEN82	#399 - DELETE AT SITE	IB*2.0*432
IB SCREEN8H	#399 - DELETE AT SITE	IB*2.0*432
IBEDIT INS CO1	#36	IB*2.0*432

List Templates

List Template	Patch
IBCAPR	IB*2.0*432
IBCEM COB MANAGEMENT	IB*2.0*432

Protocols

Protocols	Patch
IBCAPR MENU	IB*2.0*432
IBCAPR PRINT MAR	IB*2.0*432
IBCAPR PRINT MAR DEFAULT	IB*2.0*432
IBCAPR PRINTF	IB*2.0*432
IBCAPR PRINTFD	IB*2.0*432
IBCAPR2 MAIN ENTRY	IB*2.0*432
IBCE EOB VIEW	IB*2.0*432
IBCEM CLONE BILL	IB*2.0*432
IBCEM COB CANCEL	IB*2.0*432
IBCEM COB EDIT BILL	IB*2.0*432
IBCEM COB EXIT	IB*2.0*432
IBCEM COB MANAGEMENT 2	IB*2.0*432
IBCEM COB TPJI	IB*2.0*432
IBCEM COPY SECOND/THIRD	IB*2.0*432
IBCEM CORRECT REJECTED/DENIED BILL	IB*2.0*432
IBCEM MRA STATUS	IB*2.0*432
IBCEM REMOVE FROM WORKLIST	IB*2.0*432
IBCEM VIEW COMMENTS	IB*2.0*432

Routines

Routine	Description	Patch List
IBCAPP	CLAIMS AUTO PROCESSING MAIN PROCESSER	**432**
IBCAPP1	CLAIMS AUTO PROCESSING UTILITIES	**432**
IBCAPP2	CLAIMS AUTO PROCESSING	**432**

Routine	Description	Patch List
IBCAPR	PRINT EOB/MRA	**432**
IBCAPR1	CAPR PRINT FUNCTIONS	**432**
IBCAPR2	PRINT EOB/MRA	**432**
IBCAPU	CLAIMS AUTO PROCESSING UTILITIES	**432**
IBCB1	PROCESS BILL AFTER ENTER/EDITED	**70,106,51,137,161,182,155,327,432**
IBCBB	EDIT CHECK ROUTINE TO BE INVOKED BEFORE ALL BILL APPROVAL ACTIONS	**80,51,137,288,327,361,371,377,400,432**
IBCBB1	CONTINUATION OF EDIT CHECK ROUTINE	**27,52,80,93,106,51,151,148,153,137,232,280,155,320, 343,349,363,371,395,384,432**
IBCBB11	CONTINUATION OF EDIT CHECK ROUTINE	**51,343,363,371,395,392,401,384,400,436,432**
IBCBB12	PROCEDURE AND LINE LEVEL PROVIDER EDITS	**432**
IBCBB2	CONTINUATION OF EDIT CHECKS ROUTINE (CMS)	**51,137,210,245,232,296,320,349,371,403,432**
IBCBB21	CONTINUATION OF EDIT CHECK ROUTINE FOR UB	**51,137,210,232,155,291,348,349,403,400,432**
IBCBB3	CONTINUATION OF EDIT CHECKS ROUTINE (MEDICARE)	**51,137,155,349,371,377,432**
IBCBB9	MEDICARE PART B EDIT CHECKS	**51,137,155,349,371,432**
IBCC	CANCEL THIRD PARTY BILL	**2,19,77,80,51,142,137,161,199,241,155,276,320,358, 433,432**
IBCCC	CANCEL AND CLONE A BILL	**80,109,106,51,320,433,432**
IBCCC1	CANCEL AND CLONE A BILL	**80,109,106,51,320,358,433,432**
IBCCC2	CANCEL AND CLONE A BILL	**80,106,124,138,51,151,137,161,182,211,245,155, 296,320,348,349,371,400,433,432**
IBCCCB	COPY BILL FOR COB	**80,106,51,151,137,182,155,323,436,432**
IBCCPT	MCCR OUTPATIENT VISITS LISTING CONT.	**55,62,52,91,106,125,51,148,174,182,245,266,260, 339,432**
IBCECOB	IB COB MANAGEMENT SCREEN	**137,155,288,432**
IBCECOB1	IB COB MANAGEMENT SCREEN/REPORT	**137,155,288,348,377,417,432**
IBCECOB2	IB COB MANAGEMENT SCREEN	**137,155,433,432**
IBCECOB6	IB COB MANAGEMENT SCREEN	**377,432**

