Electronic Data Interchange (EDI)
Billing User Guide

U.S. Department of Veterans Affairs

Office of Information and Technology

Product Development

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Revision History

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August 2005	1	Patch IB*2*296	M. Simons
July 2006	1.1	Patch IB*2*320	M. Simons
February 2007	1.2	Patches IB*2*343, 348 and 349	C. Smith M. Simons
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Date	Revision	Description	Author
April 2015	2.3	IOC Exit Review Patch IB*2*516 Revised Sections: 6.11, 6.2.3.1, 6.2.3.2, 6.3.2, 9.2.3	M. Simons
August 2016	2.4	Patch IB*2*547 Revised Sections: 2.1.1.1, 2.1.2, 6.2.4 and all sub sections, 6.3.3, 6.7, 6.9, 6.10, 6.14, 7.2, 8., 9.3, 9.4, 9.5, 10.2.1, 10.3.16, 10.3.17, 10.3.19, Appendix B	M. Simons
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1. Introduction

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

1.1. Revenue Process

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

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

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

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

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

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

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

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

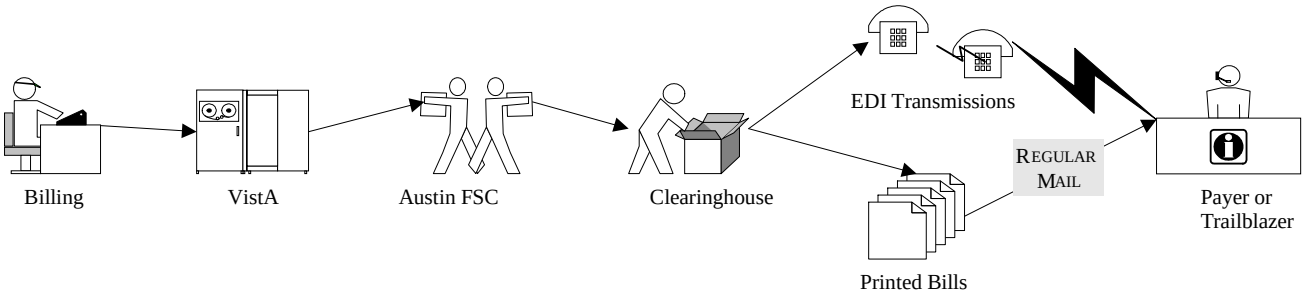
1.2. Critical EDI Process Terms

Also see APPENDIX B – GLOSSARY.

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

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

1.3. EDI Process Flow



1 DAY	OVERNIGHT	UP TO 3 DAYS	1 TO 14 DAYS

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

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

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

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

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

2. Insurance Company Set-up

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

2.1. Insurance Company Setup

2.1.1 Activate New Payer to Transmit eClaims

The typical business process for setting up new payers is:

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

	Note: Selecting the correct electronic plan type is important. This field may determine which provider IDs are transmitted and/or printed. Choosing the wrong electronic plan type for an Insurance Plan could result in claims being rejected by the clearinghouse *or by the payer*.
	Note: When Patch IB*2*477 is installed, and a claim is authorized with more than one payer, a warning is displayed unless all the Payer IDs are on the claim.

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

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

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

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


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

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

The following prompts will display.

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

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

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

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

	from the National Insurance File.

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

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

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

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

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


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

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

```
Insurance Plan List            Mar 31, 2004@16:12:52          Page:    1 of    1
All Plans for: BLUE CROSS BLUE SHIELD DEMO Insurance Company

#  + => Indiv. Plan    * => Inactive Plan                        Pre-  Pre-  Ben
    Group Name          Group Number       Type of Plan    UR?  Ct?   ExC?  As?
1   DEMO FOR TRAINING   87654              COMPREHENSIVE   NO   YES   YES   YES



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

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

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

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

  Plan Coverage Limitations
   Coverage            Effective Date   Covered?       Limit Comments
   --------            --------------   --------       --------------
   INPATIENT           02/10/04         YES
   OUTPATIENT          02/10/04         YES
   PHARMACY            02/10/04         NO
+         Enter ?? for more actions
PI  Change Plan Info                    IP  (In)Activate Plan
UI  UR Info                             AB  Annual Benefits
CV  Add/Edit Coverage                   CP  Change Plan
PC  Plan Comments                       EX  Exit
Select Action: Next Screen// PI   Change Plan Info
```

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

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

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

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

The following screen will display.

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

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



+         Enter ?? for more actions

Select Action: Next Screen//
```

2.1.2 Activate Existing Commercial Payer to Transmit eClaims

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

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

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

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

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


                               EDI Parameters
              Transmit?: NO                        Insurance Type:
+          Enter ?? for more actions                                          >>>
BP  Billing/EDI Param      IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address   AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office     ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office      PA  Payer                 DC  Delete Company
PC  Prescr Claims Of       RE  Remarks               VP  View Plans
AO  Appeals Office         SY  Synonyms              EX  Exit
Select Action: Next Screen//BP Billing/EDI Param
```

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

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

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

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

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

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

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


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

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

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

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



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

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

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

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

  Plan Coverage Limitations
   Coverage            Effective Date   Covered?       Limit Comments
   --------            --------------   --------       --------------
   INPATIENT           02/01/04         YES
   OUTPATIENT          02/01/04         YES
   PHARMACY            02/01/04         NO
+         Enter ?? for more actions
PI  Change Plan Info                   IP  (In)Activate Plan
UI  UR Info                            AB  Annual Benefits
CV  Add/Edit Coverage                  CP  Change Plan
PC  Plan Comments                      EX  Exit
Select Action: Next Screen// PI   Change Plan Info
```

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

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

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

The following screen will display.

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

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



+         Enter ?? for more actions

Select Action: Next Screen//
```

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

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

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

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

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

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

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

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


                             EDI Parameters
              Transmit?: NO                        Insurance Type:
+          Enter ?? for more actions                                        >>>
BP  Billing/EDI Param      IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address   AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office     ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office      PA  Payer                 DC  Delete Company
PC  Prescr Claims Of       RE  Remarks               VP  View Plans
AO  Appeals Office         SY  Synonyms              EX  Exit
Select Action: Next Screen//BP  Billing/EDI Param
```

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

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

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

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

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

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

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

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

[11]TRICARE Pay-To Providers: 0 defined

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

[13]HIPPA NCPDP Active Flag          : Active

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

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

3.1. Define Default Pay-to Provider

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

```
Pay-To Providers              Dec 22, 2008@13:58:13          Page:    1 of    1
            No Pay-To Providers defined.









          * = Default Pay-to provider
AP  Add Provider           DP  Delete Provider       EX  Exit
EP  Edit Provider          AS  Associate Divisions
Select Item(s): Quit// AP   Add Provider
Enter Pay-to Provider: CHEYENNE VAMC    WY  M&ROC     442
  Are you adding 'CHEYENNE VAMC' as a new PAY-TO PROVIDERS (the 1ST for this IB
SITE PARAMETERS)? No// y  (Yes)
Pay-to Provider Name: CHEYENNE VAMC//
Pay-to Provider Address Line 1: 2360 E PERSHING BLVD
           Replace
Pay-to Provider Address Line 2: Mail Stop 10234
Pay-to Provider City: CHEYENNE//
Pay-to Provider State: WYOMING//
Pay-to Provider Zip Code: 82001-5356//
Pay-to Provider Phone Number: 555-555-5555
Pay-to Provider Federal Tax ID Number: 83-0168494//
```

The following screen will display.

```
Pay-To Providers              Dec 22, 2008@14:38:21          Page:    1 of    1
 1.    *Name     : CHEYENNE VAMC                        State   : WY
       Address 1: 2360 E PERSHING BLVD                  Zip Code: 82001-5356
       Address 2:                                       Phone   :
       City     : CHEYENNE                              Tax ID  : 83-0168494









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

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

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

The following screen will display.

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



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

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

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

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

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

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



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

The following screen will display.

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

```
       6     442GE     TEST MORC

 MONTANA HEALTH CARE SYSTEM - FT. HARRISON DIVISION
       No Divisions found.



          Enter ?? for more actions
AS  Associate Division                  EX  Exit
Select Item(s): Quit// AS Associate Division
Select Division (1-6): 5
Select Pay-To Provider: Montana
```

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

The following screen will display.

```
Pay-To Provider Associations Dec 22, 2008@15:34:39          Page:    1 of    1
 CHEYENNE VAMC  (Default)
       1     442GA     CASPER
       2     442GC     FORT COLLINS
       3     442GD     GREELEY
       4     442       CHEYENNE VAMROC
       5     442GE     TEST MORC

 MONTANA HEALTH CARE SYSTEM - FT. HARRISON DIVISION
       6     442GB     SIDNEY



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

4. Provider ID Set-up

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

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

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

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

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

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

After Patch IB*2*436, old claims can be reprinted locally for legal purposes and sent to Regional Counsel even though the original claim was created prior to the requirement for providers to have an assigned NPI. A legal claim is defined as having a Billing Rate Type of "NO FAULT INS", "WORKERS' COMP", or "TORT FEASOR".

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

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

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

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

4.1. Table of IDs

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

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

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

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

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

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

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

4.2. Pay-to Provider IDs

4.2.1 Define the Pay-to Provider Primary ID/NPI

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

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

4.2.2 Define the Pay-to Provider Secondary IDs

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

4.3. Billing Provider IDs

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

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

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

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

4.3.1 Define the Billing Provider Primary ID/NPI

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

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

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

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

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

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

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

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

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

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

4.3.2 Define the Billing Provider Secondary IDs

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

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

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

4.3.2.1 Define Default Billing Provider Secondary IDs by Form Type

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

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

No Billing Provider IDs found



          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit// a    Add ID
Define Billing Provider Secondary IDs by Care Units? No//??

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

       0   No
       1   Yes

Define Billing Provider Secondary IDs by Care Units? No//No
Division: Main Division// Main Division
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: CMS-1500
Billing Provider Secondary ID: XXXXXX1B
```

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

```
Billing Provider IDs (Parent)        May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                        ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                        XXXXXX1A         UB04
2    Blue Shield                       XXXXXX1B         1500




          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit//
```

4.3.2.2 Define Billing Provider Secondary IDs by Division and Form Type

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

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

```
Billing Provider IDs (Parent)       May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA       Billing Provider Secondary IDs
     ID Qualifier                      ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                        XXXXXX1A         UB04
2    Blue Shield                       XXXXXX1B         1500




          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit// a   Add ID
Define Billing Provider Secondary IDs by Care Units? No//No
Division: Main Division// Remote Clinic
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: CMS-1500
Billing Provider Secondary ID: 1XXXXX1B
```

The following screen will display.

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

```
Billing Provider IDs          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                      ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                        XXXXXX1A         UB04
2    Blue Shield                       XXXXXX1B         HCFA

Division: Remote Clinic
3    Blue Cross                        1XXXXX1A         UB04
4    Blue Shield                       1XXXXX1B         1500



          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit//
```

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

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

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

```
Billing Provider IDs          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                    ID #            Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                      XXXXXX1A        UB04
2    Blue Shield                     XXXXXX1B        1500

Division: Remote Clinic
3    Blue Cross                      1XXXXX1A        UB04
4    Blue Shield                     1XXXXX1B        1500

          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit// a   Add ID
Define Billing Provider Secondary IDs by Care Units? No//??

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

       0   No
       1   Yes
Define Billing Provider Secondary IDs by Care Units? No//1  Yes
Division: Main Division// Main Division
Care Unit:??
   Select a Care Unit from the list:
       1 Anesthesia
       2 Reference Lab
       3 Home Health
Care Unit: 1   Anesthesia
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: CMS-1500
Billing Provider Secondary ID: 11XXXX1B
```

The following screen will display.

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

Select Action: Quit//
```

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

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

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

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

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

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

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

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

No Additional Billing Provider IDs found




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

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

The following screen will display.

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




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

Select Action: Quit// Add an ID
Type of ID: Medicare
Form Type: UB-04
Billing Provider Secondary ID: XXXXXXX11
```

4.4. Service Facility IDs (Laboratory or Facility IDs)

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

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

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

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

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

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

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

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

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

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

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

Step	Procedure
11	At the **Contact Phone Number:** prompt, enter **703-333-3333** for this example.
12	At the **Contact Phone Extension:** prompt, enter **123478**.
13	At the **ID Qualifier:** prompt, press the **<Enter>** key to accept the default.
14	At the **Lab or Facility Primary ID**: prompt, enter **111111112**.
15	At the **X12 Type of Facility:** prompt, enter **FA - Facility** for this example.
	*With Patch IB*2*371, FA will be sent as the Type of Facility on all institutional claims regardless of what is defined. HIPAA only allows FA on institutional claims.*
16	At the **Mammography Certification Number**: prompt, press the **<Enter>** key to leave it blank. If you know the Mammography number you can enter it here.
17	At the **NPI**: prompt, enter **XXXXXXXXXX** for this example.
	*Note: With Patch IB*2*516, users will have the ability to define a Non-VA Facility as a sole-proprietorship and link it to a human provider. If a facility is linked to a human provider, then the human's NPI may be used for both the human and the facility. The individual provider must be defined in VistA before he/she can be linked to the facility.*
18	At the **Select Taxonomy Code**: prompt, enter **954** for this example.
19	At the **OK?** Prompt, press the **<Enter>** key to accept the default.
20	At the **Are you adding 'General Acute Care Hospital' as a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No//** prompt, enter **Yes**.
21	At the **Primary Code**: prompt, enter **Yes** for this example.
22	At the **Status**: prompt, enter **Active**.
23	At the **Select Taxonomy Code**: prompt, press the **<Enter>** key.
	*Note: With Patch IB*2*432, the ability to define the name of a contact person at the outside facility and the telephone number for that person will be available to users.*
24	At the **Allow future updates by FEE BASIS automatic interface? YES//** prompt, press the **<Enter>** key to accept the default. (Note: This question does not impact current functionality as this is part of Future Development)

```
STREET ADDRESS: 123 Test Street
STREET ADDRESS LINE 2:
CITY: CHEYENNE// Long Beach
STATE: CALIFORNIA
ZIP CODE: 920601234//
CONTACT NAME: IB,CONTACT O//
CONTACT PHONE NUMBER: 703-333-3333//
CONTACT PHONE EXTENSION: 123478//
ID Qualifier: 24 - EMPLOYER'S IDENTIFICATION #
Lab or Facility Primary ID: 111111112//
X12 TYPE OF FACILITY: FACILITY//
MAMMOGRAPHY CERTIFICATION #:
SOLE PROPRIETORSHIP?: NO
NPI: XXXXXXXXXX
Select TAXONOMY CODE: 954  General Acute Care Hospital     282N000
00X
         ...OK? Yes//   (Yes)

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

The following screen will display.

```
Non-VA Lab or Facility Info   Jul 05, 20126@16:04:07          Page:    1 of    1


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

            Type of Facility: FACILITY
                  Primary ID: 111111112
              ID Qualifier: 24 - EMPLOYER'S IDENTIFICATION #
 Mammography Certification #:
                         NPI: XXXXXXXXXX
               Taxonomy Code: 261QV0200X (Primary)

   Allow future updates by FEE BASIS automatic interface? : YES


          Enter ?? for more actions
FI   Lab/Facility Info                 LI   Lab/Facility Ins ID
LO   Lab/Facility Own ID               EX   Exit
Select Action: Quit//
```

4.4.2 Define Non-VA Laboratory or Facility Secondary IDs

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

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

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

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

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

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


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

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

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

Provider ID: DXXXXX
```

The following screen will display.

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

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

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




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

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

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

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

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

     ID Qualifier                Form   Care Type                 ID#

  No ID's found for provider and selected insurance co
```

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

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

Provider ID: 111XXX1B
```

The following screen will display.

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

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

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




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

4.4.3 Define VA Laboratory or Facility Primary IDs/NPI

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

4.4.4 Define VA Laboratory or Facility Secondary IDs

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

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

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

```
VA-Lab/Facility IDs               May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

VA-Lab/Facility Primary ID: XX123456

VA-Lab/Facility Secondary IDs
   ID Qualifier              ID #             Form Type

No Laboratory or Facility IDs found




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

Select Action: Add an ID
```

The following screen will display.

```
VA-Lab/Facility IDs               May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

VA-Lab/Facility Primary ID: Federal Tax ID

VA-Lab/Facility Secondary IDs
     ID Qualifier                ID#              Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                  1212XX1A         UB04
2    Blue Shield                 1212XX1B         1500

Division: CBOC
3    Commercial                  1313XXG2         UB04


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

Select Action: Edit//
```

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

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

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

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

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

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

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

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

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

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

4.5.2 Define a VA Physician/Provider's Secondary IDs

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

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

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

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

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

```
Provider ID Maintenance Main Menu
```

```
   Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

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

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

   Select Provider ID Maintenance Option: PO  Provider Own IDs

(V)A or (N)on-VA provider: V// A PROVIDER
Select V.A. PROVIDER NAME:IB,DOCTOR 1
```

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

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

     ID Qualifier         Form     Care Type    Care Unit       ID#

  No ID's found for provider


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

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

Enter the Qualifier that identifies the type of ID.

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

```
LICENSING STATE: CALIFORNIA//
LICENSE NUMBER: XXXXSTATE
```

The following screen will display.

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

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




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

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

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

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

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

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
           PO   Provider Own IDs
           PI   Provider Insurance IDs

                Insurance IDs
           BI   Batch ID Entry
           II   Insurance Co IDs

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

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

    Select Provider ID Maintenance Option: PI Provider Insurance IDs

 (V)A or (N)on-VA provider: V// A PROVIDER
Select V.A. PROVIDER NAME:IB,DOCTOR 1
Select INSURANCE CO: BLUE CROSS OF CALIFORNIA
```

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

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

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


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

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

Enter the Qualifier that identifies the type of ID.

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

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

PROVIDER ID: XXXXBSHIELD
```

The following screen will display.

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

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




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

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

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

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

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

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

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

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO    Provider Own IDs
          PI    Provider Insurance IDs

                Insurance IDs
          BI    Batch ID Entry
          II    Insurance Co IDs

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

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

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

The following screen will display.

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

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

          Enter ?? for more actions
```

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

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

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

The following screen will display.

```
NON-VA PROVIDER INFORMATION   Jul 05, 20126@14:49:53          Page:    1 of    1


         Name: IB,OUTSIDEPROV
         Type: INDIVIDUAL PROVIDER
  Credentials: MD
    Specialty: 30
          NPI: 0000000006
Taxonomy Code: 207RC0000X (Primary)

Allow future updates by FEE BASIS automatic interface? : YES

          Enter ?? for more actions
ED   Edit Demographics                    PI   Provider Ins ID
PO   Provider Own ID                      EX   Exit
Select Action: Quit//
```

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

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

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

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

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

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

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

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

    Select Provider ID Maintenance Option: PO Provider Own IDs

(V)A or (N)on-VA provider: V//  n  NON-VA PROVIDER
Select Non V.A. PROVIDER NAME:IB,OUTSIDEDOC
```

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

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

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

     ID Qualifier         Form     Care Type    Care Unit       ID#

  No ID's found for provider




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

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

Enter the Qualifier that identifies the type of ID.

