RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 33
July 2021

Office of Information Technology
Division of Information Technology

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Preface

The purpose of this addendum is to provide information about the Third Party Billing package (Namespace: ABM). The system is designed to automate the creation of a claim using existing Resource and Patient Management System (RPMS) visit data.

Please review and distribute this addendum to your Third Party Billing staff ***prior to*** installation of the patch.

Refer to the notes file released with this patch for all other technical documentation.

References to “Change Requests”, “HEAT”, “Service Now” (or SNOW), and “ADO” (or Azure DevOps) will be seen throughout the document. A Change Request refers to a request to update or modify the software to correct or add additional functionality that will support the mission and goals of the Indian Health Service. HEAT is the software used to document issues reported by the field. SNOW has replaced HEAT as a means of tracking reported issues and documenting support requests. ADO is a system used to track software change requests and has replaced Serena, which was originally used to document the software change request.

Some examples in the manual may contain references to CPT codes. Please review the CPT Code Usage:

CPT Code Usage: Applicable FARS/DFARS Restrictions Apply to Government Use.

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1.0 Introduction

1.1 Summary of Changes

Patch 33 provides enhancements and minor corrections to Version 2.6 of the Third Party Billing application. This patch *is not* cumulative of prior released patches. Please refer to those patch addendums for additional information.

> **Note:** This addendum is not intended to be a billing/process guide. Consult your Business Office Manager or Area Business Office Coordinator for questions regarding insurer billing requirements and processes regarding billing.

1.1.1 Patch 33

1. Inactivate Old Export Modes (ADO60178/CR11435) - Reported by Claremore Indian Hospital

   Made changes to the Claim Editor and other options to allow the user to not see old export modes. This change also includes:

   - Added new field to 3P Export Modes file for INACTIVE FLAG and populated it for all export modes EXCEPT the current paper and electronic (837) formats.
   - Fixed the Ambulance Page (8K) so it will prompt for the mode of export, only display the active entries like the other claim editor pages and split the claim appropriately if the export mode if different from page 1.
   - Added new warning #260 to the Claim Editor on appropriate pages to let the user know if the export mode is inactive.
   - Added the new menu option EXTM-Export Mode Menu on the TMTP Table Maintenance Menu. No key is needed for this option but the user must have Table Maintenance to access.
     - EXTM contains two options; one to allow the editing of a few fields in the 3P Export Mode file, and the other to report what export modes are being using by insurer/visit type.
   - Updated SITM Default Form for Dental Billing to check if the format has the DENTAL SCREEN setup to do dental billing and that the export mode is active.
   - Updated the REPR Reprint Bill option so it will display only the most recent entry, or possibly two if they have been reactivated.

> **Note**: The expiration of export modes is ***not*** site specific, so if an export mode is inactivated for one site it will be inactivated for all sites on that database.

2. Claim Editor Warning #13: Patient Sex Unspecified (ADO60181/CR11622)

   Prior to patch 33, Claim Editor error code #13 was an error for PATIENT SEX UNSPECIFIED. This error will stop the user from approving the claim. Patch 33 changes #13 from an error to a warning, so the patient can have a SEX of Unspecified and the claim can still be approved. Additional changes include:

   - Updated the error description to be 'Unspecified or Blank'.
   - Added the policy holder SEX to the view option on page2.
   - Fixed 1500(02/12) so it will leave FL3 and FL11a blank if the SEX for either the patient or the insured is blank or UNKNOWN.
   - Changed ADA-2012 so FLs 4 and 22 will be blank for either the patient or the insured being blank or UNKNOWN.

3. SOGI - Preferred Name (ADO60185/CR11502)

   The Patient/HRN/Claim Number banner, which prints on the top of every page in the Claim Editor, has been updated to include an asterisk (*) if the patient has a preferred name, as well as an additional line underneath to display the preferred name. Some additional changes include:

   - Shortened 'Claim Number' to 'Claim' to make a little more room on the top line.
   - Updated the VPRP option to include the asterisk (*) and the preferred name if there is one.
   - For reports, made the preferred name print after the full name in exclusion parameters when a specific patient is selected for the billing entity.

4. Changes for VAMB Pharmacy Billing (ADO60186/CR12024)

   Changed the NARR option (NOC NEC Required for 5010 submissions) so the user can select, by insurer, if a particular CPT code should have the CPT Narrative field populate with the CPT description, the Medication description (if there is an NDC on the line item), or if the CPT Narrative should be left blank. The NARR option allows the user to setup the CPT Narrative by payer. Additional changes include:

   - Changed the sequence of prompts in the Claim Editor so the CPT and NDC prompts happen before the CPT Narrative.

- Added a new warning message (#259) if the NDC is associated with a controlled substance that might require the DEA number to be sent on the claim.
- Updated the first line of the CMS-1500(02/12) to print 'N4' and the NDC, 'UN' and the units, and the med name or CPT Narrative based on an updated prompt in the Add/Edit Insurer option, "Should Medication Name print?" to allow BOTH NDC, units, and med name.

5. UB-04 July 1, 2020 Table Updates (ADO60187/CR11200)

   Updated the following 3P Codes categories: Admit Source, Admit Type, Condition Codes, Discharge Status, Newborn, Occurrence Codes, Occurrence Span Codes, and Value Codes.

   It includes all codes that were sent, even if they were already in a status of inactive, were reserved for national assignment, or payer code. Includes '(inactive)' in the description as a quick indicator to the user they are inactive. Also inactivated duplicate entries so the user should only see one of each code now. Updated Page 9C in the Claim Editor so inactive Condition Codes cannot be selected. Also updated is the EDUB option so all fields can be edited.

   While testing, it was found that only one condition code was being sent. It has been updated to send the first 12 in an HI*BG segment.

6. Value Codes Display (ADO60188/CR10380)

   Value codes were not always displaying correctly in the Claim Editor on Page 9D. Sometimes they were formatting as a dollar amount when it should have been a whole number. They have been fixed so they will format correctly all the time. Changes to the display were also made so everything aligns better and fixes were implemented on the paper UB-04 to correctly align.

7. Covered and Non-Covered Days for Inpatient Billing (ADO60189/CR9512 & ADO60190/CR11505) – Reported by Cherokee Indian Hospital Authority and Claremore Indian Hospital

   Created a new summary page that displays when approving an inpatient claim so biller can view and bill for covered days and non-covered days. Part of these changes also include:

   - Corrected units (FL46 and SV205) to be the total days, not the covered days.
   - Corrected total charges to be the whole bill amount, not just the covered days amount on the summary screen, the CLM segment of the 837I, and FL47 on the UB-04.

- The Grouper Allowance was fixed to be included in the adjustments. Prior to this patch, a Grouper Allowance was not allowing the secondary to calculate correctly without manual user intervention.

8. UB-04 Alignment of Form Locator 55 and Form Locator 76 (ADO60196/CR11774/INC0037696)

   Moved UB-04 FL 55 left one character to make it align in the box corrected. Moved FL 76 one character to the right.

9. Sending Additional Data Fields to A/R (ADO60197/CR12174)

   Added the flat rate CPT, flat rate revenue code, and flat rate revenue description to the data that is captured on the 3P Bill. Additional fields have been added to the data being sent to A/R to allow for future reporting in A/R. The notes file contains a complete list of fields being sent. The user will not see these changes in A/R yet (A/R will still need to be patched to accept the data) but this will be the first step for these changes.

10. Billing COVID HCPCS from Labs (ADO61808/CR12178)

    A range of HCPCS codes (U0001-U0004) were added for COVID lab test. These HCPCS are tied to lab tests and should cross over with the rest of the visit from PCC but they were not crossing over correctly. This has been fixed so they will now display.

    Fixed claim editor error 233 to display for the 837P if the type of test result or test result is missing when required. Updated the Claim Editor error 200 to display if there is no 90 modifier and no in-house CLIA on the service line. Updated the Claim Editor page 8E view option so all CPTs will display, not just the first one for each lab.

11. Updates to the CPRP-CPT Charge Report (ADO62035/CR12338)

    Updated the delimited output option to include more data necessary for COVID and for better reporting on CPT/HCPCS/ADA codes.

    - Corrected the issue with the Primary DX missing and throwing off the remaining columns.
    - Removed second device prompt.
    - Split the entry if it was reporting the NDC code so that both NDC and CPT will be reported.
    - Made manual bills show up on report, even though several of the columns will be blank.
    - Corrected some SAR codes not showing up.
    - Added third output option so user can write a delimited report to screen.

2.0 Patch 33

2.1 Claim Editor Updates

Changes have been made to the Claim Editor in Patch 33. Please review the changes carefully for updates that affect the billing staff.

2.1.1 Inactivation of Export Modes

The installation of Patch 33 will allow the billing technician to see a limited display of export modes throughout the billing system. This was accomplished by adding a Status field to the 3P Export Mode file which allows for an entry to be marked as Inactive.

The billing technician will notice that when they type two question marks (**??**) at the "Export Mode" prompt, the system will display a short list of active entries.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:999999]                         Claim: 402621
............................. (CLAIM IDENTIFIERS) .............................

                 [1] Clinic.............: GENERAL
                 [2] Visit Type.........: OUTPATIENT
                 [3] Bill Type..........: 131
                 [4] Billing From Date..: 03/30/2021
                 [5] Billing Thru Date..: 03/30/2021
                 [6] Super Bill #.......:
                 [7] Mode of Export.....: CMS-1500 (02/12)
                 [8] Visit Location.....: 2017 DEMO HOSPITAL
-------------------------------------------------------------------------------
WARNING:075 - EMPLOYER LOCATION UNSPECIFIED
-------------------------------------------------------------------------------

Desired ACTION (Edit/View/Next/Jump/Back/Quit): N// E

Desired FIELDS:  (1-8): 1-8// 7

[7] Mode of Export..: CMS-1500 (02/12)// ??


   Choose from:
   24          NCPDP-P     NCPDP UNIVERSAL CLAIM FORM
   28          UB-04     OMB No. 0938-0997
   31          837I (UB) 5010     837 5010 INSTITUTIONAL
   32          837P (HCFA) 5010     837 5010 PROFESSIONAL
   33          837D (ADA) 5010     837 5010 DENTAL
   34          ADA-2012     ADA Claim Form dated 2012
   35          CMS-1500 (02/12)     OMB No. 0938-1197
   36          ADA-2019     ADA Claim Form dated 2019, J-430
```

Figure 2-1: Display of Condensed Export Mode List on Page 1 of the Claim Editor

If additional export modes are needed ***or*** if additional export modes need to be reactivated, please reference Section 2.3.1.1.

The other CPT pages (Pages 8A to 8K) have also been updated where the user may select a mode of export for each page. If the user types two question marks (**??**), the system will display a condensed export mode list.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:999999]                        Claim: 402621
Mode of Export: 837P (HCFA) 5010
.............................. (MEDICAL SERVICES) ..............................

     REVN                                           UNIT               TOTAL
     CODE         CPT - MEDICAL SERVICES           CHARGE     QTY     CHARGE
     ==== =====================================   ========= ====== =============
[1]  CHARGE DATE: 03/30/2021@11:00
     0510 99202 OFFICE O/P NEW SF 15-29 MIN          216.00      1        216.00
                                                                ==============
                                                                       $216.00

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// M

MODE OF EXPORT PAGE 8A: 837P (HCFA) 5010// ??


   Choose from:
   24           NCPDP-P     NCPDP UNIVERSAL CLAIM FORM
   28           UB-04     OMB No. 0938-0997
   31           837I (UB) 5010     837 5010 INSTITUTIONAL
   32           837P (HCFA) 5010     837 5010 PROFESSIONAL
   33           837D (ADA) 5010     837 5010 DENTAL
   34           ADA-2012     ADA Claim Form dated 2012
   35           CMS-1500 (02/12)     OMB No. 0938-1197
   36           ADA-2019     ADA Claim Form dated 2019, J-430

MODE OF EXPORT PAGE 8A: 837P (HCFA) 5010//
```

Figure 2-2: Display of Limited Export Mode View on Page 8A – Medical in the Claim Editor

See the Export Modes Menu for additional information on editing the Export Modes file.