Routine	Description	Patch List
IBCEF11	FORMATTER SPECIFIC BILL FUNCTIONS	**51,137,155,309,335,348,349,371,432**
IBCEF2	FORMATTER SPECIFIC BILL FUNCTIONS	**52,85,51,137,232,155,296,349,403,400,432**
IBCEF22	FORMATTER SPECIFIC BILL FUNCTIONS	**51,137,135,155,309,349,389,432**
IBCEF31	FORMATTER SPECIFIC BILL FLD FUNCTIONS	**155,296,349,400,432**
IBCEF7	FORMATTER AND EXTRACTOR SPECIFIC BILL FUNCTIONS	**232,349,432**
IBCEF71	FORMATTER AND EXTRACTOR SPECIFIC BILL FUNCTIONS	**232,155,288,320,349,432**
IBCEF72	FORMATTER AND EXTRACTOR SPECIFIC BILL FUNCTIONS	**232,320,349,432**
IBCEF73A	FORMATTER AND EXTRACTOR SPECIFIC (NPI) BILL FUNCTIONS	**343,374,395,391,400,432**
IBCEF74	FORMATTER/EXTRACT BILL FUNCTIONS	**232,280,155,290,291,320,358,343,374,432**
IBCEF74A	PROVIDER ID MAINT ?ID CONTINUATION	**320,343,349,395,400,432**
IBCEF75	PROVIDER ID FUNCTIONS	**320,371,400,432**
IBCEF76	PROVIDER ID FUNCTIONS	**320,349,400,432**
IBCEF79	BILLING PROVIDER FUNCTIONS	**400,419,432**
IBCEF80	PROVIDER ID FUNCTIONS	**432**
IBCEF81	PROVIDER ADJUSTMENTS	**432**
IBCEF82	PROVIDER ADJUSTMENTS	**432**
IBCEF83	GET PROVIDER FUNCTIONS	**432**
IBCEF84	GET PROVIDER FUNCTIONS	**432**
IBCEFP	PROVIDER ID FUNCTIONS	**432**
IBCEFP1	OUTPUT FORMATTER PROVIDER UTILITIES	**432**
IBCEMQA	MRA QUIET BILL AUTHORIZATION	**155,432**
IBCEMRAX	MEDICARE REMITTANCE ADVICE DETAIL	**155,432**

Routine	Description	Patch List
IBCEMU1	IB MRA UTILITY	**135,155,432**
IBCEMU4	MRA UTILITIES	**288,432**
IBCEOB	835 EDI EOB MESSAGE PROCESSING	**137,135,265,155,377,407,431,432**
IBCEOB21	EOB MAINTENANCE ACTIONS	**137,155,432**
IBCEP2	EDI UTILITIES FOR PROVIDER ID	**137,181,232,280,320,349,432**
IBCEP2B	EDI UTILITIES FOR PROVIDER_ID	**232,320,400,432**
IBCEP8	FUNCTIONS FOR NON-VA PROVIDER	**51,137,232,288,320,343,374,377,391,400, 436,432**
IBCEP8B	FUNCTIONS FOR NON	**391,432**
IBCEU	EDI UTILITIES	**51,137,207,232,349,432**
IBCEU0	EDI UTILITIES	**137,197,155,296,349,417,432**
IBCEU1	EDI UTILITIES FOR EOB PROCESSING	**137,155,296,349,371,432**
IBCEU3	EDI UTILITIES FOR 1500 CLAIM FORM	**51,137,155,323,348,371,400,432**
IBCEU5	EDI UTILITIES (CONTINUED) FOR CMS	**51,137,232,348,349,432**
IBCEU6	EDI UTILITIES FOR EOB PROCESSING	**155,371,432**
IBCEU7	EDI UTILITIES	**432**
IBCF23	HCFA 1500 19-90 DATA (BLOCK 24, PROCS AND CHARGES)	**52,80,106,122,51,152,137,402,432**
IBCF23A	HCFA 1500 19-90 DATA - SPLIT ROM IBCF23	**51,432**
IBCNSBL2	'BILL NEXT PAYOR' BULLETIN	**52,80,153,240,432**
IBCNSC01	INSURANCE COMPANY EDIT	**52,137,191,184,232,320,349,371,399,416,432**
IBCSC10	MCCR SCREEN 10 (UB-82 BILL SPECIFIC INFO)	**432**
IBCSC102	MCCR SCREEN 10 (UB-04 BILL SPECIFIC INFO)	**432**
IBCSC10A	ADD/ENTER CHIROPRACTIC DATA	**432**
IBCSC10B	ADD/ENTER PATIENT REASON FOR VISIT DATA	**432**
IBCSC10H	MCCR SCREEN 10 (BILL SPECIFIC INFO) CMS-1500	**432**
IBCSC5A	ADD/ENTER PRESCRIPTION FILLS	**27,52,106,51,160,137,245,309,347,405,432**
IBCSC5C	ADD/EDIT	**27,52,130,51,160,260,309,315,339,347,363,381,