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

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

PROVIDER ID: XXXXX1212
```

The following screen will display.

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

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




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

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

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

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

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

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

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

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

    Select Provider ID Maintenance Option: NP Non-VA Provider

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

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

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

     ID Qualifier         Form     Care Type    Care Unit       ID#

  No ID's found for this insurance co.



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

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

Enter the Qualifier that identifies the type of ID.

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

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

The following screen will display.

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

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

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

4.5.4 Define Insurance Company IDs

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

There are three options:

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

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

4.5.4.1 Define Default Physician/Provider Insurance Company Secondary IDs

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

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

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

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

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

    Select Provider ID Maintenance Option: II  Insurance Co IDs
Select INSURANCE COMPANY NAME:  BLUE CROSS OF CALIFORNIA     PO BOX 60007          LOS
ANGELES     CALIFORNIA       Y
SELECT DISPLAY CONTENT: A//D  INSURANCE CO DEFAULT IDS
```

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

```
INSURANCE CO PROVIDER ID      Dec 19, 2005@12:24:41          Page:    1 of    2
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
     PROVIDER NAME         FORM   CARE TYPE    CARE UNIT       ID#


Provider ID Type: BLUE SHIELD
1    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    BSDEFAULT

Provider ID Type: COMMERCIAL
2    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    COMDEFAULT

Provider ID Type: PROVIDER PLAN NETWORK
3    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    NETDEFAULT

Provider ID Type: UPIN
4    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    UPINDEFAULT

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

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

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


Select Provider ID Type: BLUE CROSS     1A

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

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

PROVIDER ID: BCDEFAULT
```

The following screen will display.

```
INSURANCE CO PROVIDER ID      Dec 19, 2005@12:34:01          Page:    1 of    2
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
PROVIDER NAME          FORM   CARE TYPE    CARE UNIT       ID#

Provider ID Type: BLUE CROSS
1    <<INS CO DEFAULT>>    UB-04  INPT/OUTPT                    BCDEFAULT

Provider ID Type: BLUE SHIELD
2    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    DEFALLProv

Provider ID Type: COMMERCIAL
3    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    COMDEFAULT

Provider ID Type: PROVIDER PLAN NETWORK
4    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    NETDEFAULT

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

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

4.5.4.2 Define Individual Physician/Provider Insurance Company Secondary IDs

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

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

```
Provider ID Maintenance Main Menu

   Enter a code from the list.

            Provider IDs
        PO  Provider Own IDs
        PI  Provider Insurance IDs

            Insurance IDs
        BI  Batch ID Entry
        II  Insurance Co IDs

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

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

   Select Provider ID Maintenance Option: ii  Insurance Co IDs
```

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

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

```
SELECT DISPLAY CONTENT: A// ??

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

     Select one of the following:

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

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

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

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

     PROVIDER ID TYPE      FORM   CARE TYPE    CARE UNIT       ID#

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

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

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

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

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

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

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

```
Select PROVIDER: IB,DOCTOR7

Select Provider ID Type:  BLUE SHIELD     1B

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

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

PROVIDER ID: BSXXXXX
```

The following screen will display.

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

     PROVIDER ID TYPE      FORM   CARE TYPE    CARE UNIT       ID#
+

Provider: IB,DOCTOR15
194  PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   GXXXXX

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

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

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

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

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

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

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

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

    Select Provider ID Maintenance Option: II  Insurance Co IDs

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

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

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

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

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

     PROVIDER NAME         FORM   CARE TYPE    CARE UNIT       ID#

Provider ID Type: BLUE CROSS
1    IB,DOCTOR7            UB-04  INPT/OUTPT                   BCXXXXX

Provider ID Type: BLUE SHIELD
2    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                   DEFALLProv
3    IB Outside Facility   BOTH   INPT/OUTPT                   BSFACXXXX
4    IB,DOCTOR8            BOTH   INPT/OUTPT                   BSINDOUT
5    IB,DOCTOR33           BOTH   INPT/OUTPT                   BSLIM
6    IB,DOCTOR7            1500   INPT/OUTPT                   BSXXXXX

Provider ID Type: PROVIDER PLAN NETWORK
7    IB,DOCTOR64           BOTH   INPT/OUTPT                   MD22356A
+         Enter ?? for more actions
AI   Add an ID             DP   Display Ins Params   VI   View IDs by Type
DI   Delete an ID          CI   Change Ins Co        CU   Care Unit Maint
EI   Edit an ID            CD   Change Display       EX   Exit
Select Action: Next Screen//AI Add an ID
```

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

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

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


Select Provider ID Type: COMMERCIAL        G2

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

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

PROVIDER ID: CMXXXXXX
```

4.6. Care Units

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

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

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

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

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

4.6.1 Define Care Units for Physician/Provider Secondary IDs

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

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

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
           PO   Provider Own IDs
           PI   Provider Insurance IDs

                Insurance IDs
           BI   Batch ID Entry
           II   Insurance Co IDs

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

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

    Select Provider ID Maintenance Option: CP  Care Units for Providers

Select INSURANCE CO:  Blue Cross of California
```

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

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

Insurance Co: BLUE CROSS OF CALIFORNIA

    CARE UNIT NAME                  DESCRIPTION
No CARE UNITs Found for Insurance Co


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

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

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

The following screen will display.

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

Insurance Co: BLUE CROSS OF CALIFORNIA

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




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

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

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

  No ID's found for provider and selected insurance co




          Enter ?? for more actions
AU   Add a Unit                          DU   Delete a Unit
EU   Edit a Unit                         EX   Exit
Select Action: Quit// AU   Add a Unit
CHOOSE 1-2: 2  BLUE SHIELD ID
FORM TYPE APPLIED TO: 0  BOTH UB-04 AND CMS-1500 FORMS
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery       Ambulatory Surgery     BLUE CROSS
 OF CALIFORNIA

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

PROVIDER ID: XXXXBS
```

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

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

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


SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

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

Selection: 1//
```

4.6.2 Define Care Units for Billing Provider Secondary IDs

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

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
           PO   Provider Own IDs
           PI   Provider Insurance IDs

                Insurance IDs
           BI   Batch ID Entry
           II   Insurance Co IDs

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

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

    Select Provider ID Maintenance Option: CB  Care Units for Billing Provider

Select INSURANCE CO: Blue Cross of California
```

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

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

Insurance Co: BLUE CROSS OF CALIFORNIA

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

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

Care Unit combination filed for this Insurance Co.
```

The following screen will display.

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

Insurance Co: BLUE CROSS/BLUE SHIELD

  Care Unit Name                    Description
------------------------------------------------------------------------------
Division: Main Division
  Anesthesia                        Free Text Description
  Reference Lab                     Free Text Description
  Home Health                       Free Text Description

Division: Remote Clinic
  Reference Lab                     Free Text Description


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

4.7. ID Parameters by Insurance Company

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

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

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

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

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


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

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

```
Billing Provider IDs (Parent) May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA    Billing Provider Secondary IDs
     ID Qualifier                ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Electronic Plan Type        XXXXXXXXX        UB-04
2    Electronic Plan Type        XXXXXXXX1X       1500




          Enter ?? for more actions
    Add an ID            Additional IDs              Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Edit// ID Parameters
```

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

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

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

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

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

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

Select Action: Next Screen// Edit Params
```

The following will display.

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

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

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

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

4.7.1 Define Attending/Rendering Provider Secondary ID Parameters

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

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

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

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

4.7.2 Define Referring Provider Secondary ID Parameters

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

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

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

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

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

4.7.3 Define Billing Provider Secondary ID Parameters

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

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

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

4.7.4 Define Billing Provider/Service Facility Parameters

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

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

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

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

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

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

4.7.5 Define VA Service Facility Parameters

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

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

4.7.6 Define No Billing Provider Secondary IDs by Plan Type

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

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

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

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

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



          Enter ?? for more actions
    Add Plan      Delete Plan       Exit

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

The following screen will display.

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

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

          Enter ?? for more actions
    Add Plan      Delete Plan       Exit

Select Action: Add Plan
```

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

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

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

```
Insurance Company Editor      Nov 22, 2005@10:26:11          Page:    5 of    7
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: BLUE CROSS                      Currently Active
+
           Associated Insurance Companies
  This insurance company is defined as a Parent Insurance Company.
  There are 4 Child Insurance Companies associated with it.
  Select the "AC  Associate Companies" action to enter/edit the children.

                   Provider IDs
Billing Provider Secondary ID
 Main Division and Default for All Divisions/1500:
 Main Division and Default for All Divisions/UB-04:
    Main Division Care Units:
    Anesthesia/1500:
    Reference Lab/1500:
    Reference Lab/UB-04:
    Home Health/UB-04:
 2nd Division Name/1500:
 2nd Division Name/UB-04:
Additional Billing Provider Secondary IDs
 Main Division and Default for All Divisions/1500:
    1st ID
    2nd ID
    3rd ID
    Maximum of 6 additional IDs
 Main Division and Default for All Divisions/UB-04:
    1st ID
    2nd ID
    3rd ID
    Maximum of 6 additional IDs
VA-Laboratory or Facility Secondary IDs
 Main Division and Default for All Divisions/1500:
    1st ID
    2nd ID
    3rd ID
    Maximum of 5 additional IDs

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

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

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

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

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

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

4.8.1 Designate a Parent Insurance Company

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

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

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


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

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

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

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

     Ins Company Name           Address                   City

     No Children Insurance Companies Found




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

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

The following screen will display.

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

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




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

4.8.2 Designate a Child Insurance Company

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

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

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

```
Insurance Company Editor      Oct 01, 2007@14:33:41          Page:    1 of    8
Insurance Company Information for: AETNA
Type of Company: HEALTH INSURANCE                     Currently Inactive

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


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

Define Insurance Company as Parent or Child: Child  CHILD
Associate with which Parent Insurance Company: AetNA LIFE INSURANCE       3541 W
INCHESTER RD.         ALLENTOWN     PENNSYLVANIA       Y.....................
```

4.8.3 Copy Physician/Provider Secondary IDs

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

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

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

4.8.4 Copy Additional Billing Provider Secondary IDs

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

4.8.5 Synchronizing Associated Insurance Company IDs

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

5. Subscriber and Patient ID Set-Up

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

5.1. Subscriber and Patient Insurance Provided IDs

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

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

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

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

5.1.1 Define Subscriber Primary ID

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

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

```
Patient Insurance Management  Sep 24, 2007@10:18:49          Page:    1 of    1
Insurance Management for Patient: IB,PATIENT TWO IXXXX  XX/XX/XXXX

    Insurance Co.    Type of Policy   Group        Holder   Effect.    Expires
1   AETNA US HEALTH  COMPREHENSIVE M  655555-19-   SELF     03/06/07
2   BLUE CROSS CA (  PREFERRED PROVI  173084       SPOUSE   05/15/07
3   IB INSURANCE CO  COMPREHENSIVE M  XXXPLANNUM   OTHER    05/16/07
4   NEW YORK LIFE    MEDIGAP (SUPPLE  F            OTHER    09/29/06


          Enter ?? for more actions                                      >>>
AP  Add Policy            EA  Fast Edit All         CP  Change Patient
VP  Policy Edit/View      BU  Benefits Used         WP  Worksheet Print
DP  Delete Policy         VC  Verify Coverage       PC  Print Insurance Cov.
AB  Annual Benefits       RI  Personal Riders       EB  Expand Benefits
RX  RX COB Determination  EX  Exit
Select Item(s): Quit// VP   Policy Edit/View
Select Policy(s):  (1-4): 1...................
```

The following screen will display.

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


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

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


  Utilization Review Info                Effective Dates & Source
          Require UR:                        Effective Date: 03/06/07
+         Enter ?? for more actions
PI  Change Plan Info      GC  Group Plan Comments   CP  Change Policy Plan
UI  UR Info               EM  Employer Info         VC  Verify Coverage
ED  Effective Dates       CV  Add/Edit Coverage     AB  Annual Benefits
SU  Subscriber Update     PT  Pt Policy Comments    BU  Benefits Used
IP  Inactivate Plan       EA  Fast Edit All         EB  Expand Benefits
EX  Exit
Select Action: Next Screen// SU  Subscriber Update
```

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

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

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

SUBSCRIBER PRIMARY ID: IDXXXXX

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

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

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

5.1.2 Define Subscriber and Patient Primary IDs

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

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

```
Patient Insurance Management  Sep 24, 2007@10:18:49          Page:    1 of    1
Insurance Management for Patient: IB,PATIENT TWO I4444  XX/XX/XXXX

    Insurance Co.    Type of Policy   Group        Holder   Effect.    Expires
1   AETNA US HEALTH  COMPREHENSIVE M  655555-19-   SELF     03/06/07
2   BLUE CROSS CA (  PREFERRED PROVI  173084       SPOUSE   05/15/07
3   IB INSURANCE CO  COMPREHENSIVE M  XXXPLANNUM   SPOUSE   05/16/07
4   NEW YORK LIFE    MEDIGAP (SUPPLE  F            OTHER    09/29/06


          Enter ?? for more actions                                      >>>
AP  Add Policy             EA  Fast Edit All          CP  Change Patient
VP  Policy Edit/View       BU  Benefits Used          WP  Worksheet Print
DP  Delete Policy          VC  Verify Coverage        PC  Print Insurance Cov.
AB  Annual Benefits        RI  Personal Riders        EX  Exit
Select Item(s): Quit// VP   Policy Edit/View
Select Policy(s):  (1-4): 3...................
```

The following screen will display.

```
Patient Policy Information    Sep 24, 2007@10:33:49          Page:    2 of    6
For: IB,PATIENT TWO  XXX-XX-XXXX   XX/XX/XXXX       DOD: XX/XX/XXXX
IB INSURANCE CO Insurance Company             ** Plan Currently Active **
+
  Subscriber Information                Subscriber's Employer Information
  Whose Insurance: SPOUSE              Emp Sponsored Plan: No
  Subscriber Name:                               Employer:
     Relationship:                      Employment Status:
       Primary ID:                        Retirement Date:
 Coord.  Benefits:                     Claims to Employer: No, Send to Insurance
 Primary Provider:                                Street:
  Prim Prov Phone:                              City/State:
                                                   Phone:

    Insured Person's Information (use Subscriber Update Action)
       Insured's DOB: XX/XX/XXXX           Str 1: 123 E.TEST BLVD
+         Enter ?? for more actions
PI  Change Plan Info       GC  Group Plan Comments   CP  Change Policy Plan
UI  UR Info                EM  Employer Info         VC  Verify Coverage
ED  Effective Dates        CV  Add/Edit Coverage     AB  Annual Benefits
SU  Subscriber Update      PT  Pt Policy Comments    BU  Benefits Used
IP  Inactivate Plan        EA  Fast Edit All         EB  Expand Benefits
EX  Exit
Select Action: Next Screen// SU  Subscriber Update
```

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

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

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

SUBSCRIBER PRIMARY ID: XXXXXID

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

PATIENT PRIMARY ID: XXXXXID2

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

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

5.1.3 Define Subscriber and Patient Secondary IDs

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

- 23 Client Number

- IG Insurance Policy Number
- SY Social Security Number

```
SUBSCRIBER PRIMARY ID: XXXXXID//

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

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

PATIENT PRIMARY ID: IDXXXXX//

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

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

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

6. Entering Electronic Claims

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

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

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

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

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

6.2. Changes Made by Specific Patches

6.2.1 Patch IB*2*447

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

6.2.1.1 Enter/Edit Billing Information

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

6.2.1.2 MEDIGAP Calculations

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

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

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

6.2.2 Patch IB*2*488:

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

6.2.2.1 Enter/Edit Billing Information

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

6.2.2.2 MRA Management Worklist (MRW)

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

The Following types of errors will be displayed:

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

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

```
View an EOB                    Apr 14, 2014@18:25:55          Page:    4 of    6
                             BILL #:442-K101EVT
 CURRENT INSURANCE COMPANY (PRIMARY): MEDICARE (WNR)
+
VistA could not match all of the Line Level data received in the EEOB
(835 Record 40) to the claim in VistA.

Mismatched Procedure Code:

Payer reported the following was billed via the Claim (837):
    Proc:71010  Mods:59  Rev Cd:324  Chg:227.40  Units:1
Payer reported adjudication via the EOB (835) as follows:
    Proc:71015  Mods:59  Rev Cd:324  Chg:227.40  Units:1
    Amt:100.00

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

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

```
MRA Management WorkList        Nov 25, 2013@14:06:58          Page:    1 of   35

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

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

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

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

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

6.2.2.3 Enhanced CMS-1500 Printed Claim Form

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

6.2.3 Patch IB*2*516

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

6.2.3.1 TRICARE/TRICARE REIMB. Pay-to Providers

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

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

6.2.3.2 NDC Numbers for non-RX Claims

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

- CMS – 1500 – Box 24: Shaded area – Format: N4NDC#<space>UN#of Units – if transmitted, the NDC number is transmitted in Record PRF/Loop 2410
- UB04 – FL80 - Format: N4NDC#<space>UN#of Units – if transmitted the NDC number is transmitted in Record INS/Loop 2410

6.2.4 Patch IB*2*547

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

6.2.4.1 Service Lines with No Print Order

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

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

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

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

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

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

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

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

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

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

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

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

6.2.4.9 ASC X12N 5010 Health Care Claim (837) Transactions
The following changes were made to 837 transactions:

- An inpatient institutional 837 transaction no longer requires a POA for each diagnosis
- An inpatient admission date can no longer be transmitted on outpatient claims
- All Rate Types for which the responsible party is equal to insurer can now be transmitted electronically when appropriate

- Institutional 837 transactions can now transmit up to twenty-five procedure codes
- Institutional 837 transactions can now transmit up to 12 External Cause of Injury codes

6.3. Handling Error Messages and Warnings

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

IB Edit Checks are done before claim authorization.

```
... Executing national IB edits

ERROR/WARNING OUTPUT DEVICE: HOME//   TELNET TERMINAL

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

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

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

6.3.1 Patch IB*2*488

Patch IB*2.0*488 added several new error messages to Enter/Edit Billing Information:

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

6.3.2 Patch IB*2*516

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

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

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

6.3.3 Patch IB*2*547

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

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

6.4. Claim versus Line Level Data

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

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

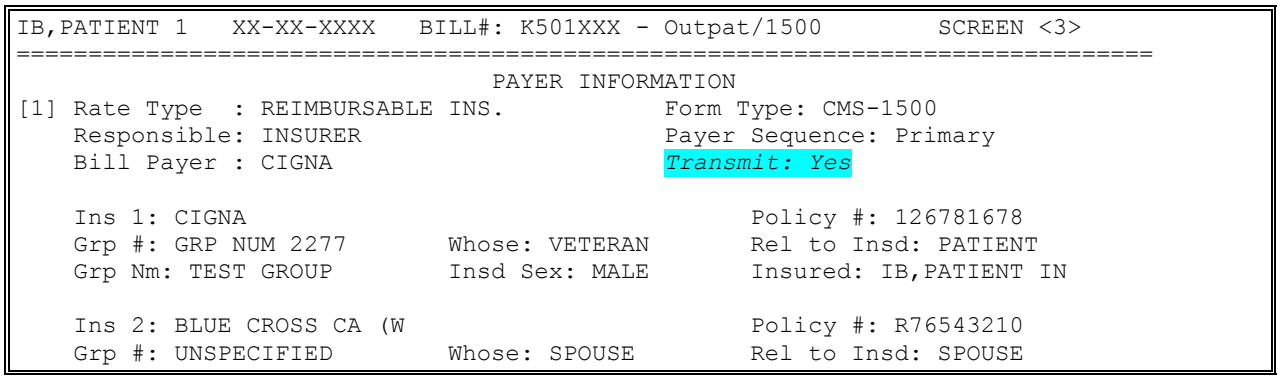
In addition, Institutional claims can have both line-level and/or claim-level Rendering, Referring, and Other Operating Providers. The Attending Provider is still the only provider required on an institutional claim and there is no longer a generic Other Provider.

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

6.5. Screen 3 – Payer Information

6.5.1 EDI Fields

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



```
    Grp Nm: TEST BCBS          Insd Sex: FEMALE      Insured: ib,wife in

                ***  Patient has Insurance Buffer entries  ***

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

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

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

6.5.2 Using Care Units for Billing Provider Secondary IDs

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

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

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

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

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

```
[2] Billing Provider Secondary IDs:
    Primary Payer: 670899
    Secondary Payer: XXXXXXX1X              Tertiary Payer:

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

6.6. Screen 10 – Physician/Provider and Print Information

6.6.1 EDI Fields UB-04/CMS-1500

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

```
IB,PATIENT2   XX-XX-XXXX   BILL#: K300XX - Outpat/UB-04  SCREEN <10>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Bill Remarks
     - FL-80           : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral      : UNSPECIFIED [NOT REQUIRED]
    Admission Source   : UNSPECIFIED
[2] Pt Reason f/Visit : UNSPECIFIED
[3] Providers         :
     - ATTENDING       : UNSPECIFIED
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
```