2.1.2 SOGI – Preferred Name Modifications

Changes have been made to the Claim Editor that allows for the preferred name to display in the Claim Editor and other menus within the billing system. The preferred name is added into the Registration Editor and is provided by the patient. The preferred name is also known as a nickname or alias the patient prefers to be called and does not replace their legal name provided on state or federal documents.

The system was updated to display the name with an asterisk (*****) to indicate that a preferred name entry exists. One line below the patient name will contain the entry for the preferred name.

The format of the name may vary slightly by option but the display will look similar to the Figure 2-3.

```
PATIENT:  DEMO,PATIENT*           M 12/31/1999  ***-**-5555  HRN: 999999
   Preferred Name: NICKNAME
```

Figure 2-3: Format of the Preferred Name that Displays to the User

The patient lookups will display the preferred name when performing a patient search. In addition, the following options have been updated to reflect the preferred name:

- CG1P Claim Generator, One Patient
- EDCL Edit Claim Data
- LOOP Claim Editor Loop
- NEW Add New Claim (Manual Entry)
- RBCL Rebuild Items from PCC
- CKCL Check Eligibility for a Visit
- CLMG Cancel Claim
- IQMG Inquire about an Approved Bill
- ADMG Add a new bill that was Manually Submitted
- OCMG Open/Close Claim
- SCMG Split Claim

The reports have not been updated to reflect the preferred name on the printed report but any references to a patient (where the patient name or chart number is selectable) will display the preferred name when searching for a specific patient entry to include on the report.

Claim Editor Menu

Figure 2-4 displays a sample of the preferred name when displaying a list of claims for the patient.

```
PATIENT:  DEMO,PATIENT*           M 12/31/1999  ***-**-5555  HRN: 999999
   Preferred Name: NICKNAME
===============================================================================

(1)  Claim# 402621     03/30/2021  OUTPATIENT              GENERAL
      2017 DEMO      UNITED HEALTH CARE-HMO       Status: In EDIT Mode




Select 1 to 1:
```

Figure 2-4: Display of Preferred Name in the Claim Editor Claims Display

All pages within the Claim Editor have been updated to display the preferred name. A change has also been made to condense the claim number label and move the field to the left to accommodate large claim number references.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT*  [HRN:999999]                       Claim: 402621
   Preferred Name: NICKNAME
............................... (CLAIM SUMMARY) ..............................
_______ Pg-1 (Claim Identifiers) _______|__________ Pg-3 (Questions) ___________
Location..: 2017 DEMO                   |Release Info: YES  Assign Benef: YES
Clinic....: GENERAL                     |
Visit Type: OUTPATIENT                  |
Bill From: 03-30-2021 Thru: 03-30-2021  |__________ Pg-4 (Providers) ___________
________ Pg-2 (Billing Entity) _________|Attn: PHYSICIAN,ROBERT
UNITED HEALTH CARE-HMO         ACTIVE   |
                                        |__________ Pg-5A (Diagnosis) __________
                                        |1) HYPERTENSION
____________ PCC Visit Data ____________|
Prim Visit: 03/30/2021@11:00  Count: 1  |
Srv Cat: A Hsp Loc: <none>              |________ Pg-8 (CPT Procedures) ________
Last Visit: No Last Visit Found         |1) OFFICE O/P NEW SF 15-29 MIN
                                        |
                                        |
WARNING:250 - DOS after ICD Indicator Date
-------------------------------------------------------------------------------

Desired ACTION (View/Appr/Pend/Next/Jump/Quit): N//
```

Figure 2-5: Display of the Preferred Name in the Claim Summary, Page 0 in the Claim Editor

Reports

If selecting a specific patient entry, the preferred name will display to the user. The preferred name will not print on the report.

```
   EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
   =======================================================================
   - Billing Entity.....: DEMO,PATIENT* - NICKNAME
   - Approval Dates from: 01/01/2011  to: 05/13/2021
   - Report Type........: BRIEF LISTING (80 Width)
```

Figure 2-6: Display of Exclusion Parameters Showing Preferred Name

2.1.3 SOGI – Claim Form Gender Reporting

The claim forms have not changed for the reporting of gender but the biller will need to be aware of their payer requirements for gender reporting for both the patient and the policy holder.

Forms that do not contain an ‘Unknown’ indicator and the gender is marked as Unknown in RPMS, will cause the form to be blank in the gender or sex field.

2.1.4 Covered/Non-Covered Billing for Hospital Inpatient Claims to Medicare

The system has been corrected to allow billing to Medicare and Medicaid without having to make manual corrections for inpatient claims that contain non-covered days. The billing requirements are based on the guidelines in the Indian Health Service Manual published by Novitas Solutions LLC, a Medicare Administrative Contractor:

Billing Requirements for Non-Covered Days

Where a beneficiary receives non-covered care at admission, but subsequently is furnished a covered level of care during the same hospital stay, the admission is deemed to have occurred when covered services became medically needed and rendered. The following additional entries are required on the bill:

- *Form Locator (FL) 35 (Occurrence Span Code) – Include occurrence code M1 and the dates indicating the period of non-covered care.*
- *FL 39 (Value code 80) – Report the total number of covered days.*
- *FL 40 (Value code 81) – Report the total number of non-covered days.*
- *FL 41 (Value Code 31) – Report the total charges of the non-covered accommodations. These charges are also included as non-covered charges on the bill.*
- *FL 48 (Non-Covered Charges) – These charges are also included as non- covered charges on the bill.*

For more information, please review our article on Guidelines for Billing Acute Inpatient Noncovered Days.

Note: This is for billing purposes only. The IHS hospital will not bill the beneficiary for days that inpatient care was no longer required.

Inpatient No-Pay Billing Instructions

A no-pay inpatient claim is submitted to track benefit periods. These claims are filed when:

- *Inpatient benefit days are exhausted.*
- *Determination is made after the patient is dismissed that the inpatient stay was not medically necessary.*
- *The patient only has Part B entitlement but has a supplemental insurance policy that will consider payment of the inpatient claim; therefore, a denial from Medicare is needed.*

The following UB-04 Form Locators should be populated when filing for no-pay claims and the patient has a supplemental insurance that will consider payment of the claim:

- *FL 4 (Type of Bill) – Enter the bill type as 0110*
- *FL 35 (Occurrence Span Code) – Enter occurrence code M1 and the same dates indicated in the "from" and "through" dates in FL 6 (Statement Covers Period)*
- *FL 39 (Non-Covered Days) – Indicate value code 81 and the number of noncovered days*
- *FL 40 (Value Code 31) – Report the total charges of the non-covered accommodations (this is patient liability)*
- *FL 47 (Total Charges) – Indicate the total charges for each line item*
- *FL 48 (Non-Covered Charges) – Indicate the total non-covered charges for each line item*

Once the inpatient "no-pay" inpatient claim has been submitted to Medicare and appears on a remittance advice, providers may then bill the ancillary Part B claim (121 TOB).

This guidance is current as of the publication of this addendum. Please refer to your MAC for updated guidance.

2.1.4.1 Claim Editor Screen Display

The process of editing the non-covered days has not changed. The billing technician must still indicate the non-covered days on Page 7 in the Claim Editor. The sum of the covered and non-covered days must still equal the number of days from the admission date to the discharge date.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 7  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MEDICARE,GLENN  [HRN:135291]                       Claim: 402622
............................... (INPATIENT DATA) ...............................

[1] Admission Date...: 04-03-2021       [2] Admission Hour....: 10
[3] Admission Type...: 02 (URGENT)
[4] Admission Source.: 02 (CLINIC OR PHYSICIAN'S OFFICE)
[5] Admitting Diag...: R42. ()

[6] Discharge Date...: 04-09-2021       [7] Discharge Hour....: 09
[8] Discharge Status.: 01 (DISCHARGED TO HOME OR SELF CARE (ROUTINE DISCHARGE))
[9] Service From Date: 04-03-2021       [10] Service Thru Date: 04-09-2021
[11] Covered Days...: 4                 [12] Non-Cvd Days...: 2
[13] Prior Auth Number.....: AAZZBBEEC0101

Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//
```

Figure 2-7: Viewing the Covered and Non-Covered Days on Page 7 – Inpatient Data in the Claim Editor

Once the claim has been edited, reviewed, and then approved, the user will see and updated summary screen.

```
                                    SUMMARY
================================================================================

Active Insurer: MEDICARE


                          Previous                       Cov'd   Non-cov'd      Bill
    Form        Charges   Payments  Adjustments   Days      Days        Amount
------------  ---------- ---------- ---------- ---------- ----------  ----------
837I (UB) 50   21,786.00       0.00       0.00  14,524.00   7,262.00   21,786.00
              ========== ========== ========== ========== ==========  ==========
               21,786.00       0.00       0.00  14,524.00   7,262.00   21,786.00


Do You Wish to APPROVE this Claim for Billing?
```

Figure 2-8: Display of Summary Page in the Claim Editor showing Non-Covered Days

Prior to this update, the system would not display the **COVERED DAYS (Cov'd Days)** column on the Summary Screen. Patch 33 has modified the screen to display the covered days along with the non-covered days. The system also changed the amount of the bill by sending the total amount of the bill (covered and non-covered amounts) to Accounts Receivable. Prior to the patch update, the system was only sending the Covered Days dollar amount to A/R.

The column header of *Write-offs* has also been replaced with ***Adjustments***. This is to better describe the type of adjustment received from the Accounts Receivable system as not all adjustments are write-offs.

Once approved, the paper claim form will reflect the following on the paper UB-04:

Table 2-1: Form Locator Descriptions and Actions

Form Locator	Description	Action
44	Serv. Units	Reflects the ***total*** number of days the patient was admitted.
47	Total Charges	Total dollar amount of both Covered and Non-Covered days **(Covered + Non-Covered Days) X (Flat Rate Amount)**
48	Non-Covered Charges	Total dollar amount of the Non-Covered days **(Non-Covered Days) X (Flat Rate Amount)**
55	Estimated Amount Due	Total dollar amount of Covered Days **(Covered Days) X (Flat Rate Amount)**

When printed, the paper claim form will print similar to the following form. In this case, the patient was admitted for six days where two days were considered non-covered (2021 rate $3,631.00 x 2 days = $7,262.00) and four days were determined to be covered (2021 rate $3,631.00 x 4 days = $14,524.00).