Routine	Description	Patch List
	PRESCRIPTION FILLS (CONTINUED)	405,432**
IBCSC6	MCCR SCREEN 6 (INPT. BILLING INFO)	**52,80,109,106,51,137,343,400,432**
IBCSC7	MCCR SCREEN 7 (INPT. BILLING INFO)	**52,80,109,106,343,400,432**
IBCSC8	MCCR SCREEN 8 (BILLING - CLAIM INFORMATION SCREEN)	**432**
IBCSCE	MCCR SCREEN EDITS	**52,80,91,106,51,137,236,245,287,349,371,400,432**
IBCSCH	MCCR HELP ROUTINE	**52,80,106,124,138,51,148,137,161,245, 232,287,348,349,374,371,395,400,432**
IBCSCP	BILLING SCREEN PROCESSOR	**52,51,161,266,432**
IBCSCU	MCCR SCREEN UTILITY ROUTINE	**52,51,348,432**
IBCU	BILLING UTILITY ROUTINE	**52,106,51,191,232,323,320,384,432**
IBCU2	BILLING UTILITY ROUTINE (CONTINUED)	**137,287,432**
IBCU7	INTERCEPT SCREEN INPUT OF PROCEDURE CODES	**62,52,106,125,51,137,210,245,228,260,348,371,432**
IBCU71	INTERCEPT SCREEN INPUT OF PROCEDURE CODES	**41,60,91,106,125,138,210,245,349,432**
IBCU74	INTERCEPT SCREEN INPUT OF PROCEDURE CODES (CONT)	**228,260,339,432**
IBCU7B	LINE LEVEL PROVIDER USER INPUT	**432**
IBCU82	THIRD PARTY BILLING UTILITIES (AUTOMATED BILLER)	**43,55,91,124,160,304,347,432**
IBCVC	VALUE CODE FUNCTIONALITY	**371,400,432**
IBJPS	IBSP IB SITE PARAMETER SCREEN	**39,52,70,115,143,51,137,161,155,320,348,349,377, 384,400,432**
IBJPS2	IBSP IB SITE PARAMETER BUILD (CONT.)	**39,52,115,143,51,137,161,155,320,348,349,377,384, 400,432**
IBJPS3	IB SITE PARAMETERS, PAY-TO PROVIDER	**400,432**
IBJTCA1	TPI CLAIMS INFO BUILD	**39,80,106,137,223,276,363,384,432**
IBJTTC	TPI AR COMMENT HISTORY	**39,377,431,432**
IBY432PO	POST-INSTALLATION	**432**

Routine	Description	Patch List
	FOR IB PATCH 432	
IBY432PR	PRE- INSTALLATION FOR IB PATCH 432	**432**

Routines Deleted at Site

Routine	Description	Patch List
IBCSC82	MCCR SCREEN 8 (UB-04 BILL SPECIFIC INFO) - DELETE AT SITE	**51,137,210,232,155,343,349,400,432**
IBCSC8A	ADD/ENTER CHIROPRACTIC DATA - DELETE AT SITE	**371,432**
IBCSC8B	ADD/ENTER PATIENT REASON FOR VISIT DATA - DELETE AT SITE	**400,432**
IBCSC8H	MCCR SCREEN 8 (BILL SPECIFIC INFO) CMS-1500- DELETE AT SITE	**51,137,207,210,232,155,320,343,349,371,400,432**