```
[5] Billing Provider  : CHEYENNE VAMC
    Taxonomy Code     : 282N00000X
[6] Force To Print?   : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)


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

```
IB,PATIENT 3   XX-XX-XXXX   BILL#: K600XX - Outpat/1500        SCREEN <10>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral      : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - RENDERING (MD)  : IB,DOCTOR 1        Taxonomy: UNSPECIFIED
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED [NOT REQUIRED]
    Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data  : UNSPECIFIED [NOT REQUIRED]
[6] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider   : CHEYENNE VAMC
    Taxonomy Code      : 282N00000X
[8] Force To Print?    : NO FORCED PRINT
[9] Provider ID Maint  : (Edit Provider ID information)

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

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

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

6.7. UB-04 Claims

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

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

```
IB,PATIENT3   XX-XX-XXXX   BILL#: K300XX - Outpat/UB-04        SCREEN <3>
```

```
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.          Form Type: UB-04
    Responsible: INSURER                    Payer Sequence: Primary
    Bill Payer : Blue Cross Fep              Transmit: Yes

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

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

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

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

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


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

Step	Procedure
4	If all information has been entered correctly, Screen 7 will be auto-populated (as shown below)

	with the necessary information to send the claim electronically. *Make sure that the Disch Stat field in Section 1 is populated*. Press the **<Enter>** key to move to Screen 8.
	Note: Allowable dollar amounts have been increased to 9999999.99 before users will be forced to split lines.
	*Note: With Patch IB*2*516, new prompts have been added to Screens 4 and 5 to allow users to enter NDCs and Units to non-RX procedures for medications administered in an outpatient setting.*
	*Note: With Patch IB*2*516, new prompts have been added to Screens 4 and 5to allow users to enter 80 character descriptions to CPT/HCPCS procedure codes for services Not Otherwise Classified.*

```
IB,PATIENT3   XX-XX-XXXX   BILL#: K300XX - Outpat/UB-04      SCREEN <7>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type    : 131              Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Charge Type  : INSTITUTIONAL      Disch Stat: DISCHARGED TO HOME OR SELF CAR
    Form Type    : UB-04               Timeframe: ADMIT THRU DISCHARGE
    Bill Classif: OUTPATIENT            Division: CHEYENNE VAMROC
[2] Sensitive?   : UNSPECIFIED                 Assignment: YES
[3] Bill From    : XXX XX, XXXX                    Bill To: XXX XX, XXXX
[4] OP Visits    : XXX XX, XXXX
[5] Rev. Code    : 750-GASTR-INST SVS     45384      $2,137.44  OUTPATIENT VISIT
    Rev. Code    : 324-DX X-RAY/CHEST     71010        $225.53  OUTPATIENT VISIT
    Rev. Code    : 510-CLINIC             99201        $108.92  OUTPATIENT VISIT
    OFFSET       :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL   :   $2,471.89
[6] Rate Sched   : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED

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

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

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


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

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

```
IB,PATIENT F      BILL#: K10001D - Outpat/1500             SCREEN <9>
================================================================================
                              AMBULANCE INFORMATION
[1] Ambulance Transport Data
                                          D/O Location:
    P/U Address1:                         D/O Address1:
    P/U Address2:                         D/O Address2:
    P/U City:                             D/O City:
    P/U State/Zip:                        D/O State/Zip:
     Patient Weight: 195                   Transport Distance: 200
    Transport Reason: Patient was transported to nearest facility for care
                      of symptoms, complaints or both.
    R/T Purpose: Patient fell and sustained possible injuries to neck
    Stretcher Purpose: Patient unable to walk due to possible injuries to
                       neck
[2] Ambulance Certification Data
    Condition Indicator: 01 - Admitted to hospital
                         04 - Moved by stretcher
                         06 - Transported in emergency situation
                         08 - Visible hemorrhaging
                         09 - Medically necessary service

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

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

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


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

```
[8] Provider ID Maint : (Edit Provider ID information)


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

	The Primary ID (NPI) for the Attending, Operating or Other Operating Physician is always transmitted with a claim.
	The Secondary IDs for the Attending, Operating or Other Operating Physician are determined from what the user enters and from entries in Provider ID Maintenance.
	If users have set a default ID type and made it required for the current or other payers, the claim cannot be authorized if the physician does not have an ID of that type defined.
	Note: A fatal error message will prevent users from authorizing an adjustment claim, Type of Bill Frequency Code of 7 or 8, in which the destination payer (primary/secondary/tertiary) individual control number (ICN/DCN) is not present
	*Patch IB*2*547added a field to Screen 10 for alternative payer primary IDs which are used to direct claims to administrative contractors who process specialized claims such as Durable Medical Equipment (DME) claims. Unless an alternative ID is added to the claim by the billing clerk, the regular EDI – Primary Payer ID will be sent with a claim.*

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

The first 2 entries in this list will always be:
1 - NO SECONDARY ID NEEDED
2 - ADD AN ID FOR THIS CLAIM ONLY

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

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

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

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

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

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

Selection: 3//
```

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

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

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

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

	*Note: If the Provider has multiple IDs defined, the one you select or the new one time only ID that you enter, will appear on Screen 10 and will be the first ID sent but the system will still transmit the remaining IDs. The one you select will just be the first one transmitted. The maximum number that will be transmitted is five.*
	*Note: With Patch IB*2*432, IDs for Line Level providers are determined in the same manner as Claim Level Providers.*

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

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

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

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

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

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

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

	Number; Network ID; SSN; State Industrial and Accident Provider

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

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

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


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

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

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

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

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

```
     License(s): WY: 1289340B

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

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

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

```
IB,PATIENT3   XX-XX-XXXX   BILL#: K300XX - Outpat/UB-04  SCREEN <10>
===============================================================================
                        BILLING - SPECIFIC INFORMATION
[1] Bill Remarks
     - FL-80          : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)        : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral     : UNSPECIFIED [NOT REQUIRED]
    Admission Source  : PHYSICIAN REFERRAL
[2] Pt Reason f/Visit : COUGH - 786.2
[3] Providers         :
    - REFERRING (MD) : IB,DOCTOR GP             Taxonomy: 208G00000X (33)
                               [P]VAD000 [S]830168494
    - RENDERING (MD) : IB,DOCTOR CARD           Taxonomy: 207RA0000X (33)
                               [P]VAD000 [S]830168494
    - ATTENDING (MD) : IB,DOCTOR4               Taxonomy: 207XS0106X (40)
                               [P]VAD000 [S]830168494
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
[5] Billing Provider  : CHEYENNE VAMC
    Taxonomy Code     : 282N00000X
[6] Force To Print?   : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)


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

If this bill is transmitted electronically, the following IDs will be sent:
  Primary Ins Co: BLUE CROSS CA (WY)                  <<<Current Ins
Secondary Ins Co: AETNA US HEALTHCARE

Provider IDs: (VistA Records OP1,OP2,OP4,OP8,OP9,OPR2,OPR3,OPR4,OPR5,OPR8):
     ATTENDING: IB,DOCTOR4
        NPI:                            8731245386
        Secondary IDs
        (P) BLUE CROSS                  VAD000
     REFERRING: IB,DOCTOR GP
        NPI:                            8731245394
        (P) BLUE CROSS                  VAD000
     RENDERING: IB,DOCTOR CARD
        NPI:                            1112220029
        (P) BLUE CROSS                  VAD000
Billing Provider Name and ID Information
     Billing Provider:  CHEYENNE VAMC
     Billing Provider NPI:  1164471991
     Billing Provider Tax ID (VistA Record PRV):  830168494
```

```
     Billing Provider Secondary IDs (VistA Record CI1A):
        (P) PROVIDER SITE NUMBER        0000          <<<System Generated ID
        (P) BLUE CROSS                  007484
Service Line Providers
     Service Line: 3
     RENDERING: IB,DOCTOR RAD
        NPI:                            1112220037
        (P) BLUE CROSS                  VAD000
        (P) EIN                         022221111
        (P) STATE LICENSE               1289340B
Press ENTER to continue
```

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

```
WANT TO EDIT SCREENS? NO// <ENTER>
WANT TO AUTHORIZE BILL AT THIS TIME? No// YES
AUTHORIZE BILL GENERATION?: YES
Adding  bill to BILL TRANSMISSION File.

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

This Bill Can Not Be Printed Until Transmit Confirmed

This Outpatient INSTITUTIONAL bill may have corresponding PROFESSIONAL
charges.
```

6.8. CMS-1500 Claims

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

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

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

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

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

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

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

Step	Procedure
3	Specify the correct diagnosis and procedure code(s) that must be on this claim. Press the **<Enter>** key to move to Screen 6.
	*Note: With Patch IB*2*516, users will have the ability to re-sequence diagnosis codes that have been linked to a specific procedure without breaking the link.*
	*Note: With Patch IB*2*516, new prompts have been added to Screens 4 and 5 to allow users to enter NDCs and Units to non-RX procedures for medications administered in an outpatient setting.*
	*Note: With Patch IB*2*516, new prompts have been added to Screens 4 and 5to allow users to enter 80 character descriptions to CPT/HCPCS procedure codes for services Not Otherwise Classified.*

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

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

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

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


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

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

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

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

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

Date Last Seen:

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

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

```
IB,PATIENT MRA   XX-XX-XXXX   BILL#: K20003E - Outpat/1500            SCREEN <9>
================================================================================
                              AMBULANCE INFORMATION
[1] Ambulance Transport Data
                                        D/O Location:
    P/U Address1:                       D/O Address1:
    P/U Address2:                       D/O Address2:
    P/U City:                           D/O City:
    P/U State/Zip:                      D/O State/Zip:
    Patient Weight:                     Transport Distance:
    Transport Reason:
    R/T Purpose:
    Stretcher Purpose:
[2] Ambulance Certification Data
    Condition Indicator: 12 - Confined to a bed or chair
                         01 - Admitted to hospital

<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: 1
P/U Address1:
P/U Address 2:
P/U City:
P/U State:
P/U Zip:
D/O Location:
D/O Address1:
D/O Address2:
D/O City:
D/O State:
D/O Zip:
Patient Weight:
Transport Distance:
Transport Reason:
R/T Purpose:
Stretcher Purpose:

<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: 2
Select Ambulance Condition Indicator: 01// ?
    Answer with AMBULANCE CONDITION INDICATOR
   Choose from:
   12
   01

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

   Answer with AMBULANCE CONDITION INDICATORS CODE
   Choose from:
   12        Confined to a bed or chair
   01        Admitted to hospital
   04        Moved by stretcher
   05        Unconscious or in Shock
   06        Transported in emergency situation
   07        Had to be physically restrained
   08        Visible hemorrhaging
   09        Medically necessary service

Select Ambulance Condition Indicator: 01//
```

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

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

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

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

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

The first 2 entries in this list will always be:
1 - NO SECONDARY ID NEEDED
2 - ADD AN ID FOR THIS CLAIM ONLY

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

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

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

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

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

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

Selection: 3//
```

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


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


Select NON-VA PROVIDER NAME: IB,OUTSIDEDOC       OI

-------------------------------------------------------------------------------
 Signature Name: OUTSIDEDOC IB
            NPI: 1234567892

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

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

Select NON-VA PROVIDER NAME:
```

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

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


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


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

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

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

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

```
Executing A/R edits
No A/R errors found

WANT TO EDIT SCREENS? NO//

THIS BILL WILL BE TRANSMITTED ELECTRONICALLY

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

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

This Bill Can Not Be Printed Until Transmit Confirmed
```

6.9. Lab Claims

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

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

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

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

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

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

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


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

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

```
IB,PATIENT3   XX-XX-XXXX   BILL#: K300XX - Outpat/1500        SCREEN <5>
================================================================================
                          EVENT - OUTPATIENT INFORMATION
[1] Event Date : XX XX,XXXX
[2] Prin. Diag.: URINARY FREQUENCY - 788.41
[3] OP Visits  : XXX XX,XXXX
[4] Cod. Method: HCPCS
    CPT Code   : URINALYSIS, AUTO W/SCOPE 81001         XXX XX,XXXX
    CPT Code   : URINE BACTERIA CULTURE 87088           XXX XX,XXXX
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]

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

Step	Procedure
4	Verify that the Form Type is CMS-1500 and that the date of billing is entered. Make sure the Disch Stat field is populated. If all the data have been entered correctly, section 5 should display the correct revenue codes and costs. Press the **<Enter>** key to move to Screen 8.

```
IB,PATIENT3   XX-XX-XXXX   BILL#: K300XX - Outpat/1500           SCREEN <7>
================================================================================
                        BILLING - GENERAL INFORMATION
[1] Bill Type    : 131              Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Charge Type  : PROFESSIONAL       Disch Stat: DISCHARGED TO HOME OR SELF CAR
    Form Type    : CMS-1500            Timeframe: ADMIT THRU DISCHARGE
    Bill Classif: OUTPATIENT            Division: CHEYENNE VAMROCY VAMC
[2] Sensitive?   : UNSPECIFIED                 Assignment: YES
[3] Bill From    : XXX XX,XXXX                   Bill To: XXX XX,XXXX
[4] OP Visits    : XXX XX,XXXX
[5] Rev. Code    : 306-LAB/BACT-MICRO     87088      $33.20  OUTPATIENT VISIT
    Rev. Code    : 307-GASTR-INST SVS     81001      $12.77  OUTPATIENT VISIT
    OFFSET       :        $0.00   [NO OFFSET RECORDED]
    BILL TOTAL   :    $45.97
[6] Rate Sched   : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED
```

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

Step	Procedure
5	On Screens 8 and 9, enter any necessary Claim level data to the claim and press the ENTER key to move to Screen 10.
	*Note: IB*2*447 moved Screen 8, Section 3 Ambulance Information to a new Screen 9.*

```
IB,PATIENT MRA   XX-XX-XXXX   BILL#: K20003D - Outpat/1500         SCREEN <8>
================================================================================
                           BILLING - CLAIM INFORMATION
[1] COB Non-Covered Charge Amt:
[2] Property Casualty Information
    Claim Number:                          Contact Name:
    Date of 1st Contact:                   Contact Phone:
[3] Surgical Codes for Anesthesia Claims
    Primary Code:                          Secondary Code:
[4] Paperwork Attachment Information
    Report Type:                           Transmission Method:
    Attachment Control #:
[5] Disability Start Date:                 Disability End Date:
[6] Assumed Care Date:                     Relinquished Care Date:
[7] Special Program:
[8] Homebound:
[9] Date Last Seen:

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

	*Note: IB*2*488 moved the following Screen 10 fields to Screen 8: Special Program; Date Last Seen; Homebound. These fields no longer print in Box 19.*

```
IB,PATIENT MRA   XX-XX-XXXX   BILL#: K20003E - Outpat/1500         SCREEN <9>
================================================================================
                              AMBULANCE INFORMATION
[1] Ambulance Transport Data
                                           D/O Location:
    P/U Address1:                          D/O Address1:
    P/U Address2:                          D/O Address2:
    P/U City:                              D/O City:
    P/U State/Zip:                         D/O State/Zip:
    Patient Weight:                        Transport Distance:
    Transport Reason:
    R/T Purpose:
    Stretcher Purpose:
[2] Ambulance Certification Data
    Condition Indicator: 12 - Confined to a bed or chair
                         01 - Admitted to hospital

<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: 1
P/U Address1:
P/U Address 2:
P/U City:
P/U State:
P/U Zip:
D/O Location:
D/O Address1:
D/O Address2:
D/O City:
D/O State:
```

```
D/O Zip:
Patient Weight:
Transport Distance:
Transport Reason:
R/T Purpose:
Stretcher Purpose:

<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: 2
Select Ambulance Condition Indicator: 01// ?
    Answer with AMBULANCE CONDITION INDICATOR
   Choose from:
   12
   01

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

    Answer with AMBULANCE CONDITION INDICATORS CODE
   Choose from:
   12        Confined to a bed or chair
   01        Admitted to hospital
   04        Moved by stretcher
   05        Unconscious or in Shock
   06        Transported in emergency situation
   07        Had to be physically restrained
   08        Visible hemorrhaging
   09        Medically necessary service

Select Ambulance Condition Indicator: 01//
```

Step	Procedure
6	From Screen 10, enter 3 to add a **Rendering** and **Referring** and **Supervising** provider, if necessary.
7	To edit, select Section 5 and enter the **CLIA** # if required by the payer.
	*After Patch IB*2.0*320, the billing software will automatically populate the CLIA# for the division on the claim when the claim is for the Service Type = 5 (Diagnostic Laboratory) if the CLIA# exists in the VistA Institution file. Users may override this value for the current claim only.*
	*For outside laboratory services, the billing software will automatically populate the CLIA# if there is a Laboratory or Facility secondary ID defined for the outside facility with a ID Qualifier of X4 (CLIA #).*
	*There will be a Error Message for laboratory claims to Medicare when there is no CLIA# on the claim and a Warning Message for laboratory claims to other payers when there is no CLIA# on the claim.*

```
IB,PATIENT3   XX-XX-XXXX   BILL#: K300XXX - Outpat/1500    SCREEN <10>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[[1] Bill Remarks
     - FL-80          : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)        : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral     : UNSPECIFIED [NOT REQUIRED]
    Admission Source  : PHYSICIAN REFERRAL
[3] Providers          :
     - REFERRING (MD)   : IB,DOCTOR5     Taxonomy: XXXXXXXXXX (XX)
                                    [P]XX0000
```

```
     - RENDERING (MD)   : IB,DOCTOR4      Taxonomy: XXXXXXXXXX (XX)
                                    [P]XXX123
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #           : DXXXX000
    Mammography Cert #   : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data    : UNSPECIFIED [NOT REQUIRED]
[6] CMS-1500 Box 19      : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider     : CHEYENNE VAMC
    Taxonomy Code        : 282N00000X
[8] Alt Prim Payer ID    : UNSPECIFIED [NOT REQUIRED]
[9] Force To Print?      : NO FORCED PRINT
[10] Provider ID Maint   : (Edit Provider ID information)

<RET> to CONTINUE, 1-10 to EDIT, '^N' for screen N, or '^' to QUIT: 6
CMS-1500 Box 19: ??
      This is an 71 character free-text field that will print in Box 19
      of the CMS-1500.  Use this field to enter additional Payer required
      IDs in the format of Qualifier<no space>ID number<3 spaces>
      Qualifier<no space>ID number.
CMS-1500 Box 19: ??
DISPLAY THE FULL CMS-1500 BOX 19?: NO//
```

	*Note: Patch IB*2*488 changed the prompt Form Locator 19 to CMS-1500 Box 19 and updated the Help text.*
	Note: There is a new field in Section 4 for the Mammography Certification Number where users can enter a certification number on claims for mammography exams. The known Mammography Certification Numbers will be stored in the Institution file, one per site.
	*Patch IB*2*547 added a field to Screen 10 for alternative payer primary IDs which are used to direct claims to administrative contractors who process specialized claims such as Durable Medical Equipment (DME) claims.*

6.10. Pharmacy Claims

1500 pharmacy claims can be submitted electronically to the clearinghouse where they will be printed and mailed. If a pharmacy claim is entered on a UB04, it must be printed locally.

The following screens give a simplified example of a pharmacy claim.

Step	Procedure
1	When processing a Pharmacy claim, information on Screens 1 and 2 should be reviewed for correctness. Press the <**Enter**> key to move from one screen to the next.
2	On Screen 3, the payer information should be reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press the <**Enter**> key to continue to Screen 5.
	For Pharmacy claims, change the form type to a CMS-1500.
	*Note: With Patch IB*2*516, users will have the ability to add a one-time HPID, per payer, to a claim if the HPID in the Insurance Company file is not the correct one. The HPID will **not** be stored in the Insurance Company file. It will only apply to the claim.*

```
IB,PATIENT5    XX-XX-XXXX   BILL#: K303XXX - Outpat/1500            SCREEN <3>
================================================================================
                                PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.          Form Type: CMS-1500
    Responsible: INSURER                    Payer Sequence: Primary
```

```
    Bill Payer : CIGNA                          Transmit: Yes

    Ins 1: CIGNA                                    Policy #: 126781678
    Grp #: GRP NUM 2277       Whose: VETERAN        Rel to Insd: PATIENT
    Grp Nm: CHALKER           Insd Sex: MALE        Insured: IB,PATIENT5

    Ins 2: BLUE CROSS CA (W                         Policy #: R76543210
    Grp #: GRP NUM 10891      Whose: SPOUSE         Rel to Insd: SPOUSE
    Grp Nm: HARTLY            Insd Sex: FEMALE      Insured: IB,WIFE5
[2] Billing Provider Secondary IDs: UNSPECIFIED [NOT REQUIRED]

[3] Mailing Address :
    NO MAILING ADDRESS HAS BEEN SPECIFIED!   (Patient has Medicare)
    Send Bill to PAYER listed above.