Total Days: 6 days at Daily Flat Rate ($3,631.00) = $21,786.00

MEDICARE
P.O. BOX 660155
DALLAS, TX 75266-0155

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	31	7262.00	81	2	80	4
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0100	ROOM AND BOARD	3631.00	040321	6	2178600	726200	
23	0001	PAGE 1 OF 1	CREATION DATE	050321	TOTALS	2178600	726200	

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1122334455
A	MEDICARE	320099	Y	Y		1452400	57 OTHER	1122334455
B								

Figure 2-9: Display of UB-04 showing Days Covered and Non-Covered Amounts

The 837 Institutional has been updated to display the following:

Table 2-2: 837 Institutional updates

Segment/ Element	Description	Action
CLM-02	Total Claim Charge Amount	Total dollar amount of both Covered and Non-Covered days **(Covered + Non-Covered Days) X (Flat Rate Amount)**
SV2-03	Line Item Charge Amount	Total dollar amount of both Covered and Non-Covered days **(Covered + Non-Covered Days) X (Flat Rate Amount)**
SV2-04	Unit or Basis for Measurement Code	Use DAYS as the units to represent inpatient days (based on the default revenue code being 100-219)
SV2-05	Service Unit Count (Quantity)	Total number of **COVERED** days
SV2-07	Non-Covered Charge Amount	Total dollar amount of the Non-Covered days **(Non-Covered Days) X (Flat Rate Amount)**

Note that the value in SV2-04 has been updated to reflect DAYS instead of UNITS if the visit is an inpatient visit. The system will also send the total amount of the claim (both covered and non-covered days).

The following is an example of how the 837 Institutional format will look:

```
CLM*402622A-DH-135291*21786.00***11:A:1**A*Y*Y~
DTP*096*TM*0900~
DTP*434*RD8*20210403-20210409~
DTP*435*DT*202104031000~
CL1*2*2*01~
REF*G1*AAZZBBEEC0101~
REF*EA*135291~
HI*ABK:R42:::::::Y~
HI*ABJ:R42~
HI*ABF:G4751:::::::Y*ABF:E860:::::::Y~
HI*BI:M1:RD8:20210407-20210409~
HI*BE:31:::7262*BE:81:::2*BE:80:::4~
HI*BG:C1~
NM1*71*1*MEDICALDOCTOR*TODD****XX*1991991997~
PRV*AT*PXC*208D00000X~
LX*1~
SV2*0101**21786.00*DA*6**7262.00~
DTP*472*D8*20210403~
REF*6R*000000006212000000~
```

Figure 2-10:Display of the 837I that shows the Total Bill Amount in CLM02 and the Covered/Non Covered days in the SV2 Segment

2.1.5 Billing Electronically to the Veterans Administration Under the IHS/THP Agreement

The Veterans Administration (VA) entered into an agreement with the Indian Health Service in December 2012. This allows the IHS Federal and Tribally owned healthcare facilities to bill to the VA for reimbursement. Visits are reimbursed at the Medicaid outpatient flat rate. Claims are submitted using Change Healthcare as the clearinghouse (or a Change Healthcare-supported vendor) and are itemized to the VA. All claims are submitted with the exception of pharmacy charges as the VA’s claim processing software was unable to receive the pharmacy charges electronically.

As of July 2020, the VA has been testing with the IHS and Tribal Health Partners that use RPMS to receive pharmacy files electronically. The claims have been received but some changes are made to alleviate the burden on the biller of having to manually add the prescription description for each medication onto the claim form.

A change has been made to allow the medication description to default for each pharmacy charge. This also required a modification to the *NARR – NOC/NEC Required for 5010 Submission* option. Another update was made to print/send the ordering provider's DEA Number for controlled substances. Minor changes have been made to the Claim Editor which are outlined in this section.

2.1.5.1 Setting the Required Medication Fields in Table Maintenance

Currently, when billing for pharmacy services to the VA, the billing technician must ensure the medication units are submitted and that the CPT narrative is accessible. This allows the medication description, as required by the VA, to be submitted on the claim. To allow the CPT narrative field to be displayed, the NOC NEC Required for 5010 Submissions will need to be set up.

If this has previously been set up, please access the menu option in Table Maintenance to review the parameters and make additional changes. The changes needed are from the new options have been added.

Setting up the Medication Units

To access the medication units, edit the VA Medical Benefit insurer (VAMB) in the Insurer file:

```
3PB>TMTP>INTM>EDIN
```

1. Add the "Select Insurer" prompt, type the name of the VA Medical Benefit insurer and press Enter.
2. Press the Enter key though the prompts to get to the "Select Visit Type" prompt. At this field, type **997** or **PHARMACY** and press Enter.
3. Press the Enter key though the prompts to get to the default "Mode of Export" field. Make sure the field is set to **CMS-1500 (02/12)**.
4. Press the Enter key to get to the "Should Medication Name print?" prompt. Type **BOTH** and press Enter.

> **Note**: If the default "Mode of Export" was previously set to the 837 Professional format, it must be changed to the paper format for the "Should Medication Name print?" field to display. Once the field has been set up, the default export mode may be set back to the electronic format.

```
Select VISIT TYPE..: 131  OUTPATIENT
         ...OK? Yes//   (Yes)

Billable (Y/N/E)....: YES//
```

```
Reporting purposes only:
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before)..:
Procedure Coding....: CPT//
Fee Schedule........:
Add Zero Fees?...: NO//
Multiple Forms?.....: NO//
Payer Assigned Provider Number.....:
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.......: NO//
Mode of Export......: CMS-1500 (02/12)//
Billing Prv Taxonomy:
Should Medication Name print?: ??

     Choose from:
       NAM      PRINT MED NAME
       UNT      PRINT NDC WITH UNITS
       BOTH     BOTH NDC WITH UNITS AND MED NAME
Should Medication Name print?: BOTH NDC WITH UNITS AND MED NAME
```

Figure 2-11:Setting the NDC, Units and Medication Name for VA Claims

Setting up the Narrative Field for the Medication Description

The process of billing the medication requires the user to submit a default HCPCS code of **J3490** for ***all*** medications, regardless of the drug or if there is a corresponding HCPCS code to describe the medication. This is a requirement for billing to the VA only.

To set up the CPT narrative for the VAMB insurer entry:

1. From the main menu in Third Party Billing, access the Table Maintenance Menu (TMTP).
2. Select the **NOC NEC Required for 5010 Submissions (NARR)** option.
3. At the “Select INSURER” prompt, type **VA MEDICAL BENEFIT (VMBP)** or the insurer that is used to bill the VA under the IHS/THP VA Agreement program.
4. The system will display all CPT/HCPCS codes that have been entered with a Req’d entry. Type **J3490** and press Enter. If the code has not been entered prior to this instruction, please add and proceed to the next field.

> **Note**: If the J3490 has already been added, re-select it so that it may be edited.

5. At the “CPTS REQ’ING NARRATIVE” prompt, press Enter.
6. Make sure **Yes** is answered at the “REQ’D FOR INSURER” prompt and press Enter.

7. The Description Type is a new field that has been added. In this case, type **R** or **MEDICATION DESCRIPTION** and press Enter. For the VA Billing, this allows the name of the drug prescribed to the patient to be used rather than the CPT description.
8. A new question has been added which asks the user to answer Yes if they wish to use the CPT description if no Medication or Drug data exists. Type **Yes** and press Enter. This is meant to use the CPT description if billing using a HCPCS drug code on Page 8H in the Claim Editor if not using the medication or drug entry on Page 8D (Pharmacy Page).
9. Type a caret (^) or press Enter at the "Select CPT" prompt if no other CPT codes are needed.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p33            |
           +         NOC NEC Required for 5010 submissions             +
           |                   2017 DEMO HOSPITAL                       |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: DEMO,USER                          4-MAY-2021 8:22 AM

     An insurer and a list of CPT/HCPCS codes will be prompted for.
     Any codes entered for that insurer will send a NARRATIVE of
     "NOT OTHERWISE CLASSIFIED" in the 5010 Professional/Institutional
     export.  If no narrative is entered, an error will display in the claim
     editor.  You will also have the option to select the CPT description
     as the narrative being sent.


Select INSURER: VA MEDICAL BENEFIT (VMBP)       OREGON     97207
         ...OK? Yes// YES  (Yes)


  Current Codes   Req'd?  Description Type  Use CPT desc if no Med desc
  A4253           YES     CPT Desc
  A4245           YES     CPT Desc
  S8490           YES     CPT Desc
  E0607           YES     CPT Desc
  A4259           YES     CPT Desc
  J3490           YES


Select CPT: J3490    Drugs unclassified injection
       UNCLASSIFIED DRUGS
CPTS REQ'ING NARRATIVE: J3490// <Enter>
REQ'D FOR INSURER: YES// <Enter>
DESCRIPTION TYPE: ??

     Choose from:
       C        CPT DESCRIPTION
       R        MEDICATION DESCRIPTION
       B        BLANK
DESCRIPTION TYPE: R  MEDICATION DESCRIPTION

For MEDICATION DESCRIPTION, answer YES if you wish to use the CPT description
if no Medication or drug data exists.  Leave blank if NO.
Use CPT description in place of Medication?: Y  YES
Select CPT:
```

Figure 2-12:Editing the NOC NEC Required for 5010 Submissions Option

2.1.5.2 Editing the Medication in the Claim Editor

Changes were made in the Pharmacy page in the Claim Editor that will allow certain new features to display to the billing technician. The changes affect how the medication entry is added or edited but the display of entries will remain the same.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,VETERAN  [HRN:140026]                        Claim: 402625
Mode of Export: 837P (HCFA) 5010
............................... (MEDICATIONS) ...............................

     REVN  CHARGE                                      DAYS             TOTAL
```

```
     CODE  DATE              MEDICATION              SUPPLY   QTY      CHARGE
     ====  ========================================  ====  =======  ==========
[1]  0250  04/04/2021@11:00     Rx:61423
    00378-1355-05 TRIAMTERENE/HYDROCHLOROTHIAZIDE
                  75MG/50MG TAB                         30       30      14.03
[2]  0250  04/04/2021@11:00     Rx:61466
    00406-0512-01 OXYCODONE/ACETAMINOPHEN 5/325MG
                  TAB                                   20       20      10.50
[3]  0250  04/04/2021@11:00     Rx:61495
    60429-0318-10 LOSARTAN 100MG TAB                    30       30       7.58
                                                                   ===========
     TOTAL                                                              $32.11

-------------------------------------------------------------------------------
WARNING:188 - PHARMACY ENTRY MISSING CORRESPONDING DIAGNOSIS.
-------------------------------------------------------------------------------
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Figure 2-13: Display of Page 8D – Pharmacy Page

When editing the medication charge entry, the billing technician may notice a change in the order the questions appear. For example, the CPT Code field now appears before the NDC prompt. This is to allow for a change where the drug name is searched and displayed to the user based on the NDC entry. This should save the user from manually typing in the drug name for each medication.

For now, each medication entry must be edited and the narrative reviewed to ensure the description is accurate.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// E
Sequence Number to EDIT:  (1-3): 3

[3]  LOSARTAN 100MG TAB

Select 1st MODIFIER:
Is this entry an IV? NO//
Prescription: 61495//
Units (at $.086 per unit): 30//
Times Dispensed (at $5.00 per each time dispensed) : 1
         //
CPT CODE: J3490( )
MTLU found no usable words.

The following word was not used in this search:
     J3

Attempting FILEMAN lookup...
NDC: 60429-0318-10//
CPT Narrative: LOSARTAN 100MG TAB// <<CONFIRM THIS ENTRY
Select SERVICE LINE PROVIDER:
```

Figure 2-14: Editing the Medication Entry to Validate the CPT Narrative

Use of the DEA Number for Controlled Substances

A new warning, **Warning #259 – The DEA Number may be required for this medication (#)**, will display if a drug has been identified as a controlled substance. This warning will appear for the controlled substance regardless of the payer. For VA billing, a copy of the DEA number is required, along with the medication description.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,VETERAN  [HRN:140026]                        Claim: 402625
Mode of Export: 837P (HCFA) 5010
................................ (MEDICATIONS) ...............................