Exported Options

Added/ Deleted/ Edited	Description
Edited	**IB THIRD PARTY BILLING MENU** Select OPTION NAME: IB THIRD PARTY BILLING MENU Third Party Billing Menu NAME: IB THIRD PARTY BILLING MENU MENU TEXT: Third Party Billing Menu DESCRIPTION: This menu contains the options necessary to create, edit, review, authorize, print, and cancel third party bills.
Added	**IBCE COB MANAGEMENT** Select OPTION NAME: IBCE COB MANAGEMENT COB Management Worklist NAME: IBCE COB MANAGEMENT// MENU TEXT: COB Management Worklist Replace DESCRIPTION: This will be a list manager screen with the option available to print an associated report. Using the screen, billing staff will be able to follow up on bills for secondary and tertiary billing for non-MRA bills.
Added	**IBCE 837 EDI MENU** Select OPTION NAME: IBCE 837 EDI MENU EDI Menu For Electronic Bills NAME: IBCE 837 EDI MENU// MENU TEXT: EDI Menu For Electronic Bills Replace DESCRIPTION:

	This menu contains the options needed to process and maintain EDI 837 bill submission functions.
Added	**IBCE PRINT EOB** Select OPTION NAME: IBCE PRINT EOB Print EOB NAME: IBCE PRINT EOB// MENU TEXT: Print EOB// DESCRIPTION: Print EOB.

Archiving

Patch IB*2.0*432 did not have anything to do with archiving.

Callable Routines/Entry Points/Application Program Interfaces

Callable Routine

Routine Name	Called by	Description	Patch
IBCAPP	IBCNSBL2	CLAIMS AUTO PROCESSING MAIN PROCESSER	IB*2.0*432
IBCAPP1	IBCAPP	CLAIMS AUTO PROCESSING UTILITIES	IB*2.0*432
IBCAPP2	IBCECOB1	CLAIMS AUTO PROCESSING	IB*2.0*432
IBCAPR	IBCAPR1 IBCAPR2	PRINT EOB/MRA	IB*2.0*432
IBCAPR1	IBCAPP	CAPR PRINT FUNCTIONS	IB*2.0*432
IBCAPR2		PRINT EOB/MRA	IB*2.0*432
IBCAPU		CLAIMS AUTO PROCESSING UTILITIES	IB*2.0*432
IBCBB12	IBCBB1	PROCEDURE AND LINE LEVEL PROVIDER EDITS	IB*2.0*432
IBCEF80	IBCEF7 IBCEFPL	PROVIDER ID FUNCTIONS	IB*2.0*432
IBCEF81	IBCEF80 IBCEFP IBCEFPL	PROVIDER ADJUSTMENTS	IB*2.0*432
IBCEF82	IBCEF81	PROVIDER ADJUSTMENTS	IB*2.0*432
IBCEF83	CALLED BY OUTPUT	GET PROVIDER FUNCTIONS	IB*2.0*432

Routine Name	Called by	Description	Patch
	FORMATTER.		
IBCEF84	CALLED FROM DICT 399, FIELDS .21 & 101 TRIGGERS FOR FIELD 27.	GET PROVIDER FUNCTIONS	IB*2.0*432
IBCEFP	IBCEF11 IBCEF74 IBCEF76 IBCEF79 IBCEF83	PROVIDER ID FUNCTIONS	IB*2.0*432
IBCEFP1	IBCEF76 IBCEFP	OUTPUT FORMATTER PROVIDER UTILITIES	IB*2.0*432
IBCEU7	IBXS3 IBXS6 IBXS7 IBXSC3 IBXSC6 IBXSC7 IBXX17	EDI UTILITIES	IB*2.0*432
IBCSC10	BILLING SCREEN 10	MCCR SCREEN 10 (UB-82 BILL SPECIFIC INFO)	IB*2.0*432
IBCSC102	BILLING SCREEN 10	MCCR SCREEN 10 (UB-04 BILL SPECIFIC INFO)	IB*2.0*432
IBCSC10A	BILLING SCREEN 10	ADD/ENTER CHIROPRACTIC DATA	IB*2.0*432
IBCSC10B	BILLING SCREEN 10	ADD/ENTER PATIENT REASON FOR VISIT DATA	IB*2.0*432
IBCSC10H	BILLING SCREEN 10	MCCR SCREEN 10 (BILL SPECIFIC INFO) CMS-1500	IB*2.0*432
IBCU7B	IBCCPT	LINE LEVEL PROVIDER USER INPUT	IB*2.0*432
IBY432PO	INSTALL PROCESS	POST-INSTALLATION FOR IB PATCH 432	IB*2.0*432
IBY432PR	INSTALL PROCESS	PRE-INSTALLATION FOR IB PATCH 432	IB*2.0*432