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

Step	Procedure
3	The highlighted fields are auto-populated. Remember that this is a professional bill that is being transmitting as a CMS-1500, so each HCPCS code will have to be associated with a diagnosis code. To begin this process, type **4** to edit the **Cod. Method** field and press the **<Enter>** key.
	*Note: With Patch IB*2*432, when adding a refill to a claim, users will be able to view the date a prescription was order along with the other data.*

```
ADD/EDIT RX FILL 2054788 FOR Oct 26, 2010 CORRECT? YES//
Date RX Ordered:  Oct 26, 2010
RX #: 2054788//
DATE: OCT 26,2010//
DRUG: HYDROCHLOROTHIAZIDE 25MG TAB//
DAYS SUPPLY: 30//
QTY: 15//
NDC #: 00172-2083-80//
FORMAT OF NDC#: 5-4-2 FORMAT//
```

```
IB,PATIENT5    XX-XX-XXXX   BILL#: K303XXX - Outpat/1500          SCREEN <5>
================================================================================
                          EVENT - OUTPATIENT INFORMATION
<1> Event Date : XXX XX,XXXX
[2] Prin. Diag.: ISSUE REPEAT PRESCRIPT - V68.1
[3] OP Visits  : UNSPECIFIED
[4] Cod. Method: HCPCS
    CPT Code   : Oral prescrip drug non chemo J8499       V68.1    XXX XX,XXXX
[5] Rx. Refills: HYDROCHLOROTHIAZIDE 25MG TAB                  XXX XX,XXXX
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
<9> Value Code : UNSPECIFIED [NOT REQUIRED]

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

Step	Procedure
4	At the **Select Procedure Date** field, re-type the date.
5	At the **Select Procedure** field, type the appropriate code. Once the code auto-populates the data, type **YES** to confirm.
6	At the **Provider** field, type the name of the physician. Information related to that provider will auto-populate.

7	Type the appropriate data related to the **Place of Service** and the **Type of Service**.
8	Press the **<Enter>** key until Screen 5 appears.

```
<<CURRENT PROCEDURAL TERMINOLOGY CODES>>

LISTING FROM VISIT DATES WITH ASSOCIATED CPT CODES
IN OUTPT ENCOUNTERS FILE

================================================================================
NO.  CODE    SHORT NAME                CLINIC           DATE
================================================================================

NO CPT CODES ON FILE FOR THE VISIT DATES ON THIS BILL


PROCEDURE CODING METHOD: HCPCS (1500 COMMON PROCEDURE CODING SYSTEM)
         //
Select PROCEDURE DATE (X/XX/XX-XX/XX/XX): XX-XX-XX
* Patient has no Visits for this date...

   Select PROCEDURE: J
 Searching for a CPT,(pointed-to by PROCEDURES)
  J8499     Oral prescrip drug non chemo
        ...OK? Yes// Yes  Oral prescrip drug non chem  Rx: 0000000D
PROCEDURES: J8499//
Select CPT MODIFIER SEQUENCE:
PROVIDER: IB,DOCTOR6//
ASSOCIATED CLINIC: CARDIAC CONSULT
DIVISION: MONTGOMERY VAMC//        619
PLACE OF SERVICE: 22       OUTPATIENT HOSPITAL
TYPE OF SERVICE: 1       MEDICAL CARE
EMERGENCY PROCEDURE?: NO//   NO
PRINT ORDER:
```

Step	Procedure
9	Notice the association has been made between the diagnosis code and the required procedure code. Press the **<Enter>** key to move to Screen 7.

```
IB,PATIENT5    XX-XX-XXXX   BILL#: K303XX - Outpat/1500          SCREEN <5>
================================================================================
                          EVENT - OUTPATIENT INFORMATION
<1> Event Date : XXX XX,XXXX
[2] Prin. Diag.: ISSUE REPEAT PRESCRIPT - V68.1
[3] OP Visits  : XXX XX,XXXX
[4] Cod. Method: HCPCS
    CPT Code   : Oral prescrip drug non chemo   J8499  V68.1   XXX XX,XXXX
[5] Rx. Refills: RANITIDINE HCL 150MG (ZANTAC) TAB             XXX XX,XXXX
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
<9> Value Code : UNSPECIFIED [NOT REQUIRED]

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

Step	Procedure
10	If all the data have been entered correctly, section 5 should display the correct revenue code and charges.. Press the **<Enter>** key to move to Screen 8.

```
IB,PATIENT5    XX-XX-XXXX   BILL#: K303XX - Outpat/1500            SCREEN <7>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 131              Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: UNSPECIFIED      Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED         Timeframe: ADMIT THRU DISCHARGE
    Charge Type : UNSPECIFIED        Disch Stat:
    Form Type   : CMS-1500             Division: MONTGOMERY VAMC
[2] Sensitive?  : UNSPECIFIED                   Assignment: YES
[3] Bill From   : XXX XX,XXXX                     Bill To: XXX XX,XXXX
[4] OP Visits   : UNSPECIFIED
[5] Rev. Code   : 253-WARFARIN SODIUM 5  J8499  1      $36.00  PRESCRIPTION
          OFFSET: $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :      $36.00
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED
```

Step	Procedure
11	On Screens 8 and 9, enter any necessary claim-level data to the claim and press the **<Enter>** key to move to Screen 10.
	Note: IB*2*447 moved Screen 8, Section 3 Ambulance Information to a new Screen 9.

```
IB,PATIENT MRA   XX-XX-XXXX   BILL#: K20003D - Outpat/1500            SCREEN <8>
================================================================================
                          BILLING - CLAIM INFORMATION
<1> COB Non-Covered Charge Amt:
<2> Property Casualty Information
    Claim Number:                        Contact Name:
    Date of 1st Contact:                 Contact Phone:
<3> Surgical Codes for Anesthesia Claims
    Primary Code:                        Secondary Code:
<4> Paperwork Attachment Information
    Report Type:                         Transmission Method:
    Attachment Control #:
<5> Disability Start Date:               Disability End Date:
<6> Assumed Care Date:                   Relinquished Care Date:
```

```
[7] Special Program:
[8] Homebound:
[9] Date Last Seen:

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

```
IB,PATIENTM M   XXX-XX-XXXX   BILL#: K101ES8 - Outpat/UB04            SCREEN <9>
================================================================================
                              AMBULANCE INFORMATION
<1> Ambulance Transport Data
                                        D/O Location:
    P/U Address1:                       D/O Address1:
    P/U Address2:                       D/O Address2:
    P/U City:                           D/O City:
    P/U State/Zip:                      D/O State/Zip:
    Patient Weight:                     Transport Distance:
    Transport Reason:
    R/T Purpose:
    Stretcher Purpose:
<2> Ambulance Certification Data
    Condition Indicator:


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

Step	Procedure
12	From Screen 10, enter **3** to add a **Rendering** provider.
	*Patch IB*2*547 added a field to Screen 10 for alternative payer primary IDs which are used to direct claims to administrative contractors who process specialized claims such as Durable Medical Equipment (DME) claims.*

```
IB,PATIENT5   XX-XX-XXXX   BILL#: K303XXX - Outpat/1500            SCREEN <10>
================================================================================
         BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Auth/Referral      : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - RENDERING       : UNSPECIFIED
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED [NOT REQUIRED]
    Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data  : UNSPECIFIED [NOT REQUIRED]
[6] CMS-1500 Box 19    : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider   : CHEYENNE VAMC
    Taxonomy Code      : 282N00000X
[8] Alt Prim Payer ID  : UNSPECIFED [NOT REQUIRED]
[9] Force To Print?    : NO FORCED PRINT
[10] Provider ID Maint  : (Edit Provider ID information)
```

<RET> to CONTINUE, 1-10 to EDIT, '^N' for screen N, or '^' to QUIT:
This claim is now ready for authorization.

6.11. Correct Rejected or Denied Claims

A claim can be rejected at some stage during either the electronic or manual process. A claim can be denied by the payer during the adjudication process. When a claim is either rejected or denied, it may be for a reason that can be corrected. Once the claim is corrected, it can be retransmitted or resent through the mail to the payer.

With Patch IB*2*433, a new option has been added to the IB Module that allows users to correct a claim while maintaining the original claim number on the resubmitted claim.
With Patch IB*2*447, users are able to correct all types of claims including a claim that processes to a non-accruing funds. It is now possible to correct a claim with one of the following rate types:

- INTERAGENCY
- SHARING AGREEMENT
- TRICARE
- WORKMAN'S COMP

Step	Procedure
1	Access the option **Third Party Billing Menu.**
2	At the **Select Third Party Billing Menu Option:** prompt, enter **CRD** for Correct Rejected/Denied Bill.
3	At the **Enter BILL NUMBER or Patient NAME:** prompt, enter the **claim number** of the claim that requires correction.
4	At the **ARE YOU SURE YOU WANT TO CANCEL THIS BILL? No//** prompt, enter **Yes** to override the default.
5	At the **CANCEL BILL?:** prompt, enter **YES**.
6	At the **REASON CANCELLED:** prompt, enter a **free-text comment**.
	*Note: This new option was designed to replace the existing option **CLON Copy and Cancel** under the majority of circumstances. The existing **CLON Copy and Cancel** option will now be locked with a new **Security Key** named **IB CLON.***
	*Note: The existing **CLON Copy and Cancel** option should only be used to correct denied claims against which a payment has been posted or to correct a claim with one of the Bill Rate Types that are excluded from the new processes..*
	*Note: The existing **CLON Copy and Cancel** option should be used to correct denied claims against which a payment has been posted, a secondary/tertiary claim or a claim in MRA Request status.*
	*Note: The IB CLON security key which restricted the use of the CLON option , was removed with Patch IB*2*516.*

The following screen will display.

```
IB,PATIENT4    (XX-XX-XXXX)                                        DOB: XXX XX,XXXX
================================================================================
Rate Type      :  REIMBURSABLE INS.
Event Date     :  XXX XX XXXX
Sensitive      :  NO
Responsible    :  INSURANCE CARRIER   (Specify CARRIER on SCREEN 3)

Loc of Care    :  HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
Event Source   :  Outpatient
Timeframe      :  ADMIT THRU DISCHARGE
                  (Specify actual bill type fields on SCREENs 6/7)
```

```
Bill From      :  XXX XX,XXXX
Bill To        :  XXX XX,XXXX

Initial Bill# :  K701XXX-01
Copied Bill#  :  K701XXX-01

Please verify the above information for the bill you just entered.  Once this
information is accepted it will no longer be editable and you will be required
to CANCEL THE BILL if changes to this information are necessary.

IS THE ABOVE INFORMATION CORRECT AS SHOWN? Yes//
```

Step	Procedure
7	Return through the claim screens correcting whatever data requires correction.
8	Complete and authorize the claim.
	*Note: The number of the original claim has been incremented and now displays with a -01 after the claim number. The original claim number has been assigned to the new claim. Each time a claim is corrected, the previous cancelled version will be incremented -01, -02, -03, etc..*

When users attempt to use the **CRD Correct Rejected/Denied Bill** option to correct a claim against which a payment has been posted, they will be warned that they must use the existing **CLON Copy and Cancel** option.

```
  Select Third Party Billing Menu Option: CRD  Correct Rejected/Denied Bill

Enter BILL NUMBER or Patient NAME:    K600XXX     IB,PATIENT1     XX-XX-XX
    Outpatient     REIMBURSABLE INS.     PRNT/TX

Please note a PAYMENT of **$45** has been POSTED to this bill. Copy and cancel
(CLON) must be used to correct this bill.
```

When users attempt to use the **CRD Correct Rejected/Denied Bill** option to correct a denied claim which has received only one of its associated split Explanation of Benefits (EOB), they will be warned that they must wait for the arrival of the second EOB before they can use this new option.

```
Select Third Party Billing Menu Option: CRD  Correct Rejected/Denied Bill

Enter BILL NUMBER or Patient NAME:    K600XXX     IB,PATIENT1     XX-XX-XX
    Outpatient     REIMBURSABLE INS.     PRNT/TX

There is a split EOB associated with this claim.  You cannot use this option to
Correct this claim until the second EOB has been received.
```

When users attempt to use the **CRD Correct Rejected/Denied Bill** option to correct a rejected or denied claim which has an excluded Billing Rate Type, they will be warned that they must use the existing **CLON Copy and Cancel** option.

```
Select Third Party Billing Menu Option: CRD  Correct Rejected/Denied Bill

Enter BILL NUMBER or Patient NAME:    K600XXX     IB,PATIENT1     XX-XX-XX
    Outpatient     REIMBURSABLE INS.     PRNT/TX

This option cannot be used to correct some Billing Rate Types (Example: TRICARE).
Use Copy and Cancel (CLON) to correct this bill.
```

When users attempt to use the **CRD Correct Rejected/Denied Bill** option to correct a rejected or denied secondary or tertiary claim, they will be notified that they must use the existing **CLON Copy and Cancel** option.

```
Please note that COB data exists for this bill.
Copy and cancel (CLON) must be used to correct this bill.
```

When users attempt to use the CRD Correct Rejected/Denied Bill option to correct a claim with a status of MRA Request, they will receive the following message.

```
This bill is in a status of REQUEST MRA.
    No MRAs have been received and there are no rejection messages on file
    for the most recent transmission of this MRA request bill.
```

*Note: The new **CRD Correct Rejected/Denied Bill** option has been added to the **CSA Claims Status Awaiting Resolution** option and the **MRW MRA Worklist** option as **Correct Bill**.*

The history of corrected claims will be available from the following locations:

- BILL - Enter/Edit Billing Information
- INQ – Patient Billing Inquiry

6.12. Viewed Cancelled Claims

If a claim has been cancelled, users can view the data stored in the Bill/Claims file (#399) for the cancelled claim.

The View Cancelled Bill option is on the Third Party Billing Menu.

```
   ADPR    Print Bill Addendum Sheet
   AUTH    Authorize Bill Generation
   BILL    Enter/Edit Billing Information
   CANC    Cancel Bill
   CLA     Multiple CLAIMSMANAGER Claim Send
   CLON    Copy and Cancel
   CRD     Correct Rejected/Denied Bill
   DLST    Delete Auto Biller Results
   GEN     Print Bill
   INQU    Patient Billing Inquiry
   LIST    Print Auto Biller Results
   PRNT    Print Authorized Bills
   RETN    Return Bill Menu ...
   VCB     View Cancelled Bill
   VIEW    View Bills Pending Transmission
   VIST    Outpatient Visit Date Inquiry

Select Third Party Billing Menu <TEST ACCOUNT> Option:
```

6.13. Printed Claims

Some claims should not be transmitted electronically and should be printed locally.

These include:

- Claims requiring clinical attachments such as progress notes;

- Professional claims containing more than the maximum number of 8 diagnosis codes;
- Professional claims containing more than the maximum number of diagnosis pointers (4);
- Institutional claims containing more than the maximum number of procedure codes (999);
- Professional claims containing more than the maximum number of procedure codes/line items (50);
- Institutional pharmacy claims; and
- Secondary claims to Medicare WNR (When Medicare WNR is NOT the primary insurance).

6.14. View/Resubmit Claims – Live or Test – Synonym: RCB

A new option, **View/Resubmit Claims – Live or Test**, has been added to the EDI menu. This option replaces: **Resubmit a Bill**; **Resubmit a Batch of Bills** and **View/Resubmit Claims as Test**. This option provides the ability to resubmit claims as test claims for testing or production claims for payment.

Patch IB*2*547 will add the ability to run the RCB option to find previously printed claims and to resubmit them to the test queue *only*. They cannot be retransmitted to the production queue. The patch will also provide the ability to look-up claims to specific payers using the EDI - Inst Payer Primary ID or EDI - Prof Payer Primary ID.

Step	Procedure
1	At the **Select EDI Menu For Electronic Bills Option**, type **RCB** and press the **Return** key.
2	At **the Run report for (P)rinted or (T)ransmitted claims?: Transmitted//** prompt, press the **Enter** key to accept the default
3	At the **SELECT BY: (C)LAIM, (B)ATCH OR SEE A (L)IST TO PICK FROM:** prompt, press the Enter key to accept the default of **List**.
4	At the **Run for (A)ll payers or (S)elected Payers?** prompt, type S for Selected Payers.
	*If you choose Selected payers, after you enter Blue Cross of CA, for example, you will be prompted to included all insurance companies with the same Electronic Billing ID. This will prevent you from having to enter every BC/BS company defined in your Insurance file.*
5	At the **Select Insurance Company:** prompt, enter an **EDI Payer Primary ID**
6	At the **Select Insurance Company** prompt, press the **Enter** key when done selecting payers
7	At the **Run for (U)B-04, (C)MS-1500 or (B)OTH:** prompt, press the **Enter** key to accept the default of Both.
	*The Date Range for the search for claims has been restricted to a **maximum of 90 days** to minimize the impact of the search on the system.*
8	At the **Start with Date Last Transmitted:** prompt, type **T-200** for this example.
9	At the **Go to Date Last Transmitted:** prompt, press the **Enter** key to accept the default of 12/1/04. This will return results for 90 days.
10	At the **Select Additional Limiting Criteria (optional):** prompt, press the **Enter** key without selecting anything additional.

```
Select EDI Menu For Electronic Bills Option: RCB  View/Resubmit Claims-Live or Test

*** NOTE: 2 '^' ARE NEEDED TO ABORT THE OPTION (^^)
          1 '^' BRINGS YOU BACK TO THE PREVIOUS SELECTION PROMPT(^)


Run report for (P)rinted or (T)ransmitted claims?: Transmitted//Transmitted

Select By: (C)laim or see a (L)ist to pick from?: List//

PAYER SELECTION:
Run for (A)ll Payers or (S)elected Payers?: Selected Payers//Selected Payers
```

```
   Include all payers with the same electronic Payer ID? Yes//   YES

   Select Insurance Company: 60054
     1   60054  AETNA HEALTH PLANS4501 N STERLING  PEORIA,IL          60054/60054
     2   60054  AETNA HEALTH PLANS620 ERIE BLVD WEST  SYRACUSE,NY     60054/60054
     3   60054  AETNA HEALTH PLANSPO BOX 16516   COLUMBUS,OH          60054/60054
     4   60054  AETNA HEALTH PLANS3541 WINCHESTER ROAD  ALLENTOWN,PA  60054/6005
4
     5   60054  AETNA HEALTH PLANSPO BOX 112     PORTLAND,OR          60054/60054
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  AETNA HEALTH PLANS4501 N STERLING  PEORIA,IL          60054/60054

   Select Another Insurance Company:

BILL FORM TYPE SELECTION:
Run for (U)B-04, (C)MS-1500 or (B)oth: Both// Both

LAST BATCH TRANSMIT DATE RANGE SELECTION:
Start with Date Last Transmitted: T-200  (XXX XX, XXXX)
Go to Date Last Transmitted:(T-200 - T-110): T-110//   (XXX XX, XXXX)

ADDITIONAL SELECTION CRITERIA:

1 - MRA Secondary Only
2 - Primary Claims Only
3 - Secondary Claims Only
4 - Claims Sent to Print at Clearinghouse Only
```