     REVN  CHARGE                                   DAYS              TOTAL
     CODE  DATE              MEDICATION            SUPPLY   QTY       CHARGE
     ====  ==================================  ====  =======  ==========
[1]  0250  04/04/2021@11:00     Rx:61423
    00378-1355-05 TRIAMTERENE/HYDROCHLOROTHIAZIDE
                  75MG/50MG TAB                        30        30      14.03
[2]  0250  04/04/2021@11:00     Rx:61466
    00406-0512-01 OXYCODONE/ACETAMINOPHEN 5/325MG
                  TAB                                  20        20      10.50
[3]  0250  04/04/2021@11:00     Rx:61495
    60429-0318-10 LOSARTAN 100MG TAB                   30        30       7.58
                                                                   ===========
     TOTAL                                                              $32.11

-------------------------------------------------------------------------------
WARNING:188 - PHARMACY ENTRY MISSING CORRESPONDING DIAGNOSIS.
WARNING:259 - The DEA number may be required for this medication (2)
-------------------------------------------------------------------------------
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Figure 2-15: Display of the Warning #259 which Indicates the DEA Number is Required

The system has been updated to print the DEA number of the ordering provider. This means that the billing technician must edit the controlled substance to add the ordering provider.

To allow the DEA entry to be used for the medication, edit the charge and add the ordering provider onto the CPT entry.

1. Edit the line item of the controlled substance on Page 8D by typing **E** to Edit along with the item number.
2. Make sure the CPT code **J3490** has been added to the “CPT CODE” prompt.
3. At the “CPT Narrative” prompt, confirm the entry that is displayed. If the field is blank, add the medication description to include the medication name and dosage.

4. At "Select Service Line Provider", type the name of the **ORDERING PROVIDER** and press Enter. The ordering provider must be able to prescribe controlled substances. The provider must have a DEA number in their provider profile to confirm they can prescribe these types of drugs. Once the ordering provider has been selected, type **O** or **ORDERING PROVIDER** to indicate the provider type and press Enter.
5. Continue to edit the entry by linking the appropriate diagnosis code that validates the prescribed medication.

```
Sequence Number to EDIT:  (1-3): 2

[2]  OXYCODONE/ACETAMINOPHEN 5/325MG TAB

Select 1st MODIFIER:
Is this entry an IV? NO//
Prescription: 61466//
Units (at $.275 per unit): 20//
Times Dispensed (at $5.00 per each time dispensed) : 1
         //
CPT CODE: J3490//
NDC: 00406-0512-01//   OXYCODONE/ACETAMINOPHEN 5/325MG TAB
CPT Narrative: OXYCODONE/ACETAMINOPHEN 5/325MG TAB
           Replace
Select SERVICE LINE PROVIDER: PROVIDER,ROBERT       PRO          PHYSICIAN
    SERVICE LINE PROVIDER: PROVIDER,ROBERT//
   SERVICE LINE PROVIDER TYPE: R// O  ORDERING
```

Figure 2-16: Adding the Ordering Provider to the Medication entry

Once the ordering provider has been added, the Medication screen will display the DEA number alongside the ordering provider entry. For electronic billing, the ordering provider is sent in Loop 2410E. The DEA will print in REF*03.

```
[2]  0250  04/04/2021@11:00     Rx:61466 CPT: J3490
                                         (PROVIDER,ROBERT)  DEA# ZZ9999999
    00406-0512-01 OXYCODONE/ACETAMINOPHEN 5/325MG
                  TAB                                  20        20      10.50
```

Figure 2-17: Display of Ordering Provider and DEA Number

Another update was added to the "Medication View Option" on Page 8D in the Claim Editor which will allow the name and the ordering provider entry to appear. This entry will display as it appears in the Patient Care Component (PCC) application.

This information can be used to help the biller identify the provider without having to exit the Claim Editor and looking in the Pharmacy Package.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,VETERAN  [HRN:140026]                        Claim: 402625
Mode of Export: CMS-1500 (02/12)
........................... (MEDICATION VIEW OPTION) ...........................
```

```
          ***** MEDICATIONS ENTERED THROUGH THE PHARMACY SYSTEM *****

Rx#     Drug                                 Qty    Issued    Last Fill  Rem
-------------------------------------------------------------------------------
61423   TRIAMTERENE/HYDROCHLOROTHIAZIDE 75MG/50MG TAB    3004-04-202104-04-2021(
4)
          NDC#: 00378-1355-05  PRV: PROVIDER,ROBERT
61466   OXYCODONE/ACETAMINOPHEN 5/325MG TAB    20    04-04-202104-04-2021 (0)
          NDC#: 00406-0512-01  PRV: PROVIDER,ROBERT  DEA# ZZ9999999
61495   LOSARTAN 100MG TAB                     30    04-04-202104-04-2021 (4)
          NDC#: 60429-0318-10  PRV: PROVIDER,ROBERT
-------------------------------------------------------------------------------
WARNING:259 - The DEA number may be required for this medication (2)
-------------------------------------------------------------------------------

 Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired):
```

Figure 2-18: Viewing the Controlled Substance, the Ordering Provider and the DEA Number

2.1.5.3 Adding a Medication into the Claim Editor

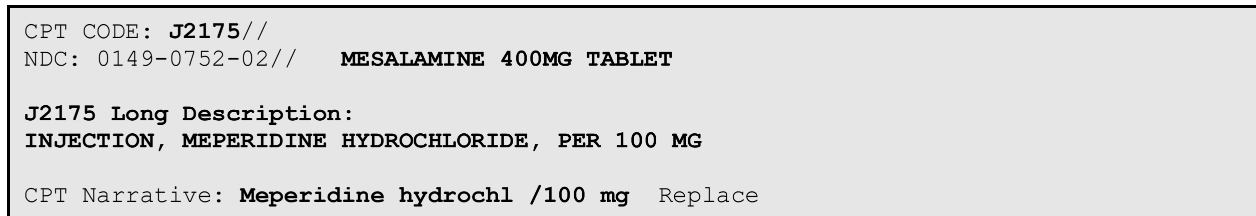
If a medication is manually added to Page 8D of the Claim Editor, the system will attempt to add the CPT Narrative based on the parameter set in the NARR option. To allow the entry to display, each medication entry must be edited and the description validated.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A
Select DRUG GENERIC NAME: VITAMIN B COMPLEX CAPSULE                  10-11-03
00536-4787-01

[4]  VITAMIN B COMPLEX CAPSULE

Select 1st MODIFIER:
Is this entry an IV? NO//
Prescription:
SERVICE TO DATE/TIME:
Units (at $0 per unit): 30
Times Dispensed (at $5.00 per each time dispensed) : 1
         //
DAYS SUPPLY: 30
PRESCRIPTION:
Refill:
DATE WRITTEN: -31  (APR 05, 2021)
CPT CODE: J3490( )
MTLU found no usable words.

The following word was not used in this search:
     J3

Attempting FILEMAN lookup...
NDC: 00536-4787-01//   VITAMIN B COMPLEX CAPSULE
CPT Narrative: VITAMIN B COMPLEX CAPSULE  Replace
```

Figure 2-19: Validating the CPT Narrative on the Medication Page

In this case, the user selected to have the CPT narrative description used in place of the NDC narrative. When this happens, the system will display the CPT/HCPCS description.

The billing technician must confirm that the entry that was added is a complete description that also contains the dosage prescribed. The user is not required to add the units (UN##) to the description. Also, make sure the description prints the dosage on the claim form.



```
CPT CODE: J2175//
NDC: 0149-0752-02//   MESALAMINE 400MG TABLET

J2175 Long Description:
INJECTION, MEPERIDINE HYDROCHLORIDE, PER 100 MG

CPT Narrative: Meperidine hydrochl /100 mg  Replace
```

Figure 2-20: Display of the CPT Narrative when the CPT Description is used instead of the NDC Drug Description

Notice that the CPT description will display to the user for informational purposes. This it to help the billing technician decide which is the appropriate description to use.

2.1.5.4 Exporting the VA Pharmacy Claim

Printing the paper claim will look similar to the following. The following has been updated in Patch 33:

- The dashes have been removed from the NDC.
- The units print between the NDC and the description.
- The description from the CPT Narrative prints up to Box 24H on the CMS-1500.
- The DEA number of the ordering provider will print in place of the provider’s taxonomy in Box 24J, line 1.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N400378135505 UN30 TRIAMTERENE/HCTZ 75/50MG															208D00000X
	04	04	21	04	04	21	22		J3490		AB	14.03	30		NPI	1991991997
2	N400406051201 UN20 **OXYCODONE/ACETAMINOPHEN 5/325MG TAB**															**ZZ9999999**
	04	04	21	04	04	21	22		J3490		B	10.50	20		NPI	1991991997
3	N460429031810 UN30 LOSARTAN 100MG TAB															208D00000X
	04	04	21	04	04	21	22		J3490		AB	7.58	30		NPI	1991991997
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Figure 2-21: Display of Block 24 of the Paper CMS-1500

2.2 Export Mode Updates

Some minor changes have been made to the export modes portion of the Third Party Billing system.

2.2.1 UB-04

2.2.1.1 Alignment of Form Locator 55 and Form Locator 76

Two fields on the paper UB-04 have been updated to print correctly. The first field is Form Locator 55 (Estimated Amount Due) and Form Locator 76 (Attending Provider, NPI, Qualifier and Legacy Number).

Figure 2-22: Display of Lower Portion of UB-04 that Reflects Form Locator 55 and Form Locator 76

2.3 Table Maintenance

A new menu option has been added into Table Maintenance. No new keys are needed (other than the Table Maintenance key) to access the new menu.