Entry Points

Routine Name	Entry Point/ Required Variables	Description	Patch
IBCBB11	AMBCK(IBIFN)	If ambulance location defined, address must be defined	IB*2.0*432
IBCBB11	COBAMT(IBIFN)	If there is a COB amt. it must equal the Total Claim Charge Amount	IB*2.0*432
IBCBB11	TMCK(IBIFN)	Attachment Control Number - REQUIRED when Transmission Method = BM, EL, EM, or FT	IB*2.0*432

Routine Name	Entry Point/ Required Variables	Description	Patch
IBCBB11	ACCK(IBIFN)	If any of the loop info is present, then Report Type & Transmission Method req'd	IB*2.0*432
IBCBB11	LNTMCK(IBIFN)	(Line Level) Attachment Control Number - REQUIRED when Transmission Method = BM, EL, EM, or FT	IB*2.0*432
IBCBB11	LNACCK(IBIFN)	(Line Level) If any of the loop info is present, then Report Type & Transmission Method req'd	IB*2.0*432
IBCC	CRD	Entry to point to add iteration # to claim	IB*2.0*432
IBCCC	ITN(IBX)	Determine iteration # for rejected or denied claim	IB*2.0*432
IBCCC	CRD	New entry point if user comes from CRD option instead of CLON	IB*2.0*432
IBCECOB1	WLRMV	Remove from EOB Work List	IB*2.0*432
IBCECOB1	WLRMVF(IBIFN,METHOD)		IB*2.0*432
IBCECOB2	CRD	Correct Rejected/Denied claim protocol action	IB*2.0*432
IBCECOB6	EOBCM	init variables and list array for new EOB Claim Comments	IB*2.0*432
IBCECOB6	EOCMT	Edit new EOB comments	IB*2.0*432
IBCEF11	GETLDAT(IBXIEN)	Extract data for 837 transmission LDAT record	IB*2.0*432
IBCEF22	RC2CP(IBIFN,IBRCIEN)	Returns "CP" multiple pointer that corresponds to a given "RC" multiple pointer in file 399	IB*2.0*432
IBCEF31	AUTRF(IBXIEN,IBL,Z)	Returns auth # and referral# if room for both, separated by a space	IB*2.0*432
IBCEF74A	LPRV	Service Line Providers	IB*2.0*432
IBCEF79	SLPROV(IBXIEN,TYPE)	Return array of service line provider data	IB*2.0*432
IBCEU3	LINSPEC(IBIFN)	Checks the specialties of line and claim level providers	IB*2.0*432
IBCEU5	CLEANUP(IBIFN,FT)	If form type changes remove any extra provider FUNCTIONS.	IB*2.0*432
IBCEU6	COB1(IBIFN,IBXDATA,IBMRAF,IBCURR)	Process the EOB	IB*2.0*432
IBCSC5A	ORDT(IBORDT,Y)	Get ISSUE DATE from file 52 and stuff into ORDER DATE of file 362.4	IB*2.0*432
IBCU7	ATTACH	Attachment control number.	IB*2.0*432
IBCVC	VC1	Code for the VC1 record of the IB 837 Transmission	IB*2.0*432
IBJTTC	EOBC	Check for new EOB comments	IB*2.0*432
IBJTTC	CONTACT()	HIPAA 5010 check for contact data in comments	IB*2.0*432