Step	Procedure
11	At the **Would you like to include cancelled claims? No//**: prompt, enter **No**.
12	At the **Would you like to include claims Forced to Print at the Clearinghouse? No//** prompt, enter **No**.
13	At the **Sort By** prompt, enter **B** to override the default of Current Payer.
	Sort by Batch if you want to resubmit batches of claims or Current Payer if you want to resubmit a variety of individual claims.
14	At the **DO YOU WANT A (R)EPORT OR A (S)CREEN LIST FORMAT?:** prompt, press the **<Enter>** key to accept the default of Screen List.

```
Would you like to include cancelled claims? No//   NO

Would you like to include claims Forced to Print at the Clearinghouse? No//   NO

Sort By: Current Payer// ??

Enter a code from the list.

     Select one of the following:

          1         Batch By Last Transmitted Date (Claims within a Batch)
          2         Current Payer (Insurance Company)

Sort By: Current Payer// Batch By Last Transmitted Date (Claims within a Batch)Do you
want a (R)eport or a (S)creen List format?: Screen List//
```

The following screen is displayed:

```
PREVIOUSLY TRANSMITTED CLAIMS Mar 21, 2005@15:52:10          Page:    1 of 1215
** A claim may appear multiple times if transmitted more than once. **
** T = Test Claim ** R = Batch Rejected
>>># of Claims Selected: 0 (marked with *)


    Claim #     Form  Type   Seq  Status           Current Payer
    Batch: 6050011182  Date Last Transmitted: Nov 30, 2004
1   K500XXX     UB-04  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
    Batch: 6050011183  Date Last Transmitted: Nov 30, 2004
2   K500XXX     UB-04  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
    Batch: 6050011184  Date Last Transmitted: Nov 30, 2004
3   K500XXX     1500  OUTPT    P  PRNT/TX           AETNA
    Batch: 6050011185  Date Last Transmitted: Nov 3 0, 2004
4   K500XXX     1500  OUTPT    S  PRNT/TX           AETNA    Batch: 6050011186  Date
Last Transmitted: Nov 30, 2004
5   K500XXX     UB-04  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
    Batch: 6050011187  Date Last Transmitted: Nov 30, 2004
6   K500XXX     1500  OUTPT    P  PRNT/TX           AETNA US HEALTHCARE
+         Enter ?? for more actions                                        >>>
  Claim(s) Select/De select             View Claims Selected
  Batch Select/De select                Print Report
  Resubmit Claims                       Exit
Action: Next Screen//
```

Step	Procedure
15	At the **Action** prompt, type **B** to select batches of claims to resubmit as test or '**C**' to select claims.
16	At the **Select EDI Transmission Batch Number:** prompt, enter the number of the desired batch.
	*You may repeat the above, entering as many batch numbers as you want.*

```
PREVIOUSLY TRANSMITTED CLAIMS Mar 21, 2005@16:07:38          Page:    1 of 1215
** A claim may appear multiple times if transmitted more than once. **
>>># of Claims Selected: 1 (marked with *)


    Claim #     Form  Type   Seq  Status           Current Payer
    Batch: 6050011182  Date Last Transmitted: Nov 30, 2004
1  *K500YRJ     UB-04  OUTPT    P  PRNT/TX          UNITED HEALTHCARE
    Batch: 6050011183  Date Last Transmitted: Nov 30, 2004
2   K50092T     UB-04  OUTPT    P  REQUEST MRA      MEDICARE (WNR)
    Batch: 6050011184  Date Last Transmitted: Nov 30, 2004
3   K500YSF     1500  OUTPT    P  PRNT/TX           UNITED HEALTHCARE
    Batch: 6050011185  Date Last Transmitted: Nov 30, 2004
4   K500YSZ     1500  OUTPT    S  PRNT/TX           SOUTHWEST ADMINISTRATORS
    Batch: 6050011186  Date Last Transmitted: Nov 30, 2004
5   K500YUD     UB-04  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
    Batch: 6050011187  Date Last Transmitted: Nov 30, 2004
6   K500YUE     1500  OUTPT    P  PRNT/TX           AETNA US HEALTHCARE
+         Enter ?? for more actions                                        >>>
  Claim(s) Select/De select             View Claims Selected
  Batch Select/Deselect                 Print Report
  Resubmit Claims as TEST               Exit
Action: Next Screen//  b   Batch Select/De select
Select EDI TRANSMISSION BATCH NUMBER: 6050011183
```

Step	Procedure
17	When you have entered all of the batches you want, at the **ACTION** prompt, type '**R**' for **Resubmit Claims**.
18	At the **Resubmit Claims:** prompt, press the **<Enter>** key to resubmit the claims for payment.
	*The system will inform you of the number of claims that will be resubmitted and whether or not they are being submitted for payment or testing.*
19	At the **Are You Sure You Want To Continue?:** prompt, type **YES** to override the default.

```
You are about to resubmit 2 claims as Production claims.
Are you sure you want to continue?: NO// y  YES
Resubmission in process...
```

7. Processing of Secondary/Tertiary Claims

With Patch IB*2*432 installed, the procedures for the processing of secondary and tertiary non-MRA claims have changed.

When electronic Explanation of Benefits (EOBs) are received for claims that are NOT Medicare (WNR) claims and the payments are processed in AR, the EOBs will be evaluated and if the data in the EOBs meets certain criteria, the secondary or tertiary claims will either be processed automatically or sent to the new COB Management Worklist for manual processing.

When a claim is processed in AR and its status becomes Collected/Closed, no MailMan message will be generated. Either the subsequent claim will be automatically processed or the claim will appear on the new worklist.

Patch IB*2*447 removed the option, Copy for Secondary/Tertiary Bill [IB COPY SECOND/THIRD]. This option became obsolete with the install of IB*2.0*432 and the introduction of the new CBW (COB Management Work list).

A new, non-human user, IB,AUTHORIZER REG, will be the clerk responsible for the automatic processing of non-MRA secondary and tertiary claims.

In order to be able to either create a subsequent claim, or to send a claim to the new COB Management Worklist for manual processing, the following conditions must be met:

- All Explanation of Benefit (EOBs), 835 Health Care Claim Payment Advice, have been received ; and
- Payment from the previous payer has been posted by AR; and
- The bill status for the previous payer is Collected/Closed.

Electronic Secondary and Tertiary claim will contain the Coordination of Benefits data from the EOBs in the 837 Health Care Claim transmission to FSC.

	*Note: Secondary and Tertiary claims will be created with a new claim number.*
	*Remember: Whether or not a Secondary or Tertiary claim to an electronic payer is transmitted or printed, is determined by the new parameter in the Insurance Company Editor. Refer to Section 2.1.1.1.*

7.1. Criteria for the Automatic Processing of Secondary or Tertiary Claims

When a non-MRA claim has received all associated EOBs and they meet the following criteria, the subsequent claim will be automatically created and either transmitted electronically to the next payer, or printed (along with the associated MRAs/EOBs) and mailed to the next payer:

- EOB contains only Adjustment Group Codes = Contractual Obligation (CO) associated with one of the following Reason Codes: A2; B6; 45; 102; 104; 118; 131; 23; 232; 44; 59; 94; 97; or 10; and
- EOB contains only Adjustment Group Codes = Patient Responsibility (PR) associated with one of the following Reason Codes; 1; 2; or 66; and
- The sum of the deductible, coinsurance and co-payment amounts is greater than $0.00; and

- The EOB status is Processed (The Claim Status Code is either 1, 2, or 3).

7.2. COB Management Worklist

Any non-MRA claim that does not meet the criteria for the automatic creation of a Secondary or Tertiary claim will be placed on the COB Management Worklist.

Step	Procedure
1	Access the **EDI Menu For Electronic Bills** menu.
2	At the **Select EDI Menu For Electronic Bills Option:** prompt, enter **CBW** for COB Management Worklist.
	*Note: Patch IB*2*516 provided the ability for users to run the worklist by one or more divisions.*
3	At the **Select Division: ALL//** prompt; press the <**Enter**> key to accept the default.
4	At the **Select BILLER: ALL//** prompt, press the **<Enter>** key to accept the default.
5	At the **Sort By: BILLER//** prompt, press the **<Enter>** key to accept the default.
6	At the **Do you want to include Denied EOBs for Duplicate Claim/Service? No//** prompt, press the **<Enter>** key to accept the default.
	*Note: A non-MRA claim which receives a DENIED EOB and which is Collected/Closed by AR and which has a subsequent payer, will also be placed on the CBW. This includes claims that have potential patient responsibility such as TRICARE and CHAMPVA.*
	*Note: Patch IB*2*547 provides additional search and sort criteria for this worklist. Users can create a list of just primary claims or just secondary claims or both and they can now sort by primary or secondary insurance company.*
	*Note: Complete CARC/RARC textual descriptions will display from Print or View an EOB from within the COB Management Worklist.*

The following screen will display.

```
COB Management WorkList        JAN 01, 2011@13:41:16          Page:    1 of   20

    Bill #       Svc Date Patient Name        SSN   Pt Resp  Bill Amt  Care/Form
BILLER: IB,CLERK 1
1   442-K401XXX* 12/07/10 IB,PATIENT 27      XXXX      0.00     87.58  OP/1500
      Insurers:  AETNA US HEALTHCARE
    EOB Status:  DENIED, Feb 25, 2004
2   442-K401XXX* 12/07/10 IB,PATIENT 4       XXXX     86.40     72.00  OP/UB-04
      Insurers:  AETNA US HEALTHCARE
    EOB Status:  DENIED, Jun 09, 2004
3   442-K401XXX  12/08/10 IB,PATIENT 33      XXXX      0.00    243.16  OP/UB-04
      Insurers:  AETNA US HEALTHCARE
    EOB Status:  DENIED, Jul 28, 2004
4   442-K401XXX  12/08/10 IB,PATIENT 102     XXXX      0.00     45.61  OP/1500
      Insurers:  AETNA US HEALTHCARE
    EOB Status:  DENIED, Jun 09, 2004
5   442-K402XXX  12/14/10 IB,PATIENT 10      XXXX      0.00     30.74  OP/1500
      Insurers:  AETNA US HEALTHCARE
+         Enter ?? for more actions
PC  Process COB           CB  Cancel Bill           RM  Remove from Worklist
VE  View an EOB           CR  Correct Bill          PE  Print EOB/MRA
EC  Enter/View Comments   CC  Cancel/Clone A Bill   TP  Third Party Joint Inq.
RS  Review Status         VB  View Bill             EX  Exit
Select Action: Next Screen//
```

7.2.1 Data Displayed for Claims on the COB Management Worklist

The following data is displayed on the COB Management Worklist:

- List number
- Claim number
- Asterisk – when claim is under review
- Claim date
- Patient name
- Last 4 numbers of patient's SSN
- Patient Responsibility monetary amount
- Monetary amount on the claim
- Patient status, Inpatient/Outpatient
- Claim form type
- Status of EOB
- Insurance company(s)
- Clerk name – depends on Sort criteria
- Division(s)
- Days since last transmission – depends on Sort criteria
- Date of EOB - depends on Sort criteria

7.2.2 Available COB Management Worklist Actions

The following actions are available to users to help them managed those claims which failed to meet the automatic processing criteria:

- PC Process COB – Process a claim on the list to the next payer on the bill
- VE View an EOB – View the EOB(s) associated with a claim on the list
- EC Enter/View Comments – Enter new comments for a claim on the list or view previously entered comments
- RS Review Status – Change the review status for a claim on the list
- CB Cancel Bill – Cancel a bill that does not need to be resubmitted
- CR Correct Bill – Correct a bill that needs to be resubmitted
- CC Cancel/Clone A Bill – Clon a bill that needs to be resubmitted (locked with IB CLON)
- VB View Bill – View the billing screens
- RM Remove from Worklist – Remove claim from worklist if no need to resubmit
- PE Print EOB/MRA – Print associated MRAs or EOB
- TP Third Party Joint Inq. – Select a claim and go directly to it in TPJI
- EX Exit – Exit the worklist and return to the EDI Menu

	*Note: Remove from Worklist was added so that claims that have been Collected/Closed and place on the worklist can be removed if there is no reason to process it to the next payer (i.e. no Patient Responsibility). These claims should not be cancelled as they have been Collected/Closed in AR.*
	*Remember: It is possible that a tertiary claim on the COB Management Worklist began as an MRA claim. The Print EOB/MRA action will provide users with the option to print both EOBs and MRAs.*

8. Requests for Additional Data to Support Claims

Patch IB*2*547 added a new worklist and a new inbound transaction, the ASC X12N 5010 Health Care Claim Request for Additional Information (277RFAI) to VistA. The 277RFAI transaction is initiated by the payer in response to a claim for health care services when they need additional information in order to adjudicate the claim correctly. A 277RFAI might, for example, request an image, a test result or a Certificate of Medical Necessity. At the time that Patch IB*2*547 is installed, the methods for providing this additional data will be manual. In the future, it will be possible to respond to a 277RFAI with a ASC X12N 5010 Additional Information to Support a Health Care Claim or Encounter (275) transaction.

The RFAI Management Worklist was added to provide a method for displaying and managing these requests for additional documentation to support the adjudication of a claim.

Step	Procedure
1	Access the **EDI Menu For Electronic Bills** menu.
2	At the **Select EDI Menu For Electronic Bills Option:** prompt, enter **RFI** for RFAI Management Worklist
3	At the **Select Authorizing Biller: ALL//** prompt, press the **Enter** key to accept the default
4	At the **Select Primary Sort: LOINC Code//** prompt, press the **Enter** key to accept the default of LOINC

The following screen is displayed:

```
RFAI Management Worklist     Apr 28, 2015@14:25:12          Page:    1 of   16

     Bill #   Payer Name          Patient Name          SSN  Svc Date   Curr Bal
  1  K100XXX  MEDICARE (WNR)      IB,PATIENT 333       XXXX  06/29/09  $43851.78
     55115-0 - Requested imaging studies information Document
  2  K100XXX  MEDICARE (WNR)      IB,PATIENT 22        XXXX  11/05/10   $1226.18
     64286-8 – Deprecated Diagnostic imaging order
  3  K100XXX  UNITEDHEALTHCARE    IB,PATIENT 765       XXXX  11/05/10      $9.65
     55115-0 – Requested imaging studies information Document
  4  K100XXX  MEDICARE (WNR)      IB,PATIENT 22        XXXX  11/05/10   $1226.18
     22034-3 – Path report.total Cancer
+         * Indicates RFAI review in progress
    Select Message            Exit
    ReSort Messages
Select Action: Next Screen//Select Message
Select RFAI Message:  (1-4):1
```

Step	Procedure
5	At the **Select RFAI Message: (1-4) :** prompt, enter **1** to select a message to expand

The following screen is displayed:

```
RFAI Message             Apr 28, 2015@14:43:44          Page:    1 of    2

   Bill #   Payer Name          Patient Name          SSN  Svc Date   Curr Bal
   K100XXX  IB INSURANCE CO     IB,PATIENT 33        XXXX  06/29/09  $43851.78

Information Source
Payer Name: IB INSURANCE COMPANY
Payer Contact 1: FAX Number ← There can be up to 3 contact methods
```

```
Payer Contact #: XXX XXX-XXXX
Payer Contact 2: Telephone
Payer Contact #: XXX XXX-XXXX EXT: XXXXXXX
Payer Response Contact 1: ← There can be up to 3 contact methods
Payer Response Contact #: XXX XXX-XXXX
Payer Response Contact 2: Telephone
Payer Response Contact #: XXX XXX-XXXX EXT: XXXXXXX
Payer Address: PO BOX XYZ New York, New York 10001
Payer Claim Control Number: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Claim Level Status Information
Patient Control #: XXXXXXX ← Claim Number
Date of Service: XX/XX/XX
Medical Records Number: XXXXXXXX
Member Identification Number: XXXXXXXXXX
Type of Service: XXX  ← Institutional Only Type of Bill
Health Care Claim Status Category: ← These 3 can repeat
Additional Information Request Modifier:  ← Show LOINC Code Text not just code
Status Information Effective Date: XX/XX/XX
Response Due Date: XX/XX/XX

Service Line Information/ Service Line Status Information
Line Item Control Number: XXXXXX
Service Line Date:
Revenue Code:
Coding Method: HCPCS
Procedure Code:XXXXXXX
Procedure Modifier: ← There can be up to 4
Procedure Modifier:
Line Item Charge Amount: XXXXXXXXXXXXXXXXXX
Health Care Claim Status Category: ← These 3 can repeat
Additional Information Request Modifier:  ← Show LOINC Code Text not just code
Status Information Effective Date: XX/XX/XX
Response Due Date: XX/XX/XX

+         Enter ?? for more actions
  EC  Enter Comments       TJ Third Party Joint Inq.
  RS  Review Status        EX Exit
  RE  Remove Entry
Select Action: Next Screen// Remove Entry
```

From the RFAI message Screen, users can take the following actions:

- Enter comments – user name and date/time will be automatically captured
- Change the Review Status – the entry with be marked by an asterisk
- Remove an entry from the list once it has been addressed – user name and date/time will be captured along with free text removal comment

Jump to the claim in TPJI – comments from the RFAI Management Worklist will be viewable from within TPJI

9. IB Site Parameters

9.1. Define Printers for Automatically Processed Secondary/Tertiary Claims

New fields were added to the MCCR Site Parameter Display/Edit option so that users can define printers to which to print automatically processed secondary or tertiary claims and their associated EOB/MRAs to payers which cannot support electronic claim transmissions.

Step	Procedure
1	Access the **MCCR System Definition Menu**.
2	At the **Select MCCR System Definition Menu Option:** prompt, enter **Site** for MCCR Site Parameter Display/Edit.
3	At the **Select Action:** prompt, Enter **IB** to access the IB Site Parameters.

```
MCCR Site Parameters          Feb 01, 2011@15:04:47          Page:    1 of    1
Display/Edit MCCR Site Parameters.
Only authorized persons may edit this data.


 IB Site Parameters                          Claims Tracking Parameters
    Facility Definition                         General Parameters
    Mail Groups                                 Tracking Parameters
    Patient Billing                             Random Sampling
    Third Party Billing
    Provider Id
    EDI Transmission

 Third Party Auto Billing Parameters         Insurance Verification
    General Parameters                          General Parameters
    Inpatient Admission                         Batch Extracts Parameters
    Outpatient Visit                            Service Type Codes
    Prescription Refill

          Enter ?? for more actions
IB  Site Parameter        AB  Automated Billing     EX  Exit
CT  Claims Tracking       IV  Ins. Verification
Select Action: Quit// IB Site Parameters
```

The following screen will display.

```
IB Site Parameters            Feb 01, 2011@16:22:02          Page:    1 of    5
Only authorized persons may edit this data.

[1] Copay Background Error Mg: IB ERROR
    Copay Exemption Mailgroup: IB ERROR
    Use Alerts for Exemption : NO

[2] Hold MT Bills w/Ins      : YES            # of Days Charges Held: 90
    Suppress MT Ins Bulletin : NO
    Means Test Mailgroup     : IB MEANS TEST
    Per Diem Start Date      : 11/05/90

[3] Disapproval Mailgroup    : MCCR - BUSINESS OFFICE
    Cancellation Mailgroup   : UB-82 CANCELL
    Cancellation Remark      : BILL CANCELLED IN BUSINESS OFFICE

[4] New Insurance Mailgroup  : IB NEW INSURANCE
    Unbilled Mailgroup       : IB UNBILLED AMOUNTS
    Auto Print Unbilled List : NO

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit
Select Action: Next Screen//
```

Step	Procedure
4	At the **Select Action:** prompt, press the **<Enter>** key to accept the default of Next Screen until Section 7 is displayed.

```
IB Site Parameters            Feb 01, 2011@16:25:43          Page:    2 of    5
Only authorized persons may edit this data.
+
[5] Medical Center     : CHEYENNE VAMC        Default Division   : CHEYENNE VAMR
    MAS Service        : BUSINESS OFFICE      Billing Supervisor : WAITHE,MOSES

[6] Initiator Authorize: YES                  Xfer Proc to Sched : YES
    Ask HINQ in MCCR   : YES                  Use Non-PTF Codes  : YES
    Multiple Form Types: YES                  Use OP CPT screen  : YES

[7] UB-04 Print IDs    : YES                  UB-04 Address Col  :
    CMS-1500 Print IDs : YES                  CMS-1500 Addr Col  : 40
    CMS-1500 Auto Prter: RM340                UB-04 Auto Prter   : RM340
    EOB Auto Prter     : RM340                MRA Auto Prter     : RM340

[8] Default RX DX Cd   : V68.1                Default ASC Rev Cd : 490
    Default RX CPT Cd  : J8499                Default RX Rev Cd  : 250

[9] Bill Signer Name   : <No longer used>     Federal Tax #      : 83-0168494
    Bill Signer Title  : <No longer used>
+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit
Select Action: Next Screen//
```

Step	Procedure
5	At the **Select Action:** prompt, enter **EP=7**.
6	At the **CMS-1500 Auto Printer**: prompt, enter the name of the printer to which CMS secondary or tertiary claims will print.