2.3.1 Export Modes Menu

A new menu option has been added to the Table Maintenance menu that allows the user to make edits to the Export Mode which includes both the paper and electronic claim formats. This also allows the use to reactivate formats that have been made inactive if the format is needed by the facility for billing or tracking purposes.

2.3.1.1 Export Mode Maintenance

3PB>TMTP>EXTM>EXTM

The Export Mode Maintenance option is used to make edits to the claim forms. This option mainly allows the format to be inactivated if no longer used. The form may also be reactivated if it is needed for billing or other activities in the system.

To edit a format, select Export Mode Maintenance:

1. Type the name or the number of the format at the "Select 3P EXPORT MODE FORMAT" prompt and press Enter.
2. The system will display the TOP MARGIN. If the margin on the paper claim form needs to be adjusted by a line, use this field to adjust by typing in the number of lines the form needs to be moved down by. Once added, press Enter.
3. The system will display the LEFT MARGIN field. If the left margin needs to be adjusted, type the number of columns needed to move the to the right. Once added, press Enter.

> **Note**: Use caution when making adjustments to the margins and work with the RPMS Administrator at the facility as the format settings may be printer or system controlled. Changing the margins may affect how the claim form is printed and result in printing onto multiple pages.

4. At the "INACTIVE FLAG" prompt, type **INACTIVE** if the format needs to be removed or is no longer in use and press Enter.
   a. If the format is not displaying to the user and needs to be active, the INACTIVE entry may be deleted by typing the at symbol (**@**) symbol and pressing Enter.
5. The UPPER LIMIT will be displayed next. This field allows the user to place a dollar amount that will be used to warn the user that they are approving a claim where the total amount exceeds the upper limit. This is meant to alert the billing technician, prior to approving the claim in the Claim Editor and prevent billing for an erroneous large dollar amount.
6. The DENTAL SCREEN is used to indicate whether the format is used for dental billing or not. This is usually set by the development staff and is used when setting up the billing parameters as this is used to indicate whether or not the form will be used for dental billing.

```
+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
|        THIRD PARTY BILLING SYSTEM - VER 2.6p33          |
+                Export Mode Maintenance                   +
|                   2017 DEMO HOSPITAL                     |
+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
```

```
           User: USER, DEMO                          12-MAY-2021 10:25 AM
Select 3P EXPORT MODE FORMAT: HCFA-1500 Y2K       HCFA 1500 Y2K version


TOP MARGIN: 2//
LEFT MARGIN: 0//
INACTIVE FLAG: INACTIVE//
UPPER LIMIT:
DENTAL SCREEN: CAN BE USED FOR DENTAL//

Press RETURN to continue...
```

Figure 2-23:Display of the Export Mode Maintenance Option

2.3.1.2 Export mode Report

3PB>TMTP>EXTM>EXRP

A new report has been created that will allow the user to audit the system to view the payers that have one or more Visit Types set up along with the defaulted export mode. This allows the user to determine if a newer or recent export mode needs to be updated for the payer and will be especially important if the insurer file has not been updated in some time and if the insurers contain old or outdated export modes.

The report may be generated one of four ways to provide the following data:

1. D – Select a date (insurers billed from this date thru today)

   This option allows the user to add a date. The date is used as a starting point to pull insurers onto the report that fall within the start date and the date the report is generated. These are insurers that were billed within that time period and may be more ideal for the user to run and update current payers.

2. A – Run for ALL insurers (regardless of date last billed)

   This option will generate a list of all payers in the system that contain a Visit Type and list the default export mode for each of those charges. This option may not be viable as some payers may not have been billed for a while but will print on the report.

3. I – Only for insurers that contain an inactive export mode

   This report will generate a list of payers that contain a Visit Type with an export mode that has been marked as Inactive. This allows the user to identify those insurers that need to be updated but this list will also generate old payers that may not have been billed in years.

4. O – One specific insurer

   This report will provide the details by Visit Type for one specific insurer.

Figure 2-24 displays the menu available to the user:

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |        THIRD PARTY BILLING SYSTEM - VER 2.6p33          |
          +                  Export Mode Report                     +
          |                  2017 DEMO HOSPITAL                     |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: USER, DEMO                       12-MAY-2021 1:15 PM

  This report is a quick reference to find out what insurers and visit types
  are using what export mode, so you can review and update the export modes to
  current formats.  You can run the report either by selecting a date range of
  insurers (for example, all insurers that have been billed in the last year),
  or you can choose all insurers (keep in mind this output could be large
  depending on the number of insurers/visit types you have set up).  You'll
  have the option to send the output to a printer or to a delimited file that
  can be imported into Excel.


     Select one of the following:

          D         Select a Date (insurers billed from this date thru today)
          A         Run for ALL insurers (regardless of date last billed)
          I         Only insurers that contain an inactive export mode
          O         One specific insurer

Enter response:
```

Figure 2-24: Display of the Export Mode Report Selection Criteria Menu

Generating an Export Mode Report by Date

In the Export Mode Report option, select **D** to generate a report by date. Enter the Start Date which would be equivalent to the date the insurer was used to bill. The report may be printed or sent to the Host File (HFS) for import into Microsoft Excel.

```
Enter response: D  Select a Date (insurers billed from this date thru today)
Enter a start date:  5/1/21  (MAY 01, 2021)

     Select one of the following:

          P         Print Report
          H         Print Delimited Report to the HOST FILE

<P> to Print, <H> to Host File: P// rint Report

Output DEVICE: HOME//   VT
```

Figure 2-25:Generating the Export Mode Report by Date

The generated report will look similar to the following example. Use this report to determine which insurers and Visit Types will need updates to a current export mode.

```
===============================================================================
3P Insurer/Export Mode Report run by DEMO,USER   MAY 12,2021@13:15:25   Page 1
For insurers billed from 05/01/2021 thru 05/12/2021
Billing Location: 2017 DEMO
===============================================================================
                          Insurer Visit       Visit
```

```
      Insurer              IEN   Type#       Type                Export Mode
-------------------------------------------------------------------------------
BC/BS UNITED OF WI         188    111 INPATIENT                UB-82

DELTA DENTAL OF NEW MEXICO 83     998 DENTAL                   837D (ADA) 5010

MEDICARE                   2      111 INPATIENT                837I (UB) 5010
                                  121 ANCILLARY (MCR PART B O 837I (UB) 5010
                                  131 OUTPATIENT               837I (UB) 5010
                                  994 OPTOMETRY                837I (UB) 5010
                                  996 LABORATORY               HCFA-1500B
                                  999 PROFESSIONAL COMPONENT  837P (HCFA) 5010

MONTANA MEDICAID           452    131 OUTPATIENT               837I (UB) 5010

NEW MEXICO BC/BS INC       261    111 INPATIENT                837P (HCFA) 5010
                                  131 OUTPATIENT               837P (HCFA) 5010
                                  151 AMBULANCE SERVICES       837P (HCFA) 5010
                                  996 LABORATORY               837P (HCFA) 5010
                                  998 DENTAL                   837D (ADA) 5010
                                  999 PROFESSIONAL COMPONENT  CMS-1500 (02/12)

NEW MEXICO MEDICAID        453    111 INPATIENT                UB-82
                                  131 OUTPATIENT               837I (UB) 5010
                                  151 AMBULANCE SERVICES       837P (HCFA) 5010
                                  998 DENTAL                   837I (UB) 5010

RAILROAD RETIREMENT        1      131 OUTPATIENT               837I (UB) 5010
                                  999 PROFESSIONAL COMPONENT  837P (HCFA) 5010

UNITED HEALTH CARE         1197   111 INPATIENT                837I (UB) 5010
                                  131 OUTPATIENT               837I (UB) 5010
                                  998 DENTAL                   837I (UB) 5010

VA MEDICAL BENEFIT (VMBP)  1992   131 OUTPATIENT               837P (HCFA) 5010
                                  997 PHARMACY                 837P (HCFA) 5010
                                  998 DENTAL                   837D (ADA) 5010
                                  999 PROFESSIONAL COMPONENT  837P (HCFA) 5010


(REPORT COMPLETE):
```

Figure 2-26:Display of Export Mode Report by Date

The following example shows what the Export Mode Report by Date will look like if printed to the HFS and imported into Microsoft Excel.

ABM_EXPORTMRPT_DATE.txt - Excel

===

3P Insurer/Export Mode Report run by LUJAN,ADRIANMAY 14,2021@07:28:51 Page 1

For insurers billed from 05/01/2021 thru 05/14/2021

Billing Location: 2017 DEMO

===

Insurer	Insurer	Visit Type#	Visit Type	Export Mode
BC/BS UNITED OF WI	188	111	INPATIENT	UB-82
DELTA DENTAL OF NEW MEXIC	83	998	DENTAL	837D (ADA) 5010
MEDICARE	2	111	INPATIENT	837I (UB) 5010
MEDICARE	2	121	ANCILLARY (MCR PART B (	837I (UB) 5010
MEDICARE	2	131	OUTPATIENT	837I (UB) 5010
MEDICARE	2	501	UNBILLABLE	837I (UB) 5010
MEDICARE	2	502	PENDING	837I (UB) 5010
MEDICARE	2	851	851 CAH O/P	837I (UB) 5010
MEDICARE	2	994	OPTOMETRY	837I (UB) 5010
MEDICARE	2	996	LABORATORY	HCFA-1500B
MEDICARE	2	999	PROFESSIONAL COMPONENT	837P (HCFA) 5010
MONTANA MEDICAID	452	131	OUTPATIENT	837I (UB) 5010
NEW MEXICO BC/BS INC	261	111	INPATIENT	837P (HCFA) 5010
NEW MEXICO BC/BS INC	261	131	OUTPATIENT	837P (HCFA) 5010
NEW MEXICO BC/BS INC	261	151	AMBULANCE SERVICES	837P (HCFA) 5010
NEW MEXICO BC/BS INC	261	996	LABORATORY	837P (HCFA) 5010
NEW MEXICO BC/BS INC	261	998	DENTAL	837D (ADA) 5010
NEW MEXICO BC/BS INC	261	999	PROFESSIONAL COMPONENT	CMS-1500 (02/12)
NEW MEXICO MEDICAID	453	111	INPATIENT	UB-82
NEW MEXICO MEDICAID	453	131	OUTPATIENT	837I (UB) 5010
NEW MEXICO MEDICAID	453	151	AMBULANCE SERVICES	837P (HCFA) 5010
NEW MEXICO MEDICAID	453	998	DENTAL	837I (UB) 5010
RAILROAD RETIREMENT	1	131	OUTPATIENT	837I (UB) 5010
RAILROAD RETIREMENT	1	501	UNBILLABLE	837I (UB) 5010
RAILROAD RETIREMENT	1	502	PENDING	837I (UB) 5010
RAILROAD RETIREMENT	1	851	851 CAH O/P	837I (UB) 5010
RAILROAD RETIREMENT	1	999	PROFESSIONAL COMPONENT	837P (HCFA) 5010
UNITED HEALTH CARE	1197	111	INPATIENT	837I (UB) 5010
UNITED HEALTH CARE	1197	131	OUTPATIENT	837I (UB) 5010
UNITED HEALTH CARE	1197	998	DENTAL	837I (UB) 5010
UNITED HEALTH CARE-HMO	1100	111	INPATIENT	837I (UB) 5010
UNITED HEALTH CARE-HMO	1100	131	OUTPATIENT	CMS-1500 (02/12)
UNITED HEALTH CARE-HMO	1100	996	LABORATORY	UB-04
UNITED HEALTH CARE-HMO	1100	999	PROFESSIONAL COMPONENT	837P (HCFA) 5010
VA MEDICAL BENEFIT (VMBP)	1992	131	OUTPATIENT	837P (HCFA) 5010
VA MEDICAL BENEFIT (VMBP)	1992	997	PHARMACY	837P (HCFA) 5010
VA MEDICAL BENEFIT (VMBP)	1992	998	DENTAL	837D (ADA) 5010
VA MEDICAL BENEFIT (VMBP)	1992	999	PROFESSIONAL COMPONENT	837P (HCFA) 5010

Figure 2-27:Display of Export Mode Report by Date in Excel

Generating the Export Mode Report for One Specific Insurer

In the Export Mode Report option, select **O** to generate a report for a specific insurer. At the “Select One Insurer to Report Visit Type Export Modes for” prompt, type the name of the insurer and press Enter. The report may be printed or sent to the HFS for import into Microsoft Excel.