Routine Name	Entry Point/ Required Variables	Description	Patch
IBCAPP2	CAP	Build list from CAP x-ref entry point. Called from BLD^IBCECOB1 for non-MRA work list.	IB*2.0*432
IBCBB12	LNPROV (IBIFN)	Edits for line level providers.	IB*2.0*432
IBCBB12	OPPROVCK (IBIFN)	Other Operating Provider edit checks.	IB*2.0*432
IBCBB12	UBPRVCK (IBIFN)	Check if claim requires operating provider or rendering provider.	IB*2.0*432
IBCEF83	GETPRV(IBIEN,CPST,IBPRTYP,IBITEM)	MAIN ENTRY POINT for returning provider information.	IB*2.0*432
IBCEF83	CMSBOX24(IBIEN,IBXIJ,IBXDATA)	Provider Qualifier or Provider ID and Provider NPI for CMS-1500 BOX J	IB*2.0*432
IBCEF84	CREATE (DA)	Create Condition ENTRY POINT. Called From DICT 399, Fields .21 & 101 Triggers for Field 27.	IB*2.0*432
IBCEF84	DELETE (DA)	Delete Condition ENTRY POINT. Called From DICT 399, Fields .21 & 101 Triggers for Field 27.	IB*2.0*432
IBCEFP	ALLIDS(IBIFN,IBXSAVE,IBSTRIP,SEG)	Return all of the Provider IDS	IB*2.0*432
IBCEFP1	CLEANUP(IBXSAVE)	Clean up	IB*2.0*432
IBCEFP1	NPI(IBDATA)	look for NPI in #200 or #355.93	IB*2.0*432
IBCEFP1	NAME(IBDATA,IBIFN,IBCRED,IBSPEC)	Parse person's nm into 6 pieces LAST^FIRST^MIDDLE^CRED^SUFFIX^SPECIALITY	IB*2.0*432
IBCEFP1	TAXON(IBDATA,IBTAX)	Returns taxonomy code from NEW PERSON or non/other VA BP	IB*2.0*432
IBCEFP1	COBID(IBIFN,IBTYP,IBMRAND,IBD)	Get COB ID	IB*2.0*432

External Relationships

IA #	Between IB and	Related to	FORUM Status	Patch
IA#380	ACCOUNTS RECEIVABLE	The following function calls are made to the routine PRCAFN.	Active	IB*2.0*432
IA#2171	KERNEL	Function API's to access parts of the Institution file.	Active	IB*2.0*432
IA#4129	KERNEL	The IB package has MRA (Medicare Remittance Advice) functionality using a specific, non-human user in file 200.	Active	IB*2.0*432
IA#4677	KERNEL	To support the J2EE	Active	IB*2.0*432

IA #	Between IB and	Related to	FORUM Status	Patch
		middle tier the concept of an APPLICATION PROXY user was created. This is a user name that an application sets that has a user class of Application Proxy.		

Global Variables

No non-standard variables were introduced with patch IB*2.0*432.

SECURITY

File Protection

The Electronic Data Interface contains files that are standardized. They carry a higher level of file protection with regard to Delete, Read, Write, and LAYGO access, and should not be edited locally unless otherwise directed. The data dictionaries for all files should NOT be altered.

The following is a list of recommended VA FileMan access codes associated with each file contained in the KIDS build for the EDI interface.

File #	File Name	DD	RD	WR	DEL	LAYGO	AUDIT	Patch
36	INSURANCE COMPANY	#		D	d	d		No Changes in IB*2.0*432
350.8	IB ERROR	@	@	@	@	@	@	No Changes in IB*2.0*432
350.9	IB SITE PARAMETERS	@	@	@	@	@	@	No Changes in IB*2.0*432
353.3 **NEW**	IB ATTACHMENT REPORT TYPE	@	@	@	@	@	@	**New** with patch IB*2.0*432
355.3	GROUP INSURANCE PLAN	@		@	@	@	@	No Changes in IB*2.0*432

File #	File Name	DD	RD	WR	DEL	LAYGO	AUDIT	Patch
355.93 **BEFORE**	IB NON/OTHER VA BILLING PROVIDER	@					@	**Changed** IB*2.0*432
355.93 **AFTER**	IB NON/OTHER VA BILLING PROVIDER	@		@	@	#		**Changed** IB*2.0*432
362.4	IB BILL/CLAIMS PRESCRIPTION REFILL	@		@	@	@	@	IB*2.0*432
364.5	IB DATA ELEMENT DEFINITION							No Changes in IB*2.0*432
364.6	IB FORM SKELETON DEFINITION							No Changes in IB*2.0*432
364.7	IB FORM FIELD CONTENT							No Changes in IB*2.0*432
399	BILL/CLAIMS	@	@	@	@	@		No Changes in IB*2.0*432

Security Keys External Relationships

No new security keys were introduced with patch IB*2.0*432.

Security Key Name	Description	Patch
n/a		

Options Locked by Security Keys

No new options locked by security keys were introduced with patch IB*2.0*432.