7	At the **UB04 Auto Printer**: prompt, enter the name of the printer to which CMS secondary or tertiary claims will print.
8	At the **EOB Auto Printer**: prompt, enter the name of the printer to which CMS secondary or tertiary claims will print.
9	At the **MRA Auto Printer**: prompt, enter the name of the printer to which CMS secondary or tertiary claims will print.
	Note: The same printer can be used to print more than one thing if your printers are setup to handle more than one form type.
	Remember: The MRA is a 132 column printout.

```
UB-04 PRINT LEGACY ID: YES//
CMS-1500 PRINT LEGACY ID: YES//
UB-04 ADDRESS COLUMN:
CMS-1500 ADDRESS COLUMN: 40//
CMS-1500 Auto Printer:
UB-04 Auto Printer:
EOB Auto Printer:
MRA Auto Printer:
```

9.2. Enable Automatic Processing of Secondary/Tertiary Claims

A new field was added to the MCCR Site Parameter Display/Edit option so that users can enable/disable the automatic processing of secondary/tertiary non-MRA claims.

Step	Procedure
1	Access the **MCCR System Definition Menu**.
2	At the **Select MCCR System Definition Menu Option:** prompt, enter **Site** for MCCR Site Parameter Display/Edit.
3	At the **Select Action:** prompt, Enter **IB** to access the IB Site Parameters.

```
MCCR Site Parameters          Feb 01, 2011@15:04:47          Page:    1 of    1
Display/Edit MCCR Site Parameters.
Only authorized persons may edit this data.


 IB Site Parameters                          Claims Tracking Parameters
    Facility Definition                         General Parameters
    Mail Groups                                 Tracking Parameters
    Patient Billing                             Random Sampling
    Third Party Billing
    Provider Id
    EDI Transmission

 Third Party Auto Billing Parameters         Insurance Verification
    General Parameters                          General Parameters
    Inpatient Admission                         Batch Extracts Parameters
    Outpatient Visit                            Service Type Codes
    Prescription Refill

          Enter ?? for more actions
IB  Site Parameter         AB  Automated Billing     EX  Exit
CT  Claims Tracking        IV  Ins. Verification
Select Action: Quit// IB Site Parameters
```

The following screen will display.

```
IB Site Parameters            Feb 01, 2011@16:22:02          Page:    1 of    5
Only authorized persons may edit this data.

[1] Copay Background Error Mg: IB ERROR
    Copay Exemption Mailgroup: IB ERROR
    Use Alerts for Exemption : NO

[2] Hold MT Bills w/Ins      : YES            # of Days Charges Held: 90
    Suppress MT Ins Bulletin : NO
    Means Test Mailgroup     : IB MEANS TEST
    Per Diem Start Date      : 11/05/90

[3] Disapproval Mailgroup    : MCCR - BUSINESS OFFICE
    Cancellation Mailgroup   : UB-82 CANCELL
    Cancellation Remark      : BILL CANCELLED IN BUSINESS OFFICE

[4] New Insurance Mailgroup  : IB NEW INSURANCE
    Unbilled Mailgroup       : IB UNBILLED AMOUNTS
    Auto Print Unbilled List : NO

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit
Select Action: Next Screen//
```

Step	Procedure
4	At the **Select Action:** prompt, press the **<Enter>** key to accept the default of Next Screen until Section 14 is displayed.

```
IB Site Parameters            Sep 16, 2011@14:32:21          Page:    3 of    5
Only authorized persons may edit this data.
+
[10]Pay-To Providers   : 1 defined, default - CHEYENNE TEST1 VAMC

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

[12]HIPPA NCPDP Active Flag          : Not Active
    Drug Non Covered Recheck Period  : 0 days(s)
    Non Covered Reject Codes
                                     : 70 Product/Service Not Covered

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

[14] EDI/MRA Activated               : BOTH EDI AND MRA
+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit
Select Action: Next Screen//
```

Step	Procedure
5	At the **Select Action:** prompt, enter **EP=14**.
6	The **Enable Auto Reg EOB Processing?:** prompt will be set to YES.
	*This parameter should not be changed unless there is a compelling reason to stop the automatic processing of secondary/tertiary claims.*

```
Select Action: Next Screen// ep=14   Edit Set
SITE CONTACT PHONE NUMBER: 307-778-7581//
LIVE TRANSMIT 837 QUEUE: MCT//
TEST TRANSMIT 837 QUEUE: MCT//
AUTO TRANSMIT BILL FREQUENCY: 1//
HOURS TO TRANSMIT BILLS: 1130;1500;1700//
MAX # BILLS IN A BATCH: 10//
ONLY 1 INS CO PER CLAIM BATCH: YES//
DAYS TO WAIT TO PURGE MSGS: 15//
Allow MRA Processing?: YES//
Enable Automatic MRA Processing?: YES//
Enable Auto Reg EOB Processing?: YES//
```

9.3. Printed Claims Rev Code Excl: 17 Activated Codes Defined

Patch IB*2*547 added Section 8, Printed Claims Rev Code Excl:, to the IB Site Parameters. When the Patch is installed, the following revenue codes, if active, will be pre-populated:

- 270-279
- 290-299

Users will be able to add and/or delete additional revenue codes. Revenue codes that are defined here will be used to screen out claims from the Printed Claims report.

```
IB Site Parameters            Nov 03, 2015@10:43:20          Page:    2 of    5
Only authorized persons may edit this data.
+
[5] Medical Center     : CHEYENNE VAMC        Default Division   : CHEYENNE VAMR
    MAS Service        : BUSINESS OFFICE      Billing Supervisor : WAITHE,MOSES

[6] Initiator Authorize: YES                  Xfer Proc to Sched : YES
    Ask HINQ in MCCR   : YES                  Use Non-PTF Codes  : YES
    Multiple Form Types: YES                  Use OP CPT screen  : YES

[7] UB-04 Print IDs    : YES                  UB-04 Address Col  :
    CMS-1500 Print IDs : YES                  CMS-1500 Addr Col  : 40
    CMS-1500 Auto Prter:                      UB-04 Auto Prter   :
    EOB Auto Prter     :                      MRA Auto Prter     :

[8] Printed Claims Rev Code Excl: 17 Activated Codes Defined

[9] Default RX DX Cd   : Z76.0 (ICD-10)       Default ASC Rev Cd : 490
    Default RX CPT Cd  : J8499                Default RX Rev Cd  : 250

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit
Select Action: Next Screen//
```

```
Excluded Revenue Codes        Nov 03, 2015@11:05:06          Page:    1 of    1

    #    RCD    DESCRIPTION
    1.   270    MED-SUR SUPPLIES
    2.   271    NON-STER SUPPLY
    3.   272    STERILE SUPPLY
    4.   273    TAKEHOME SUPPLY
    5.   274    PROSTH/ORTH DEV
    6.   275    PACE MAKER
    7.   276    INTRA OC LENS
    8.   277    O2/TAKEHOME
```

```
    9.   278    SUPPLY/IMPLANTS
   10.   279    SUPPLY/OTHER
   11.   290    MED EQUIP/DURAB
   12.   291    MED EQUIP/RENT
   13.   292    MED EQUIP/NEW
   14.   293    MED EQUIP/USED
   15.   294    MED EQUIP/SUPPLIES/DRUGS
   16.   299    MED EQUIP/OTHER
          Enter ?? for more actions
AC  Add Revenue Code       DC  Delete Revenue Code    EX  Exit
Select Item(s): Quit// ac    Add Revenue Code
Revenue Code: 118       REHAB/PVT     REHABILITATION
Revenue Code:
```

Step	Procedure
1	Access the **MCCR System Definition Menu**.
2	At the **Select MCCR System Definition Menu Option:** prompt, enter **Site** for MCCR Site Parameter Display/Edit.
3	At the **Select Action:** prompt, Enter **IB** to access the IB Site Parameters.
4	At the **Select Action: Next Screen//** prompt, enter EP=8 to access Excluded Revenue Codes
5	At the **Select Item(s): Quit//** prompt, enter **AC** for Add Revenue Code
6	At the **Revenue Code**: prompt, enter a **Revenue Code** number
7	At the **Revenue Code**: prompt, press the **Enter** key when done adding codes

9.4. Alternate Primary Payer ID Types

Patch IB*2*547 added Sections 17 and 18, Alt Prim Payer ID Typ-Medicare and Alt Prim Payer ID Typ-Commercial. Users can define qualifiers to be used to define alternative professional and/or institutional primary payer IDs by type in Insurance Company Entry/Edit. These ID types provide the ability to direct 837 transactions to different processing entities depending on the type of claim.

```
IB Site Parameters            Nov 03, 2015@11:21:32          Page:    4 of    5
Only authorized persons may edit this data.
+
[16] EDI/MRA Activated               : BOTH EDI AND MRA
     EDI Contact Phone               : (307)778-7581
     EDI 837 Live Transmit Queue     : MCT
     EDI 837 Test Transmit Queue     : MCT
     Auto-Txmt Bill Frequency        : Every Day
     Hours To Auto-Transmit          : 1130;1500;1700
     Max # Bills Per Batch           : 10
     Only Allow 1 Ins Co/Claim Batch?: NO
     Last Auto-Txmt Run Date         : 03/08/11
     Days To Wait To Purge Msgs      : 15
     Allow MRA Processing?           : YES
     Enable Automatic MRA Processing?: YES
     Enable Auto Reg EOB Processing? : YES

[17]Alt Prim Payer ID Typ-Medicare: 2 defined

[18]Alt Prim Payer ID Typ-Commercial: 2 defined
+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit
Select Action: Next Screen//
```

Step	Procedure
1	Access the **MCCR System Definition Menu**.
2	At the **Select MCCR System Definition Menu Option:** prompt, enter **Site** for MCCR Site Parameter Display/Edit.
3	At the **Select Action:** prompt, Enter **IB** to access the IB Site Parameters.
4	At the **Select Action: Next Screen//** prompt, enter **EP=17** to access Alt Prim Payer Typ-Medicare
5	At the **Select Item(s): Quit//** prompt, enter **AT** for Add ID Type
6	At the **Enter a Primary ID Type**: prompt, enter a **Free Text** ID Type
7	At the **Are you adding 'HOSPICE' as a new IB ALTERNATE PRIMARY ID TYPES (the 2nd)? No//** prompt, enter **YES**
8	At the **Enter a Primary ID Type**: prompt, press the **Enter** key when done adding types

```
Alt Primary Payer ID Types     Nov 03, 2015@11:32:18          Page:    1 of    1


1    DME









          Enter ?? for more actions
AT  Add ID Type           DT  Delete ID Type        EX  Exit
Select Action: Quit//AT Add ID Type
Enter a Primary ID Type: HOSPICE
  Are you adding 'HOSPICE' as
    a new IB ALTERNATE PRIMARY ID TYPES (the 4TH)? No// y
```

9.5. ASC X12N Health Care Claim Request for Additional Information (277RFAI)

Patch IB*2*547 added Section 20 to the IB Site Parameters. When the Patch is installed, the following 277RFAI parameters will be pre-populated:

- Days to store 277RFAI Transactions
- Days to wait to purge entry on RFAI Management Worklist

```
IB Site Parameters            Nov 03, 2015@12:33:34          Page:    5 of    5
Only authorized persons may edit this data.
+

[19]Are we using ClaimsManager?  : NO
    Is ClaimsManager working OK? : NO
    ClaimsManager TCP/IP Address : 10.152.21.145
    ClaimsManager TCP/IP Ports   : 10040
                                   10050
                                   10060
                                   10070
                                   10080
    General Error MailGroup      : IBCI GENERAL ERROR
    Communication Error MailGroup: IBCI COMMUNICATION ERROR
    MailMan Messages             : PRIORITY

[20]Days to store 277RFAI Transactions: No Purge
```

```
    Days to wait to purge entry on RFAI Management Worklist: 20


          Enter ?? for more actions
EP  Edit Set                                        EX  Exit
Select Action: Quit// ep=20   Edit Set
PURGE DAYS 277 RFAI: ??
        Enter the number of days (between 365 and 3000) to
        retain 277 RFAI transactions in VistA.
        A null entry (the default) indicates the transactions
        will be stored forever.

PURGE DAYS 277 RFAI:
WORKLIST PURGE DAYS 277 RFAI: 20//
```

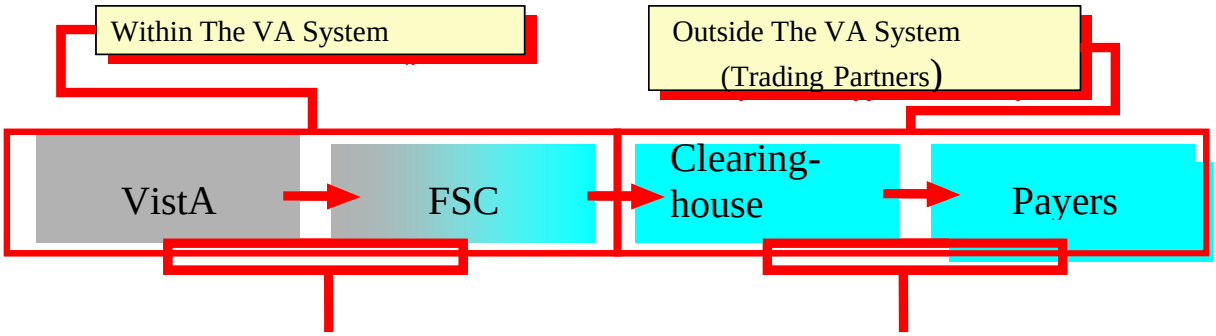
Step	Procedure
1	Access the **MCCR System Definition Menu**.
2	At the **Select MCCR System Definition Menu Option:** prompt, enter **Site** for MCCR Site Parameter Display/Edit.
3	At the **Select Action:** prompt, Enter **IB** to access the IB Site Parameters.
4	At the **Select Action: Quit//** prompt, enter **EP=20** to access the 277RFAI parameters
5	At the **PURGE DAYS 277 RFAI:** prompt, press the **Enter** key to accept the default
6	At the **WORKLIST PURGE DAYS 277 RFAI**: prompt, enter a Number that represents the number of days a 277 RFAI entry will remain on the RFAI Worklist before being automatically removed

10. Reports

There are a number of reports available to monitor and manage electronic claims. The EDI menu option can be accessed from the Billing Clerk's Menu.

10.1. EDI Reports – Overview

TR reports provide the end-user with information to monitor and manage EDI claims still within the VA, that is, between the VAMC and the FSC in Austin, TX. The MM reports provide the end-user with information and feedback from parties external to the VA such as the clearinghouse and the various electronic payers.



TR- EDI Transmission Status Reports -

BAR Bills Needing Resubmission Action
ECS EDI Claim Status Report
MP EDI Messages Not Yet Filed
PBT Pending Batch Transmission Status Report
PND EDI Batches Pending Receipt
REX Ready for Extract Status Report
VPE View/Print EDI Bill Extract Data

MM-EDI Return Message Management

EDI Return Message Management Option Menu
CSA Claim Status Awaiting Resolution
MCS Multiple CSA Message Management
TCS Test Claim EDI Transmission Report
EDI Message Text to Screen Maint
EDI Message Not Reviewed Report
Electronic Error Report
Electronic Report Disposition
Return Message Filing Exceptions
Status Message Management

10.2. Most Frequently Used Menus/Reports

10.2.1 Claims Status Awaiting Resolution – Synonym CSA

What is the purpose of this report?
Billing and Accounts Receivable (or Accounts Management) staff use CSA to review the most current status messages and to perform follow-up actions on the bills. Electronic status messages, which include information and rejection messages from the clearinghouse or the payers, are accessed using this option.

When is this option used?
This is an option that must be checked **Daily** to determine which claims have rejection or warning messages that were returned from the clearinghouse or from payers. The cause for rejections must be resolved. This option should be used in conjunction with supporting reports (e.g. R022, R0SS, R0SC).

The CSA report contains a Primary, Secondary and Tertiary sort capability and can be sorted by:

A	Authorizing Biller
B	Bill Number
C	Current Balance
S	Date of Service
D	Division
E	Error Code Text
N	Number of Days Pending
M	Patient Name
P	Payer
R	Review in Process
L	SSN Last 4

Once the CSA screen list is displayed, users can select new sort criteria and **re-sort** the list without exiting the option.

Reports can be run showing rejections only (R), or both informational and rejection messages (B). Users most often run the CSA report to show rejections only so they can focus on those claims that require corrective action.

These messages are automatically assigned a status of **Not Reviewed** and require users to review them and make corrections to update this status in IB. Users select a bill from the list to view the details and the entire message text. Messages are marked as **reviewed** or **review in process**. Users may document comments.

	*With Patch IB*2.0*320, changes were made to suppress the display of 2Q Claim Status Messages and duplicate claim status messages.*

As messages are reviewed they can be marked as follows:

- Not Reviewed – No action has been taken on a bill that has been returned from the clearinghouse/payer
- Review in Process – While a claim is being reworked, the status can be changed to "Review in Process"
- Review Complete – The error has been resolved and the message from this report will be cleared

Actions such as Cancel Bill, Copy/Cancel Bill, TPJI and Print Bill are available to the user via this option and the user can make needed corrections and re-submit claims from within this option.

Other options available on the CSA include:

- CSA-EDI History Display – The EDI History display option shows all the status messages under the selected bill/message. This information is similar to information that can be viewed under the TPJI menu options.
- CSA-Enter/Edit Comments – The enter/edit comments option gives the user the ability to add a comment onto a bill (status message) in order to inform AR and billing why the issue hasn't been resolved or why the claim was printed to paper.
- CSA-Resubmit by Print – The Resubmit by Print action is used when the user reviews the status message or bill and determines the only way to correct the problem is to submit the claim on hard copy as it cannot pass the electronic edits. The user may "resubmit by print" to the payer instead of retransmitting electronically. If printed from this option, users will be asked if they wish to "review complete" the status message, which will automatically clear it from the report.
- CSA-Retransmit a Bill – Similar to the Resubmit by Print action, the Retransmit Bill is used when the user reviews the status message or bill and determines the reason for the rejection has been corrected elsewhere in the system and the claim just needs to be resent. The user may then retransmit to the payer.
- CSA-Review Status – A bill will continue to show up on the report until it is cancel/cloned, canceled or the status is changed to Review Complete.

Users also have access to the option Multiple CSA Message Management from within the CSA list if they hold the IB Message Management security key.

	*Note: After Patch IB*2*547 is installed, the source of a claim status message will include the name of the clearinghouse when the clearinghouse is the soutce.*

10.2.2 Multiple CSA Message Management – Synonym: MCS

What is the purpose of this option?
This option is designed to allow users to take action on CSA messages when a problem arises during the processing of electronic claims that causes a large volume of erroneous status messages to be sent to the site. This option performs tasks similar to the CSA option.

	*This option is locked by the **IB Message Management** security key.*

When is this option used?
This option is used when there are pages of erroneous messages in CSA that were caused by a processing problem. Use this option to take a similar action (such as retransmission of the associated claims) on multiple claims at the same time.

The initial search for claims and claims status messages is done automatically when the option is selected. The initial search results in the display of all claims that are **Not Cancelled** and for which the review status is **Not Reviewed** or **Review in Process**.

	*If someone else is working on a claim in CSA, it will not display in MCS. Only one user can be in MCS at a time. The following message will be displayed: **Sorry, another user is currently using the MCS option. Please try again later.***

Once the initial list has been built, users may further refine their search or work from the default list.