```
Enter response: One specific insurer
Select one insurer to report visit type, export modes for:    VA MEDICAL BENEFIT
 (VMBP)     OREGON     97207
         ...OK? Yes//   (Yes)


     Select one of the following:

          P         Print Report
          H         Print Delimited Report to the HOST FILE

<P> to Print, <H> to Host File: P//
```

Figure 2-28: Generating an Export Mode Report for a Specific Insurer

The generated report will look similar to the following example. Use this report to review one insurer and determine which Visit Types will need an update to a current export mode.

```
===============================================================================
3P Insurer/Export Mode Report run by DEMO,USER    MAY 13,2021@15:36:27   Page 1
For insurer VA MEDICAL BENEFIT (VMBP)
Billing Location: 2017 DEMO
===============================================================================
                          Insurer Visit       Visit
       Insurer              IEN   Type#       Type                 Export Mode
-------------------------------------------------------------------------------
VA MEDICAL BENEFIT (VMBP)   1992   131 OUTPATIENT               837P (HCFA) 5010
                                   997 PHARMACY                 837P (HCFA) 5010
                                   998 DENTAL                   837D (ADA) 5010
                                   999 PROFESSIONAL COMPONENT   837P (HCFA) 5010


(REPORT COMPLETE):
```

Figure 2-29: Display of Export Mode Report for a Specific Insurer

2.4 Reports

2.4.1 CPT Charge Report (CPRP) Modifications

The CPT Charge Report has been modified to allow for additional reporting of CPT data and for better report formatting during output. This report is meant to provide detailed charge data by CPT, HCPCS or ADA code. The report will also provide statistics for pharmacy services billed using an NDC. Some of the other changes to this report include:

- Additional fields to print when selecting the delimited output option
- Corrected issue with the primary diagnosis missing from some entries which would cause the data to import in the wrong columns
- Displaying manual bills on the report
- Corrected some Standard Adjustment Reason codes (SAR) to appear if missing
- Added option to allow delimited report to generate to the screen

The option most updated was the Output Type (Option #6) on the list of Exclusion Parameters which allows for generating the report to:

1. A printer. This is the standard way of generating a report but will print in a condensed format.
2. Delimited to HFS file (for Excel Importing). This is used to print a data file which is imported into Microsoft Excel). This type of report contains more detail than the printed report in option 1.
3. Delimited to screen. This new option allows the report to generate on screen and provides the same detail as option #2. Note, this output requires at least 180-columns to print correctly so temporarily modifying your telnet software to expand to 180 characters may be required for easier display. This type of option also requires session logging to capture the report data.

```
Select ONE or MORE of the above EXCLUSION PARAMETERS: 6  OUTPUT TYPE

     Select one of the following:

          1         Printer
          2         Delimited to HFS file (for Excel Importing)
          3         Delimited to screen

Select TYPE of Output:
```

Figure 2-30: Exclusion Parameter for the CPT Charge Report showing Output types

If the first option (Printer) is selected, the report output will look similar to the following.

```
===============================================================================
Bill Status Report for ALL BILLING SOURCES      MAY 16,2021@10:44:36   Page 1
with VISIT DATES from 05/01/2021 to 05/16/2021
Billing Location: 2017 DEMO
===============================================================================
Bill#       DOS         CPT   Active Insurer   Billed    Paid      Denied    SAR
-------------------------------------------------------------------------------

   Provider: DEMO,PROVIDER
402634A     05/01/2021  12001   UNITED HEALT     501.00       0.00      0.00
                        J7613                      9.93
                        99211                    100.00
                        99215                    479.00
```

```
                        71046                    150.00
                        85025                     46.00
                        00120                     15.00
                        J7613                     11.00
                        94640                     72.00
                                               ---------  --------- ---------
                    Total for Bill: 402634A    1,383.93       0.00      0.00

   Provider: DEMO 2,PROVIDER
402635A     05/02/2021  A0427   NEW MEXICO B     500.00       0.00      0.00
                        A0425                    150.00
                                               ---------  --------- ---------
                    Total for Bill: 402635A      650.00       0.00      0.00

                                                     ======
                                               Total:2

(REPORT COMPLETE):
```

Figure 2-31: CPT Charge Report using the Printer Output Type

2.4.1.1 Using "Delimited to Screen" Option

Selecting to print the report **Delimited to Screen** allows the user to print the report to their screen. Depending on your terminal emulator (telnet), you can expand the width of the output. This is not possible.

The following example shows the delimited report that was generated to the HFS and imported into Excel.

```
Select ONE or MORE of the above EXCLUSION PARAMETERS: 6  OUTPUT TYPE

     Select one of the following:

          1         Printer
          2         Delimited to HFS file (for Excel Importing)
          3         Delimited to screen

Select TYPE of Output: 3  Delimited to screen

   EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
   =======================================================================
   - Visit Dates from...: 01/01/2021  to: 07/19/2021
   - Output Type........: Delimited to screen

     Select one of the following:

          1         LOCATION
          2         BILLING ENTITY
          3         DATE RANGE
          4         APPROVING OFFICIAL
          5         PROVIDER
          6         OUTPUT TYPE

Select ONE or MORE of the above EXCLUSION PARAMETERS:
DEVICE: HOME// 0;80;200  VT

........................................................................
```

Figure 2-32:Selecting Delimited to Screen as an Option

Notice the output of the report print with the caret (^) as the delimiter. Also, each line will print a tilde (~) at the end of each line. This is done to make importing into Excel easier.