Options/Programs locked by a Security Key	Security Key	Patch
n/a		

Glossary

Term	Description
Accounts Receivable (AR)	The financial computer system used by the Department of Veterans Affairs Medical Centers.
AITC	Austin Information Technology Center (formerly AAC); located in Austin, Texas; responsible for maintaining the hardware that supports the Lockbox system, including FSC servers, the MailMan routing system, and EPHRA database
CBO	Chief Business Office
Claim Status Message	Electronic messages returned to the VAMC providing status information on a claim from the Financial Service Center (FSC) in Austin, Texas. These messages can originate at FSC, at the payer or at the clearinghouse.
Clearinghouse	A company that provides batch and real time transaction processing services and connectivity to a payer or provider. Transactions include insurance eligibility verification, claims submission processing, electronic remittance processing and payment posting for electronic claims.
Data Dictionary	The structure of a file, table or any group of related information as defined for and by VA FileMan.
eClaim	A claim that is transmitted to FSC electronically.
ECME	e-Claims Management Engine
EDI	Electronic Data Interchange (EDI) is the process of transacting business electronically. It includes submitting claims electronically (paperless claims processing), as well as electronic funds transfer and electronic inquiry for claim status and patient eligibility.
EEOB	Electronic Explanation of Benefits; one line item within an ERA
Electronic Remittance Advice	An electronic record transmitted to the sites with EEOB detail information included. An Electronic Remittance Advice can consist of one or more EEOBs from one payer.
Emdeon	The clearinghouse used by VA.
EOB	An Explanation of Benefits (EOB) is a document from a payer that details the amount of payment on a claim and if not paid in full, the reasons for it.
EPHRA	EEOB and Payment Healthcare Resolution Application; Web-based archival repository and research tool; allows user to search for missing EEOBs that are not received due to incorrect routing information; allows Austin FSC 224-unit staff to route unroutable EEOB data
ERA	Electronic Remittance Advice; the equivalent to a stack of paper Explanation of Benefits (EOB)

Term	Description
	statements for many patients from one payer
Express Bill	An Emdeon (clearinghouse) printing service that prints and mails claims to payers who do not have the capability to accept electronic claims or in specific circumstances when a paper claim is required.
FSC	The Financial Service Center (Austin, Texas) receives 837 claims transmissions from VistA and transmits this data to a clearinghouse. FSC also receives error/informational messages and 835 data from the clearinghouse and transmits this data to VistA.
Health Level Seven (HL7)	Health Level Seven, a standardized application level communications protocol that enables systems to exchange information and to affect requests and responses. Basically, HL7 is an agreement between two HL7-compliant systems that specifies where to expect certain data in a stream of characters.
HHS	The U.S. Department of Health and Human Services
HIPAA	In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. This will enable the entire health care industry to communicate electronic data using a single set of standards thus eliminating all non standard formats currently in use. Once these standards are in place, a health care provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.
IB	Integrated Billing
Integration Agreement (same as IRC)	Programming agreements made between two VISTA packages enabling the sharing/management of data and or functions.
MailMan Message	The messaging system used to communicate between the users of the VISTA software. MailMan messages will be used to process automatic payments and to communicate between the Accounts Receivable software and the users.
NPI	National Provider Identifier

Term	Description
OED	Office of Enterprise Development
Option	A unique method defined in the Option file (^DIC(19,). Options are usually defined as part of a user driven menu system but may be invoked as extensions of other options or VA MailMan messages.
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.
Routines	A unique identifiable containment of software pertinent to a computer system function. The routines contain the programming logic to implement the functionality for the EDI Lockbox Project.
Security Key	Used in conjunction with locked options or functions. Only holders of this key may perform these options/functions. Security Keys are used for options, which perform a sensitive task.
VistA	Veterans Health Integrated Systems Technology Architecture
VHA	Veterans Health Administration
835	The HIPAA adopted standard for electronic remittance advice to report the processing of all claim types (including retail pharmacy). The term "835" represents the data set that is sent from health plans to health care providers and contains detailed information about the processing of the claim. This includes payment information and reduction or rejection reasons. All health plans are required to use the same explanation of benefit codes (adjustment reason codes) and adhere to very specific reporting requirements. The term "835" is used interchangeably with electronic remittance advice (ERA) and Medicare remittance advice (MRA).
837	The HIPAA adopted standard for electronic submission of hospital, outpatient and dental claims. The term "837" represents the data set that is sent from health care providers to insurance companies (payers). The 837 standard includes the data required for coordination of benefits and is used for primary and secondary payer claims submission. The term "837" is used interchangeably with electronic claim.