	*The purpose of MCS is to select multiple claims and then apply the same action to all the selected claims. For example, users can enter a comment once and then apply the comment to 1-n claims.*

Other actions available on the MCS include:

- Message Search – Allows the user to change the criteria upon which the list of claims will be built
- Change Review Status – Same as CSA
- Cancel Claims – Same as CSA
- Enter Comment – Same as CSA
- Resubmit by Print – Same as CSA
- Retransmit Bill – Same as CSA
- Select/Deselect Claims – Allows users to select the claims to which they want to apply an action

	*When using the Resubmit by Print action, the claims selected will not be removed from the list of claims until the claims have actually been printed.*

10.2.3 Electronic Report Disposition

What is the purpose of this option?
This option allows the site to determine which clearinghouse generated electronic messages/reports are to be sent to the EDI mail group and which should be ignored.

When is this option used?
The default setting on this report will contain a disposition of "Mail Report to Mail Group". It is up to the individual site's supervisory staff to determine what reports should be ignored.

	*Further explanations of these reports are available in documents provided by the clearinghouse. They are entitled Claim Submitter Reports – Providers Reference Guide.*

The following reports should be reviewed when they are received. They contain information that cannot be translated into claim status messages therefore, this information is not available in CSA.

R000 NETWORK NEWS
Provides news on system problems, updates and other pertinent information.

RPT-02 FILE STATUS REPORT
Provides an initial analysis of the file by displaying file status of accepted or rejected and a description of the status. It also indicates the total number of claims and the dollar value if the file contains valid claims.

RPT-03 FILE SUMMARY REPORT
Provides summarized information on the quantity of accepted, rejected, and pending claims, as well as the total number of claims received by the clearinghouse for each submitted file.

RPT-08 PROVIDER MONTHLY SUMMARY
Displays the number and dollar value of claims accepted and forwarded by the clearinghouse for the month. Monthly and Y-T-D Totals for both accepted and rejected claims are included as well as the provider's top 25 errors for the month.

The following reports contain information that is also translated into status messages and displayed on CSA.

RPT-04 FILE DETAIL SUMMARY REPORT
Contains a detail summary of the file submitted for processing. It provides a file roll-up listing of all accepted, rejected, and pending claims contained in each file submitted to the clearinghouse. It also contains payer name/id and status of claim.

RPT-04A AMENDED FILE DETAIL SUMMARY REPORT
Contains a detailed listing of all claims for which the status was amended during the previous processing day. Claims statuses are amended when a pending claim is processed and/or a claim is reprocessed at the clearinghouse.

RPT-05 BATCH & CLAIM LEVEL REJECTION REPORT
Contains rejected batches and claims listed with detailed error explanations. In order to prevent "lost" claims, the RPT-05 report must be reviewed and worked after each file transmission.

RPT-05A AMENDED BATCH & CLAIM LEVEL REJECTION REPORT
Contains rejected batches and claims listed with detailed error explanations. In order to prevent "lost" claims, the RPT-05A report must be reviewed and worked after each file transmission.

RPT-10 PROVIDER CLAIM STATUS
This report contains information provided from payers who are receiving claims for adjudication from the clearinghouse. Not all payers who process claims through the clearinghouse system provide information for this Provider Claim Status Report and the amount/frequency of information produced will vary from payer to payer.

RPT-11 SPECIAL HANDLING/UNPROCESSED CLAIMS REPORT
This report contains information provided from payers who are receiving claims for adjudication from the clearinghouse. Not all payers who process claims through the clearinghouse system provide information for this Provider Claim Status Report and the amount/frequency of information produced will vary from payer to payer. The RPT-11 returns Unprocessed, Request for Additional Information, and Rejected statuses only.

10.2.4 EDI Claim Status Report- Synonym: ECS

What is the purpose of this report?
View electronic transmission status to assure claims move through the system in a timely fashion.

When is this option used?
It is recommended that initially this report be viewed daily as it provides transmission status of all claims that were transmitted to FSC. Once a comfort zone is established and everything is flowing correctly, this report may only need to be run monthly.

Reports can be created based on:
- Specific Claim or Search Criteria
- Division
- Payer
- Transmission Date range
- EDI Status

Reports can be sorted by:

- Transmission Date
- Payer
- EDI Status
- Current Balance
- Division
- Claim Number
- AR Status
- Age

Possible EDI claim statuses include:

- Ready for Extract
- Pending Austin Receipt
- Accepted by Non-Payer
- Accepted Payer
- Error Condition
- Cancelled
- Corrected/Retransmitted
- Closed

10.3. Additional Reports and Options

10.3.1 Ready for Extract Status Report - Synonym: REX

What is the purpose of this report?
This report provides a list of claims held in a Ready for Extract status. These claims are held in a queue until batch processing occurs.

When is this option used?
Initially this option is used to assure claims are being transmitted at the times set in the MCCR Site Parameters. This option should by reviewed daily until there is a comfort level with the transmission timeframes and then less frequently based on local experience.

Claims that are trapped due to the EDI parameters being turned off can also be viewed. It is rare that EDI is turned off during processing. If this occurs, use EXT Extract Status Management to Cancel or Cancel/Clone/Auth the trapped claims.

Choices to view are:

1 All bills in Ready for Extract status
2 Bills trapped due to EDI parameter being turned off
(If EDI is on, no bills will be trapped in extract)

10.3.2 Transmit EDI Bills – Manual - Synonym: SEND

What is the purpose of this option?
This option is used to by-pass the normal daily/nightly transmission queues if the need arises to get the claim to the payer quickly.

When is this option used?

There are occasions when there is a need to transmit a claim(s) immediately instead of waiting for the batching frequency as scheduled in the MCCR Site Parameter. This option will allow sending individual claim(s) or all claims in a ready for extract status.

Select one of the following:

A Transmit (A)LL bills in READY FOR EXTRACT status
S Transmit only (S)ELECTED bills

10.3.3 EDI Return Message Management Menu – Synonym: MM

This menu contains the options needed to define the types of electronic reports from the clearinghouse that the site needs to see and defines the text that should/should not allow automatic review and filing for informational status messages. It also contains an option to purge old status messages, reports for maintaining the integrity of the return message subsystem and the option for reviewing electronically returned messages.

10.3.4 EDI Message Text to Screen Maintenance

What is the purpose of this option?
This option controls what status and/or error messages users may wish to review using special text words and/or phrases. This will either require the message to be reviewed or it will auto-file the message and flag it as not needing a review.

This option allows for the display of a list of words or phrases that, if found in the text of an informational status message, will either always require the message to be reviewed or will auto-file the message and flag it as not needing a review.

When is this option used?
Depending on what types of status messages users wish to review for follow-up on rejected claims and/or monitoring claims status, users may want to add or edit additional text as needed.

The words and phrases for "Requiring Review" and "Not Requiring Review" will initially populate as shown in the screen print below. This option is used to edit or add more words or phrases, as required, to manage and control the status messages.

10.3.5 EDI Messages Not Reviewed Report

What is the purpose of this report?
This option allows for the display of all EDI return messages that were filed without needing a review based on the text entries in the message screen text file.

When is this option used?
The report can be run for a user-selected date range, based on the date the message was received at the site, and may be sorted by the message text that caused the message to not need a review or by the bill number. Users may want to use this option for analysis or review of all EDI messages that they were not able to view initially.

10.3.6 Electronic Error Report

What is the purpose of this report?
This report provides a tool for billing supervisors and staff to identify the "who, what, and where" of errors in the electronic billing process. This is a report that will allow the supervisory staff to review "frequently received" errors. This is an informational management tool requiring no actions on the part of the billing staff.

When is this option used?
This option can be used at any time by a supervisor or other management staff when they want to determine the reason for various errors (i.e., the same error being made by one or more of the billing staff). The report can be sorted by:

A	AUTHORIZING BILLER
B	BILLED AMOUNT
E	EPISODE OF CARE
P	PATIENT NAME
S	PATIENT SSN
Y	PAYER NAME
C	ERROR CODE

10.3.7 Return Messages Filing Exceptions

What is the purpose of this option?
After users have transmitted claims and they have been received for EDI processing, a message will be sent to the mail groups shown in the set-up section of this manual.

When is this option used?
When a message is sent, it is temporarily stored in the "EDI MESSAGES" file. Normally, these messages are in and out of this file in a matter of seconds. If, however, a problem is detected and a message cannot be filed in the appropriate file (s) for its message type, the message will remain in this temporary file. There are two (2) ***statuses*** for messages in this file.

- **Pending**: The task to force a message to update the IB files has either not yet been created or has been created, but has not yet begun to run.
- **Updating**: The task to force a message to update the IB files has started. It may or may not still be running. If you try to file a message with this status, a check is made to see if it is currently running. If it is, the message will not be re-tasked.

Any message may be viewed or printed. This does not affect the message in any way, but looking at the message may help to indicate the next course of action needed.

There are two (2) ***actions*** available to get these messages out of the file.

- **File Message**: This action re-executes the tasked job to update the database with the contents of the message.
- **Delete Message**: This is a drastic action that should only be taken when it has been determined there is no other possible way to process a message. When a message is deleted using this action, a bulletin is sent to the IB EDI Mail Group with the text of the message and the name of the user who deleted the message. Users must hold the IB SUPERVISOR security key to perform this action.

10.3.8 Status Message Management

What is the purpose of this option?
This option allows users to print/purge electronically returned status messages that have been in a final review status for a user-selected number of days.

When is this option used?
There will be an accumulation of status messages in a final review status. This option will delete or purge status messages in one of the Final Review statuses prior to a selected date. Auto purging of messages can also be set in the IB Site Parameters.

This report can be sorted by:

A ALL STATUS MESSAGES
S SELECTED STATUS MESSAGES

Selected status message reports can be run showing:

A Auto Filed/No Review Only
B Bill Number
S Message Severity
T Specific Message Text

10.3.9 Bills Awaiting Resubmission – Synonym: BAR

What is the purpose of this report?
This report lists all batches that have been resubmitted but which did not include all of the bills from the original batch. These are batches that have at least one bill still not resubmitted or canceled.

When is this option used?
When a batch is identified to have a claim in error, the batch may be re-submitted with the claim in error removed. This option will track and report specific bills in this category. The report can sort data by:

B BILL NUMBER
L LAST SENT DATE
A BILLED AMOUNT
N BATCH NUMBER (LAST SENT IN)

The report also indicates the "Bill Transmission Status".

10.3.10 EDI Messages Not Yet Filed –Synonym: MP

What is the purpose of this report?
This report allows you to select receipt, rejection or both message types and a minimum number of days these messages have been in a PENDING or UPDATING status before they will be included on the report. The report will then list all messages in the file that meet these criteria.

When is this option used?
This is a status report that allows for review of messages not yet filed.

10.3.11 Pending Batch Transmission Status Report – Synonym: PBT

What is the purpose of this report?
This report shows the current transmission status of a batch's mail message. It also includes the mail message number; the first and last date/time it was sent. Only batches in a pending transmission status will be on this report.

When is this option used?
This is another option to track the batch(s) of claims after authorizing and transmission to be sure all batches transmitted have been received in Austin. Users can omit both the station number prefix at the front of the batch number and the following zeroes and use only the final digits of the batch number for lookup.

10.3.12 EDI Batches Pending Receipt– Synonym: PND

What is the purpose of this report?

This report lists all batches by batch number that have been in a PENDING status and have not yet received confirmation of receipt from Austin for more than one (1) day. The report includes individual claims if the users choose to include them.

The report includes:

- Batch Number
- Transmission Date
- Mail Message #

Claims display the following:

- Claim Number
- Payer Sequence
- Balance Due
- EDI Status
- IB Status
- AR Status

```
EDI Batches Pending Austin Receipt After 1 Day                          Page: 2
Run Date: 01/07/2008@14:44:28

  Batch #       Transmission Date         Mail Message #
 ------------------------------------------------------------------------------

     Claim    Seq     Bal Due   EDI Stat   IB Status     AR Status
     K600KQD   P       198.54      P       PRNT/TX       NEW BILL
     K600NEU   P        76.36      P       PRNT/TX       NEW BILL
     K600QR2   P       305.11      P       PRNT/TX       NEW BILL
     K600WS7   P        76.36      P       PRNT/TX       NEW BILL
     K600WSF   P       880.71      P       PRNT/TX       NEW BILL

  4420029590    03/29/2006@21:05:33       1321

     Claim    Seq     Bal Due   EDI Stat   IB Status     AR Status
     K600FN7   P        76.36      P       REQUEST MRA   BILL INCOMPLETE
     K600IPF   P        73.01      P       REQUEST MRA   BILL INCOMPLETE
     K600WSA   P      4390.06      P       REQUEST MRA   BILL INCOMPLETE
     K600WSK   P        73.01      P       REQUEST MRA   BILL INCOMPLETE

Enter ENTER to continue or '^' to exit:
```

Members of the G.IB EDI mail group will receive an email message when there are batches of claims that have not received a confirmation message from Austin after 1 day.

```
Subj: EDI BATCHES WAITING AUSTIN RECEIPT FOR OVER 1 DAY  [#21387]
06/19/04@19:02  6 lines
From: XXXXXXXXXXX,XXXX X  In 'IN' basket.   Page 1  *New*
-------------------------------------------------------------------------------
There are 30 EDI batch(es) still pending Austin receipt
for more than 1 day.  Please investigate why they have not yet been confirmed
as being received by Austin.

Since there were more than 10 batches found, please run the
  EDI BATCHES WAITING FOR AUSTIN RECEIPT OVER 1-DAY report to get a list of the
se batches.

Enter message action (in IN basket): Delete//
```

When is this option used?
Users may use this option to obtain Batch or Messages numbers when a problem arises or to monitor the status of batches recently transmitted. Batches should not be in a "Pending Austin Receipt" status for more than a day.

	***Contact IRM** for assistance in finding out why a confirmation message has not been received from Austin.*
	*Before contacting IRM, note the **Message Numbers** for the batches that you need investigated. These numbers can be found in the **PND** option.*
	*If IRM needs assistance, log a **REMEDY ticket** or call the **National Help Desk at 1-888-596-4357.***

10.3.13 View/Print EDI Bill Extract Data – Synonym: VPE

What is the purpose of this option?
This option displays the EDI extract data for a bill.

When is this option used?
This option is used only if there is a need to determine what data was transmitted for a specific bill. The detailed extract data will contain all the elements in the flat file that is transmitted to FSC. FSC, in turn, translates the data to a HIPAA-compliant format for transmission to the clearinghouse.

10.3.14 Insurance Company EDI Parameter Report – Synonym: EPR

What is the purpose of this option?
This option will display the EDI Parameters of the Active Insurance Companies defined in Vista.

The contents of the following parameters will be included in this report:

- Insurance Company Name
- Street Address and City of Insurance Company
- Electronic Transmit?
- Institutional Electronic Bill ID
- Professional Electronic Bill ID
- HPID/OEID
- Electronic Type
- Type of Coverage
- Always Use main VAMC as Billing Provider

```
All Companies                  Insurance Company EDI Parameter Report                    Page: 1
Sorted By Ins Company Name                                                  Mar 02, 2015@10:30:28
Only Blank or 'PRNT' Bill ID's = NO
'*' indicates the HPID/OEID failed validation checks
                                        Electron  Inst  Prof  HPID/ Electronic
Insurance Company Name Street Address City Transmit   ID    ID   OEID   Type        Coverage Type
=============================================================================================
INSURANCE COMPANY ONE  PO BOX 141159 XXX,OH  YES-L  8XXXX 8XXXX 7999999999 GROUP PLAN HEALTH INS…
INSURANCE COMPANY TWO  PO BOX 30101  XXX,UT  YES-L              6999999999* OTHER     HEALTH INS…
```

When is this option used?
This option can be used whenever there is a need to confirm that the Insurance Company parameters are correctly defined to support the electronic transmission of claims. This option will be of value when the eClaims Plus patches are loaded and sites gain the ability to transmit secondary claims to the payers (electronic, end-to-end processing). **Example:** Sites can use this option to make sure the payers' Electronic Bill IDs are defined.

10.3.15 Test Claim EDI Transmission Report – Synonym: TCS

What is the purpose of this option?
The Claim Status Messages for claim(s) and batch(es) submitted via the RCB option as Test claims will not appear in CSA. No action will be required in response to these messages. For informational purposes, these messages will be available through the Test Claim EDI Transmission Report. This option can be used to investigate the status of test claims to see, for example, whether the transmission was accepted/rejected by FSC or accepted/rejected by the clearinghouse.

The messages in this option will be automatically purged after 60 days.

When is this option used?
This option can be used whenever a user needs to investigate the current status of a claim or batch of claims. The messages in this report will be like the messages in TPJI.

```
Test Claim EDI Transmission Report                                          Page: 1
Selected Batches                                              Mar 22, 2005@12:14:38
================================================================================

Batch#:  6050011719
Claim#:  K404XXX    IB,Patient7      (1500, Prof, Outpat)
--------------------------------------------------------------------------------
Transmission Information
 03/17/2005@11:11:25  Bch#11719  IB,Clerk2   CIGNA HEALTHCARE  (S)
```

10.3.16 Third Party Joint Inquiry – Synonym: TPJI

What is the purpose of this option?
This option provides a convenient location for both claim, AR, Insurance and EDI data related to a claim.

When is this option used?
This option is used by both Integrated Billing and Accounts Receivable personnel who require information about a claim. Both AR and IB users can also add comments to an MRA Request or non-MRA Request claim using this option.

The following actions are available from TPJI:

BC	Bill Charges
DX	Bill Diagnosis
PR	Bill Procedures
CB	Change Bill
ED	EDI Status
AR	Account Profile
CM	Comment History
IR	Insurance Reviews
HS	Health Summary
AL	Active List
VI	Insurance Company
VP	Policy
AB	Annual Benefits
EL	Patient Eligibility

	*Patch IB*2*377 included changes to allow the addition of and the viewing of MRA Request claim comments using TPJI. Comment History now pertains to MRA Request claims as well as regular claims. MRA Request claim comments are not stored as AR comments though.*
	*Note: Patch IB*2*516 changed the lists of Active and Inactive claims to display the claim type of either Institutional or Professional in addition to Inpatient, Inpatient Humanitarian, Outpatient, or Outpatient Humanitarian.*
	*Note: Patch IB*2*516 also added the ability for users to view related claims for which the patient is responsible, when reviewing Claim Information for a selected claim.*
	*Note: After Patch IB*2*547 is installed, the source of a claim status message will include the name of the clearinghouse when the clearinghouse is the source.*
	*Note: After Patch IB*2*547 is installed, users will be able to view the comments that were added to an entry on the new RFAI Management Worklist in the comment section of the TPJI.*
	*Note: After Patch IB*2*547 is installed, users will be able to view the complete and current textual description associated with the Claims Adjustment Reason Codes/Remittance Advice Remark Codes (CARC/RARC) received in an electronic EOB.*

Patch IB*2*488 modified the way message storage errors (created when an EEOB or MRA is received and all the line items cannot be matched correctly) are displayed in TPJI. Internal MUMPS code will no longer be displayed to the users.