```
===============================================================================
Bill Status Report for ALL BILLING SOURCES      JUL 19,2021@12:30:20   Page 1
with VISIT DATES from 01/01/2021 to 07/19/2021
Billing Location: 2017 DEMO
===============================================================================
Visit Location^Bill#^Bill Status^HRN^Patient^Date of Service^Visit Type#^Visit T
ype^Clinic#^Clinic^Insurer Type^Active Insurer^Provider^Billed^Bill Type^Export
Mode^Primary DX^CPT/HCPCS/ADA^Revenue Code^NDC^CPT Amount^Payment^Denied/SAR~
2017 DEMO HOSPITAL^402622A^BILLED^135291^MEDICARE,GLENN^04/03/2021^111^INPATIENT
^1^GENERAL^MEDICARE FI^MEDICARE^PROVIDER,ROBERT J^21,786.00^111^837I (UB) 5010^R42.
^^100^^21786^0^~
2017 DEMO HOSPITAL^402625C^BILLED^140026^DEMO,VETERAN^04/04/2021^997^PHARMACY^66
^ENDOCRINOLOGY^VETERANS ADMINISTRATION^VA MEDICAL BENEFIT (VMBP)^PROVIDER,ROBERT^
32.11^131^CMS-1500 (02/12)^I10.^J3490^250^00378-1355-05^14.03^0^~
```

Figure 2-33:Data Dump Showing Unformatted Report

The user may need to import the report into Microsoft Word prior to uploading into Excel in order to re-format the data that will go into Excel. If the formatting is not performed, the data will import into Excel with incomplete data lines as the system will place the wrapped data as a new line.

Open Microsoft Word and paste all the report data into a blank document.

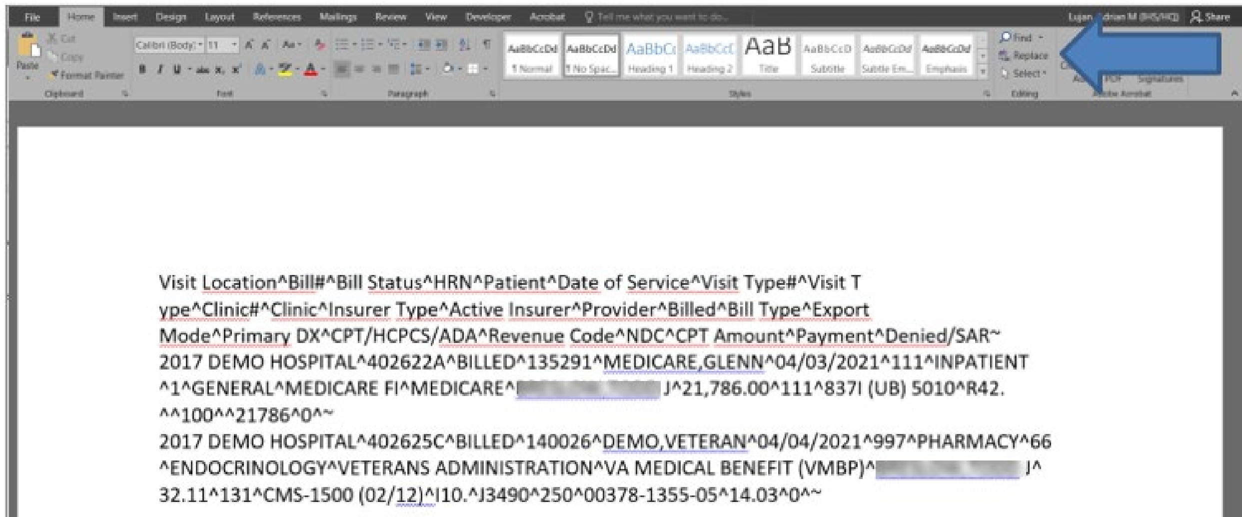


Figure 2-34: Pasting the Report Data into Word

Click **Replace**. The **Find and Replace** dialogue box will display. Click on the blank box to the right of the **Find what:** label so that the curser is blinking in the empty box.

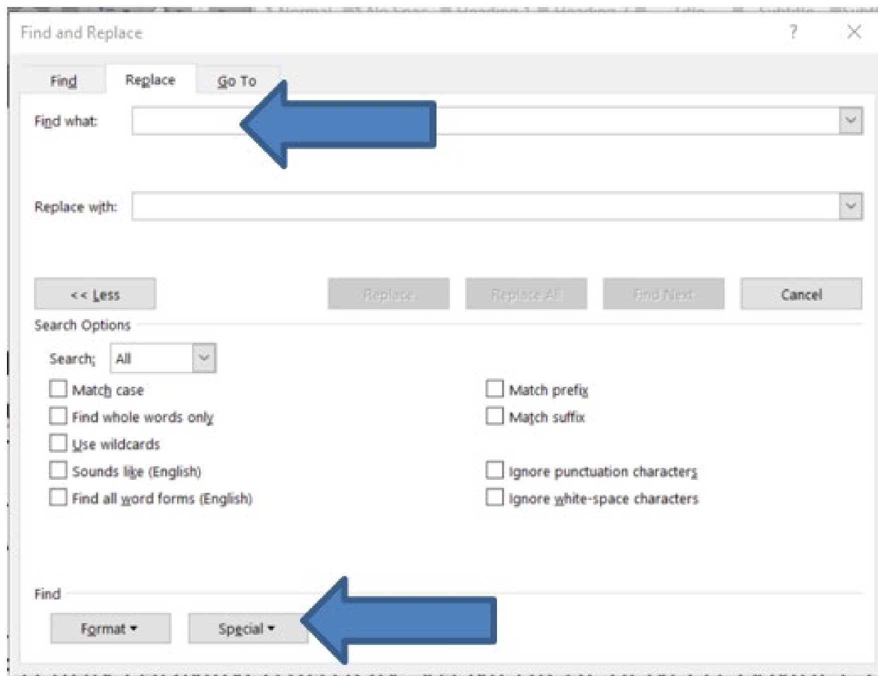


Figure 2-35: Clicking on Find What and then Special in the Find and Replace box

Next, click the **Special** button located at the bottom of the screen.

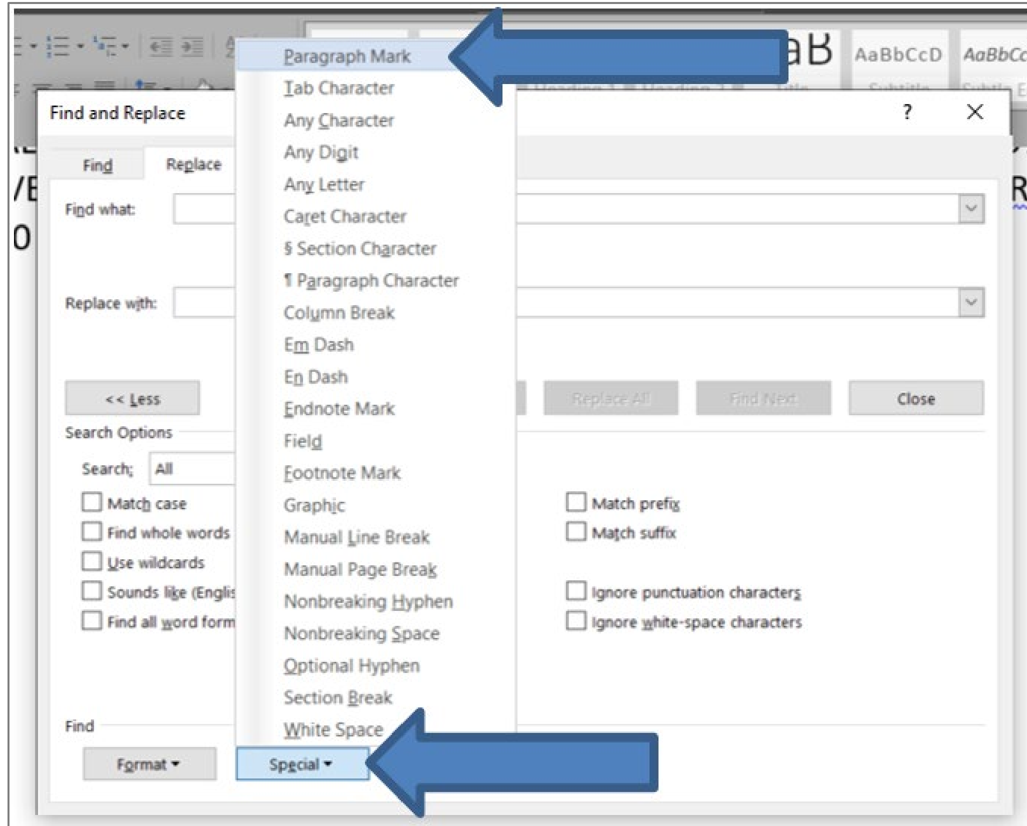


Figure 2-36:Clicking on the Paragraph Mark after clicking the Special button

Select **Paragraph Mark**. The **Find what:** field will populate with **^p**. Leave the **Replace with:** field blank which will place all data on one continuous line.

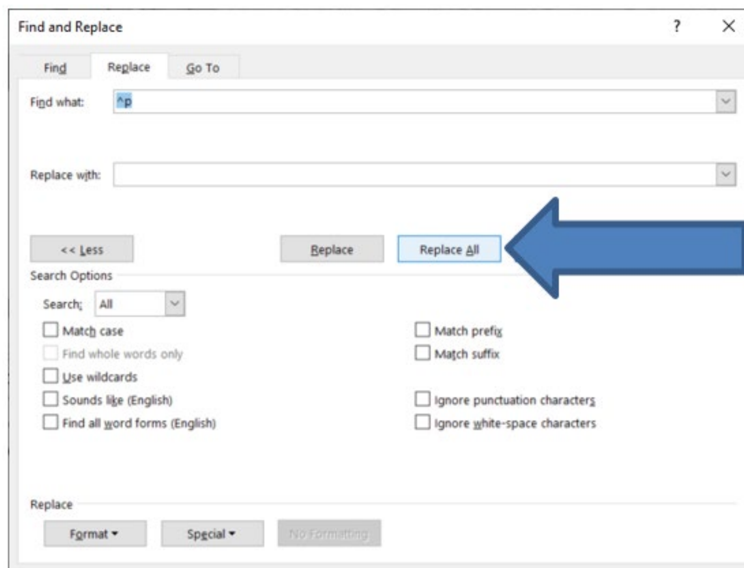


Figure 2-37: Clicking on Replace All in the Find and Replace field

Click **Replace All** and the system will re-format the data. The next steps will cover adding the line break back into the data.

The user must then replace the tilde (~) with a manual line break. Performing this step will ensure the file will upload to Excel with minimal user intervention.

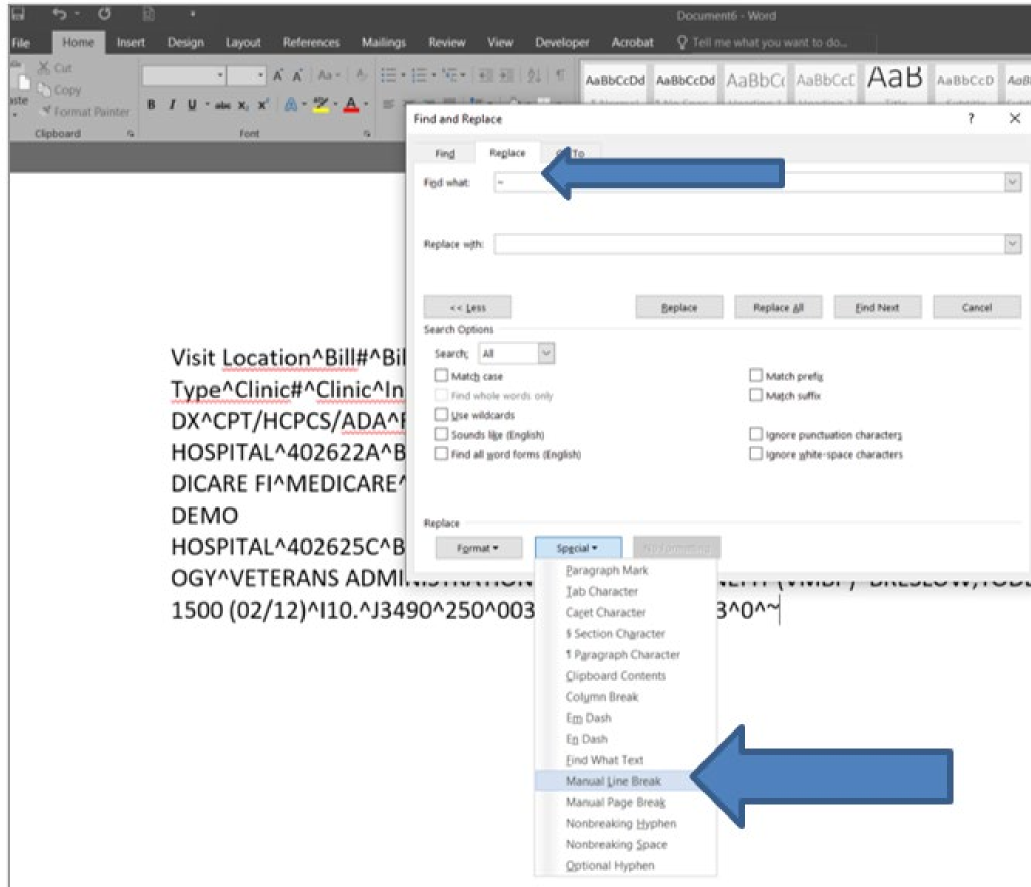


Figure 2-38:Adding the Tilde (~) and clicking on Manual Line Break in Find and Replace

Make sure the ^| appears in the **Replace With:** field and click the **Replace With** button.

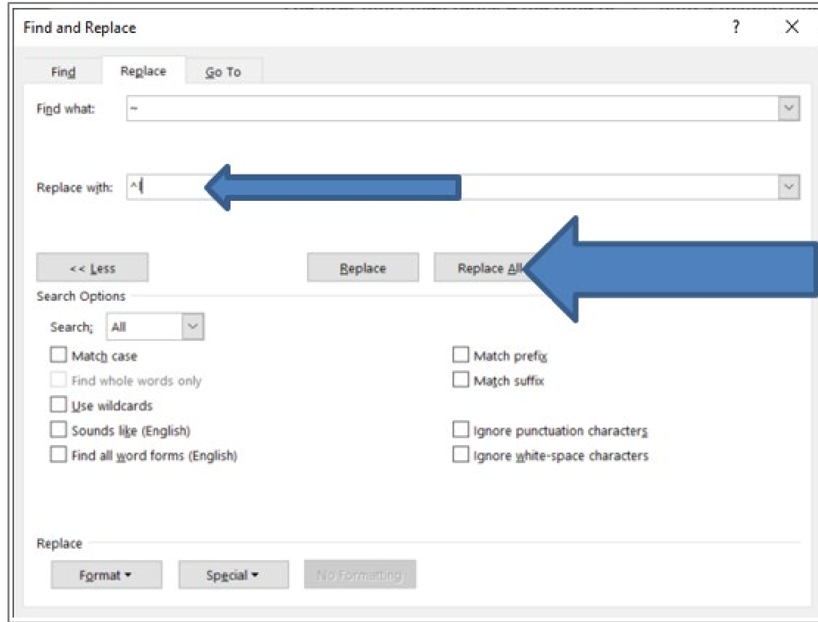


Figure 2-39: Clicking on Replace With after Validating the Replace With entry

The final output will format the report to add line breaks for each line. The data is now ready to import into Excel.

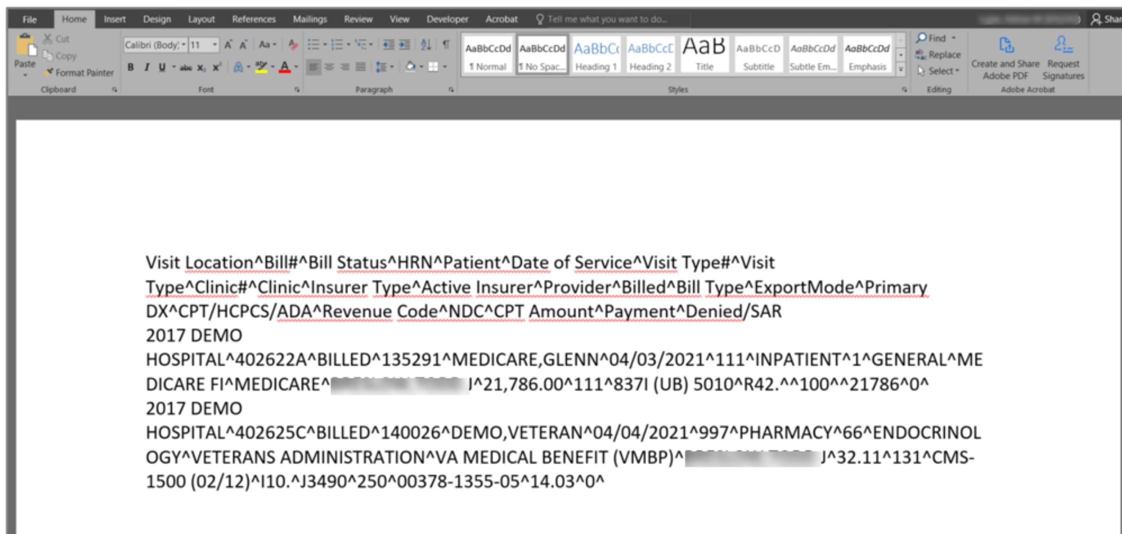


Figure 2-40: Final Output of the CPT Charge Report prior to Importing into Excel.

The next image shows what the report would look like after being uploaded into Excel.