The Following types of errors will be displayed:

- Procedure Code mismatch
- Procedure Modifier mismatch
- Revenue Code mismatch

- Charge Amount mismatch
- Number of Units mismatch

```
Claim Information             Nov 25, 2013@14:56:02          Page:    1 of    2
%K101XXX   IB,PATIENT 123       IXXXX       DOB: XX/XX/XX   Subsc ID: XXXXXXXXX

  Insurance Demographics                  Subscriber Demographics
    Bill Payer: IB INSURANCE CO            Group Number: GRP PLN XXXXX
 Claim Address: PO BOX XXXXX                 Group Name: STATE OF WY
                CHEYENNE, WY 820031234    Subscriber ID: XXXXXXXXXX
   Claim Phone: 800/XXX-XXXX                    Employer: STATE OF WYO
                                         Insured's Name: IB,PATIENT 123
                                          Relationship: PATIENT
                             Claim Information
  Bill Type: OUTPATIENT                    Charge Type: INSTITUTIONAL
 Time Frame: ADMIT THRU DISCHARGE         Service Dates: XX/XX/XX - XX/XX/XX
  Rate Type: REIMBURSABLE INS.               Orig Claim:    145.49
  AR Status: ACTIVE                         Balance Due:    145.49
+         |% EEOB | Enter ?? for more actions|
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CB  Change Bill           HS  Health Summary        EL  Patient Eligibility
ED  EDI Status            AL  Go to Active List     EB  Expand Benefits
RX  ECME Information      EX  Exit
Select Action: Next Screen// BC   Bill Charges
DO YOU WANT ALL EEOB DETAILS?: NO// Y
```

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

```
Bill Charges                   Apr 14, 2014@16:27:18          Page:    7 of    8
K101EVT   IB,PATIENT MRA  I4321          DOB: 12/01/66   Subsc ID: 011871234A
 04/10/14 - 04/10/14        ADMIT THRU DISCHARGE         Orig Amt: 0.00
+
--------------------------------------------------------------------------------
VistA could not match all of the Line Level data received in the EEOB
(835 Record 40) to the claim in VistA.

Mismatched Procedure Code:

Payer reported the following was billed via the Claim (837):
    Proc:71010  Mods:59  Rev Cd:324  Chg:227.40  Units:1
Payer reported adjudication via the EOB (835) as follows:
    Proc:71015  Mods:59  Rev Cd:324  Chg:227.40  Units:1
    Amt:100.00

------------------------------------------------------------------------
Service line adjustment (EEOB Record 41) has no matching service line
    Allowed Amt: 114.80  Per Diem Amt: 0.00
------------------------------------------------------------------------
Service line adjustment (EEOB Record 45) has no matching service line
+         |% EEOB | Enter ?? for more actions|
PR  Bill Procedures       CM  Comment History       AB  Annual Benefitslity
CI  Go to Claim Screen    IR  Insurance Reviews     EL  Patient Eligibility
                          HS  Health Summary        EX  Exit
ED  EDI Status            AL  Go to Active List
                          VI  Insurance Company
Select Action: Next Screen//
```

10.3.17 Re-generate Unbilled Amounts Report

What is the purpose of this option?
This option provides some basic information about billable events that have not yet been billed to a payer and dollar amounts associated with billable events in a specified time-frame.

When is this option used?
This option can be used to view the number of inpatient or outpatient care events and/or prescriptions that have not been billed and the dollar amounts attributed to the events.

```
Subj: UNBILLED AMOUNTS SUMMARY REPORT  [#197848] 06/23/14@12:41  34 lines
From: INTEGRATED BILLING PACKAGE  In 'IN' basket.   Page 1  *New*
-------------------------------------------------------------------------------
SUMMARY UNBILLED AMOUNTS FOR CHEYENNE VAMC (442).
PERIOD: FROM 09/01/04 TO 09/30/06
DETAILED REPORT PRINTED TO '/dev/pts/5'

Inpatient Care:
   Number of Unbilled Inpatient Admissions :           0
   Number of MRA Unbilled Inpt Admissions  :           2
   Number of Inpt. Institutional Cases     :           0
   Average Inpt. Institutional Bill Amount :    15321.18
   Number of Inpt. Professional Cases      :           0
   Average Inpt. Professional Bill Amount  :     1036.36
   Total Unbilled Inpatient Care           :        0.00
   Total MRA Unbilled Inpatient Care       :        0.00
```

*Note: Patch IB*2*547 provided the ability for users to run this report by division (one or more) or not and to sort the report by division or by patient name in alphabetical order. If users do search by division, the Re-generate Unbilled Amount Summary will display the summary totals before the division data. The display of CPT codes and monetary amounts for outpatient claims has also been restored.*

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

Search by Division?? NO//

Start with DATE: 08/23/1966// t-1000  (FEB 07, 2013)
     Go to DATE: 11/04/2015//   (NOV 04, 2015)

Choose report type(s) to print:

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

Select:  (1-4): 4//

You have selected

    4 - ALL OF THE ABOVE

Are you sure? NO// y  YES

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

10.3.18 Patient Billing Inquiry – Synonym: INQU

What is the purpose of this option?
This option provides some basic information about a particular claim. It is a simple inquiry option.

When is this option used?
This option can be used to view the following type of information related to a bill:

- Bill Status
- Rate Type
- Form Type
- Visit Date(s)
- Charges
- AR Status
- Statement Dates
- Dates related to actions such as Entered, Cancelled or Printed
- Bill Number copied from or to
- Patient, Mailing and Insurance Company address

The data available varies based upon when the inquiry is made and what actions have been carried out regarding the claim

10.3.19 Printed Claims Report

What is the purpose of this option?

This option provides information about claims that are printed locally but which had the potential to be transmitted electronically. The report can be generated for either the Consolidated Patient Account Centers (CPACs) or the sites which process TRICARE claims.

When is this option used?

This report is used by billing personnel to monitor the printing of potentially transmittable claims and displays the following information:

- Biller
- Outpatient/Inpatient and Institutional/Professional
- Rate Type
- Plan Type
- Division
- Revenue Codes
- Insurance Company

	*Note: The revenue codes that determine whether or not a printed claim will be included in this report are defined in the IB Site Parameters.*
	*Note: Claims to the payer – Department of Labor and certain types of rate types and types of plans are not included in this report because they do not have the potential to be transmitted electronically.*

11. APPENDIX A – BATCH PROCESSING SETUP

BATCH PROCESSING SETUP

The following example shows you how to define batch processing for a payer:

Step	Procedure
1	Under the **IB Site Parameters**, go to field [15] **EDI/MRA Activated**.
2	Edit fields as necessary (fields are highlighted in yellow for this example).
	Details on each field follow the screen example.
	*When the MRA software was loaded (Patch IB*2.0*155), the* **EDI/MRA Activated** *field was removed from this screen. Only an* **IRM** *is able to access this field via* ***FileMan****. The reason for this is to prevent MRA from being activated before the FSC is ready to accept MRA transmissions from a particular site.*

```
IB Site Parameters            Aug 13, 2003@10:22:46          Page:    5 of 6
Only authorized persons may edit this data.
+---------------------------------------------------------------------------

[15] EDI/MRA Activated               : EDI
     EDI Contact Phone               :
     EDI 837 Live Transmit Queue     : MCH
     EDI 837 Test Transmit Queue     : MCT
     Auto-Txmt Bill Frequency        : Every Day
     Hours To Auto-Transmit          : 1300;1600
     Max # Bills Per Batch           : 50
     Only Allow 1 Ins Co/Claim Batch?: NO
     Last Auto-Txmt Run Date         : 08/13/03
     Days To Wait To Purge Msgs      : 120
```

EDI/MRA Activated: Controls whether EDI is available for the site.
Choose from:

0 - NOT EDI OR MRA;
1 - EDI ONLY;
2 – MRA ONLY; or
3 – BOTH EDI AND MRA

	This prompt is no longer accessible to anyone except an IRM.

```
IB Site Parameters            May 27, 2004@14:14:24          Page:    5 of    6
Only authorized persons may edit this data.
+
      HMO NUMBER                    :
      STATE INDUSTRIAL ACCIDENT PROV:
      LOCATION NUMBER               :

[15] EDI/MRA Activated               : BOTH EDI AND MRA
     EDI Contact Phone               : 217-554-3135
     EDI 837 Live Transmit Queue     : MCH
     EDI 837 Test Transmit Queue     : MCT
     Auto-Txmt Bill Frequency        : Every Day
     Hours To Auto-Transmit          : 1000;1400;2000
     Max # Bills Per Batch           : 10
```

```
     Only Allow 1 Ins Co/Claim Batch?: NO
     Last Auto-Txmt Run Date         : 05/26/04
     Days To Wait To Purge Msgs      : 45
     Allow MRA Processing?           : YES
     Enable Automatic MRA Processing?: YES

+         Enter ?? for more actions
EP  Edit Set                                      EX  Exit Action
```

EDI Contact Phone: The phone number of the person at the site contact to whom EDI inquiries will be directed. The Pay-to Provider telephone number that is defined in Section 10 for each Pay-to Provider, will be printed on the UB04 and CMS-1500 form starting with Patch IB*2.0*400.

EDI 837 Live Transmit Queue: The name of the Austin data queue that will receive claims to be processed via a live connection to the clearinghouse. These data are populated at the time of installation and would not normally be edited by the site.

EDI 837 Test Transmit Queue: The name of the Austin data queue that will receive test claims. These data are populated at the time of installation and would not normally be edited by the site.

Auto Txmt Bill Frequency: The desired number of days between each execution of the automated bill transmitter. For example, if the automated bill transmitter should run only once a week, this number would be 7. If the automated bill transmitter should run every night, then the number should be 1. If this is left blank or zero then the automated bill transmitter background job will never run.

Hours To Transmit Bills: Contains the times of the day when EDI transmission of bills should occur. A maximum of 4 daily times daily may be entered and the times must be separated by a semi-colon. Times must be entered in 4-digit military format, without punctuation (HHMM;HHMM;HHMM;HHMM). If no times are entered, EDI transmission will take place as a normal part of the nightly job.

Max # Of Bills Per Batch: The maximum number of bills allowed in a single batch. With a new payer, it is suggested that you begin with fairly small batches (10-20 claims).

Only Allow 1 Ins Co/Claim Batch: Indicates whether or not the site wishes to limit batches to claims for a single insurance company.

Last Auto-Txmt Run Date: The last date the auto transmit of bills was run at the site. These data are display only and cannot be edited.

Days To Wait To Purge Msgs: This is the number of days after an electronic status message has been marked reviewed, that the purge message option can delete it from the system.

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12. APPENDIX B – GLOSSARY

GLOSSARY OF TERMS

Acronym or Term	Definition/Explanation
835	HIPAA Standard Electronic Transaction ASC X12 835, Health Care Claim: The HIPAA-adopted standard for electronic remittance advice to report the processing of all claim types (including retail pharmacy). The 835 is sent from health plans to healthcare providers and contains detailed information about the processing of the claim. This includes payment information and reduction or rejection reasons. The 835 transactions generally contain information about multiple claims. All health plans are required to use the same explanation of benefit codes (adjustment reason codes) and adhere to very specific reporting requirements. The term "835" is used interchangeably *with Electronic Remittance Advice (ERA) and Medicare Remittance Advice (MRA).*
837	HIPAA Standard Electronic Transaction ASC X12 837, Health Care Claim Payment/Remittance Advice: The HIPAA-adopted standard for electronic submission of hospital, professional and dental claims or encounters. The 837 is sent from healthcare providers to health plans (payers). The 837 transactions are generally multiple claims (batches). The 837 standard includes the information for coordination of benefits and is also used for secondary payer claims submission. The term "837" is used interchangeably with *electronic claim*.
277 RFAI	Hipaa Standard Electronic Transaction ASC X12 277, Health Care Claim Request for Additional Information The HIPAA adopted standard for requesting additional information for health care claims submitted. Payers utilize this transaction for requesting additional information or missing information from providers on previously submitted health care claims.
Billing Provider Secondary ID Number	This is either the facility tax ID # (default) or an ID assigned to the facility by the insurance company.
Care Unit	Specific data related to patient care (pre-defined by an insurance company) that provides the insurance company with a finer breakdown of the care being billed. The data that comprises the breakdown are insurance company specific and are not required by all payers. (For example, Orthopedics, Dermatology, Urology, etc.).
Claims Status Awaiting Resolution (CSA)	Used to reference the option used by billing staff to review the most current status messages received for a bill(s) and do follow-up on the bills. Users will be able to select a bill from the list to view the details and the entire message text as well as to mark the message as reviewed or under review and document user comments.
Claim Status Message	Electronic messages returned to the VAMC providing status information on a claim from the Financial Service Center (FSC), Clearinghouse or a payer
Clearinghouse	A company that provides batch and real-time transaction processing services. Transactions include insurance eligibility verification, claims submission process and electronic remittance information and payment posting for electronic claims.

Acronym or Term	Definition/Explanation
CPAC	Consolidated Patient Account Center
CSA	*See* Claims Status Awaiting Resolution
eClaim	A claim that is submitted electronically from the VA
EDI	*See* Electronic Data Interchange
Electronic Data Interchange (EDI)	EDI is the process of transacting business electronically. It includes submitting claims electronically (paperless claims processing), as well as electronic funds transfer and electronic inquiry for claim status and patient eligibility.
Electronic Payer	A payer that has an electronic connection with the clearinghouse
ePayer	Payer that accepts electronic claim from the clearinghouse pays electronically. See Payer.
Facility Fed Tax ID #	This is the number that will be the default for all providers for the ID type at the facility if the payer does not have specific requirements
Fiscal Intermediary	A fiscal intermediary performs services on behalf of healthcare payers. These services include claim adjudication, reimbursement and collections. Trailblazer is an example of a fiscal intermediary that acts on behalf of Medicare. Trailblazer receives claims from the VA in the form of an 837 file and then adjudicates the claims to create a MRA/EOB 835 file.
Form Types	The UB-04 or CMS-1500 billing form on which services will be billed
FSC	The VA Financial Services Center in Austin. The Financial Service Center translates claims into an industry-standard format (HIPAA 837) and forwards claims to the clearinghouse. The FSC is the single point for the exchange of data between VistA and the clearinghouse.
Healthcare Company	*See* Payer
Health Insurance Portability and Accountability Act (HIPAA)	In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain healthcare data between healthcare payers, plans, and providers. This will enable the entire healthcare industry to communicate electronic data using a single set of standards thus eliminating all non-standard formats currently in use. Once these standards are in place, a healthcare provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.
HPID	Health Plan Identifier
Insurance Company	*See* Payer
Legacy IDs	This term refers to those payer-provided or users own IDs (individual and organizational) which will eventually be made obsolete by the use of National

Acronym or Term	Definition/Explanation
	Provider Identifiers
Non-VA Facility	Any facility that provides services to a VA patient and subsequently bills the VA for those services
Non-VA Provider	Any individual provider who provides services to a VA patient and subsequently bills the VA for these services
National Provider Identifier	A standard, unique health identifier for healthcare providers, both individuals and organizations
OEID	Other Entity Identifier
Parent	The top facility in a hierarchical domain
Payer	The insured's insurance company. Other terms that are used to denote Payer include ePayer, insurance company, healthcare company, etc.
Payer Code	A code used for enrollment that uniquely identifies the payer.
Payer List	List of payers that consist of the payer category, claim type, payer code, and payer name
Provider	Provider of healthcare services
Provider ID	A provider ID can represent a facility or an individual physician/provider.
Taxonomy Code	The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category.
UPIN	Unique Provider Identification Number
URL	Uniform Resource Locator
VAMC	Veterans Affairs Medical Center
VISN	Veterans Integrated Service Network

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13. APPENDIX C – HIPAA Provider ID – Reference Guide

This table displays the HIPAA qualifiers and associated ID types. This table can be used to help identify what type of Provider ID is being used in the electronic format.

Institutional										
Qualifier	**Definition**	**Billing Provider**	**Attending**		**Operating**		**Other**		**Service**	
		2010AA	**2310A**	**2330D**	**2310B**	**2330E**	**2310C**	**2330F**	**2310E**	**2330H**
	Payer Type:		**C**	**O**	**C**	**O**	**C**	**O**	**C**	**O**
	VPE Segment:	**PRV1**	**OPR2**	**OP1**	**OPR3**	**OP2**	**OPR4**	**OP9**	**SUB2**	**OP3**
OB	State License Number	-	OB		OB		OB		OB	
1A	Blue Cross Provider Number	1A	1A	1A	1A	1A	1A	1A	1A	-
1B	Blue Shield Provider Number	-	1B	1B	1B	1B	1B	1B	1B	1B
1C	Medicare Provider Number	1C	1C	1C	1C	1C	1C	1C	1C	1C
1D	Medicare Provider Number	1D	1D	1D	1D	1D	1D	1D	1D	1D
1G	Provider UPIN Number	1G	1G	1G	1G	1G	1G	1G	1G	-
1H	TRICARE ID Number	1H	1H	1H	1H	1H	1H	1H	1H	-
1J	Facility ID Number	1J	-	-	-	-	-	-	1J	-
B3	PPO Number	B3	-	-	-	-	-	-	-	-
BQ	HMO Code Number	BQ	-	-	-	-	-	-	-	-
EI	Employer's ID Number	EI	EI	EI	EI	EI	EI	EI	EI	EI
FH	Clinic Number	FH	-	-	-	-	-	-	FH	-
G2	Provider Commercial Number	G2	G2	G2	G2	G2	G2	G2	G2	G2
G5	Provider Site Number	G5	-	-	-	-	-	-	G5	-
LU	Location Number	LU	LU	LU	LU	LU	LU	LU	LU	LU
N5	Provider Plan Network ID Number	-	N5	N5	N5	N5	N5	N5	N5	N5
TJ	Federal Taxpayer's ID Number	-		-	-	-	-	-	-	-
X4	Clinical Lab Improvement Amendment (CLIA #)	-	-	-	-	-	-	-	-	-
U3	Unique Supplier ID Number (USIN)	-	-	-	-	-	-	-	-	-
SY	Social Security Number	SY	SY	-	SY	-	SY	-	-	-
X5	State Industrial Accident Provider Number	X5	X5	-	X5	-	X5	-	X5	-
C = Current Payer **O** = Other Payer										

Professional												
Qualifier	**Definition**	**Billing Provider**	**Referring**		**Rendering**		**Purchased**		**Service Facility**		**Supervising**	
	HIPAA Loop	**2010AA**	**2310A**	**2330D**	**2310B**	**2330E**	**2310C**	**2330F**	**2310D**	**2330G**	**2310E**	**2330H**
	Payer Type:		**C**	**O**	**C**	**O**	**C**	**O**	**C**	**O**	**C**	**O**
	VPE Record	**PRV1**	**OPR5**	**OP4**	**OPR2**	**OP1**	**SUB1**	**OP6**	**SUB2**	**OP7**	**OPR8**	**OP8**
OB	State License Number	-	OB	-	OB	-	OB	-	OB	-	OB	-
1A	Blue Cross Provider Number	-	-	-	-	-	1A	-	1A	-	-	-
1B	Blue Shield Provider Number	1B	1B	1B	1B	1B	1B	1B	1B	1B	1B	1B
1C	Medicare Provider Number	1C	1C	1C	1C	1C	1C	1C	1C	1C	1C	1C
1D	Medicare Provider Number	1D	1D	-	1D	-	1D	1D	1D	1D	1D	1D
1G	Provider UPIN Number	1G	1G	-	1G	-	1G	-	1G	-	1G	-
1H	TRICARE ID Number	1H	1H	-	1H	-	1H	-	1H	-	1H	-
1J	Facility ID Number	1J	-	-	-	-	-	-	-	-	-	-
B3	PPO Number	B3	-	-	-	-	-	-	-	-	-	-
BQ	HMO Code Number	BQ	-	-	-	-	-	-	-	-	-	-
EI	Employer's ID Number	EI	EI	EI	EI	EI	EI	EI	-	-	EI	EI
FH	Clinic Number	FH	-	-	-	-	-	-	-	-	-	-
G2	Provider Commercial Number	G2	G2	G2	G2	G2	G2	G2	G2	G2	G2	G2
G5	Provider Site Number	G5	-	-	-	-	-	-	-	-	-	-
LU	Location Number	LU	LU	LU	LU	LU	LU	LU	LU	LU	LU	-
N5	Provider Plan Network ID Number	-	N5	N5	N5	N5	N5	N5	-	N5	N5	N5
TJ	Federal Taxpayer's ID Number	-	-	-	-	-	-	-	TJ	-	-	-
X4	Clinical Lab Improvement Amendment (CLIA #)	-	-	-	-	-	-	-	X4	-	-	-
U3	Unique Supplier ID Number (USIN)	U3	-	-	-	-	U3	-	-	-	-	-
SY	Social Security Number	SY	SY		SY		SY	-	-	-	SY	-
X5	State Industrial Accident Provider Number	X5	X5	-	X5	-	X5	-	X5	-	X5	-
C = Current Payer **O** = Other Payer												