```
==============================================================================
Bill Status Report for ALL BILLING SOURCES     MAY 10,2021@13:53:06  Page 1
with VISIT DATES from 01/01/2021 to 01/31/2021
Billing Location: 2017 DEMO
==============================================================================
```

Visit Location	Bill#	Bill Status	HRN	Patient	Date of Service	Visit Type#	Visit Type	Clinic#	Clinic	Insurer Type	Active Insurer	Provider	Billed	Bill Type	Export Mode	Primary DX	CPT/ HCPCS / ADA	Revenue Code	NDC	CPT Amount	Payment	Denied / SAR
2017 DEMO HOSPITAL	402574A	BILLED	124100	HERO, PRESTON	1/1/2021	131	OUTPATIENT	13	INTERNAL MEDICINE	MEDICARE FI	MEDICARE	COOPER,STEVEN	142	730	837I (UB) 5010	E10.9	99212	510		142	0	
2017 DEMO HOSPITAL	402575A	BILLED	147003	BOLT, HALO	1/1/2021	131	OUTPATIENT	13	INTERNAL MEDICINE	PRIVATE	NEW MEXICO BC/BS INC	COOPER,STEVEN	162	131	UB-04	E10.9	99212	510		162	0	
2017 DEMO HOSPITAL	402577A	BILLED	127259	BUNNY ,BLUE	1/1/2021	131	OUTPATIENT	13	INTERNAL MEDICINE	PRIVATE	NEW MEXICO BC/BS INC	COOPER,STEVEN	162	131	UB-04	E10.9	99212	510		162	0	
2017 DEMO HOSPITAL	402580A	BILLED	116258	JALAPENO,ARIEL	1/2/2021	131	OUTPATIENT	1	GENERAL	VETERANS ADMINISTRATION	VA MEDICAL BENEFIT (VMBP)	COOPER,STEVEN	206	131	UB-04	N39.0	99213	510		206	0	
2017 DEMO HOSPITAL	402586A	BILLED	185963	NO CASH,JOHNNY	1/1/2021	131	OUTPATIENT	13	INTERNAL MEDICINE	HMO	GEHA	COOPER,STEVEN	299	131	837P (HCFA) 5010	R07.89	99214	510		299	0	
2017 DEMO HOSPITAL	402587A	BILLED	185963	NO CASH,JOHNNY	1/1/2021	131	OUTPATIENT	13	INTERNAL MEDICINE	MEDICARE FI	RAILROAD RETIREMENT	COOPER,STEVEN	327	131	837I (UB) 5010	R07.89		510		327	0	
2017 DEMO HOSPITAL	402588A	BILLED	185963	NO CASH,JOHNNY	1/1/2021	131	OUTPATIENT	13	INTERNAL MEDICINE	MEDICARE FI	MEDICARE	COOPER,STEVEN	299	730	837I (UB) 5010	R07.89	99214	510		299	0	
2017 DEMO HOSPITAL	402591A	APPROVED	116258	JALAPENO,ARIEL	1/6/2021	131	OUTPATIENT	13	INTERNAL MEDICINE	VETERANS ADMINISTRATION	VA MEDICAL BENEFIT (VMBP)	COOPER,STEVEN	299	131	837P (HCFA) 5010	R07.89	99214	510		299	0	

Figure 2-41: CPT Charge Report using the Host File Server Output

2.5 Table Updates

2.5.1 UB-04 Table Update

An update to the UB-04 tables have been performed which affects the 3P Codes file. The 3P Codes file stores all code sets used by the UB-04 and most other billing formats. The July 2020 update uses the code set received by the American Hospital Association (AHA). This update was applied to the following categories:

- 'O' FOR OCCUR for occurrence codes from FL31-34
- 'C' FOR COND for condition codes from FL18-28
- 'V' FOR VALUE for value codes from FL39-41
- 'S' FOR OCCUR. SPAN for occurrence span codes for FL35-36
- 'A' FOR ADMIT SRCE for admit source for FL15 (Point of Origin for Admission)
- 'N' FOR NEWBORN for newborn for FL15 (Point of Origin for Admission)
- 'P' FOR DISCH. STATUS for patient discharge status for FL17
- 'T' FOR ADMIT TYPE for admit type for FL14 (Priority (Type) of Admission or Visit)

The 3P Codes File was also checked for duplicate entries as prior updates may have caused duplicated entries. If a duplicate is found during the installation of Patch 33, those duplicate entries will be marked as inactive.

Some of the changes that the billing staff will notice:

1. A status of *Inactive* will be included in the description of the code if it has been designated as being inactive in the July 2020 update.
2. The description will be updated to reflect the published code set but if an entry was marked as ‘Payer Code’, those entries will be updated to reflect this description.
3. The biller will not be able to use an inactive code in the Claim Editor. If the inactive code is needed, the code may be reactivated in Table Maintenance using the UB-92 Code Maintenance option (EDUB) by deleting the INACTIVE flag.
4. The listing of codes on Page 9C (Condition Codes) and Page 9D (Value Codes) was updated to display in a more formal order. Prior to Patch 33, the page would display the codes in no particular order. The updated screen will list the codes numerically then alphabetically in a better formatted listing.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:126129]                      Claim Number: 403333
```

```
.............................. (VALUE CODES) ..............................
```

```
    VALU
    CODE               VALUE CODE DESCRIPTION                          VALUE
    ====  ====================================================    ========
[1]  01   MOST COMMON SEMI-PRIVATE RATE                                1.00
[2]  04   PROFESSIONAL COMPONENT CHARGES WHICH ARE COMBINED BILL       4.00
[3]  10   LIFETIME RESERVE AMOUNT IN THE SECOND CALENDAR YEAR         10.00
[4]  23   RECURRING MONTHLY INCOME                                    23.00
[5]  28   OFFSET TO THE PATIENT-PAYMENT AMOUNT - DENTAL SERVICES      28.00
[6]  29   OFFSET TO THE PATIENT-PAYMENT AMOUNT - CHIROPRACTIC SE      23.00
[7]  40   NEW COVERAGE NOT IMPLEMENTED BY HMO (FOR INPATIENT SER      40.00
[8]  54   NEWBORN BIRTH WEIGHT IN GRAMS                             54
[9]  80   COVERED DAYS                                              80
[10] 81   NON-COVERED DAYS                                          81
[11] A1   DEDUCTIBLE PAYER A                                          12.00
[12] A2   COINSURANCE PAYER A                                         20.00
[13] B7   CO-PAYMENT PAYER B                                         123.00


Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N//
```

Figure 2-42: Display of Value Codes Page showing the Order of Codes

2.5.2 UB-92 Codes Listing

3PB>TMTP>UCTM>LSUB

The codes listing was updated to reflect the changes to the 3P Codes file. One of the new fields added to the file was the Long Description. This allows more descriptive text to be stored for clarification on the use of the code. The reviewed listing will also display the status of Inactive, if present.

To generate the report, select the UB-92 Codes Listing option. The report will look similar to the following condensed example:

```
3P CODES LIST                                 MAY 16,2021  09:53    PAGE 1
                                 INACTIVE
CODE  SHORT DESCRIPTION          FLAG      LONG DESCRIPTION
--------------------------------------------------------------------------------



        CODE TYPE: ADMIT SRCE
1     NON-HEALTH CARE FACILITY             NON-HEALTH CARE FACILITY POINT OF
      POINT OF ORIGIN                      ORIGIN
2     CLINIC OR PHYSICIAN'S                CLINIC OR PHYSICIAN'S OFFICE
      OFFICE
3     HMO REFERRAL               INACTIVE
4     TRANSFER FROM A HOSPITAL             TRANSFER FROM A HOSPITAL
      (DIFFERENT FACILITY)                 (DIFFERENT FACILITY)
5     TRANSFER FROM A                      TRANSFER FROM A SKILLED NURSING
```

```
      SNF/ALF/ICF/NF (EFF                  FACILITY (SNF), ASSISTED LIVING
      7/1/17)                              FACILITY (ALF), INTERMEDIATE CARE
                                           FACILITY (ICF) OR OTHER NURSING
                                           FACILITY (NF) (EFFECTIVE 7/1/17)

        CODE TYPE: BILL TYPE
111   INPATIENT ADMIT THRU
      DISCHARGE
121   INPATIENT (MCR PART B)
      ADMIT THRU DISCHARGE
131   OUTPATIENT
730   FQHC NONCVRD              ACTIVE F
731   RHTC BILLING
831   AMBULATORY SURGERY
999   PROFESSIONAL COMPONENT

        CODE TYPE: COND
10    PATIENT AND/OR SPOUSE IS             PATIENT AND/OR SPOUSE IS EMPLOYED
      EMPLOYED BUT NO EGHP                 BUT NO EGHP EXISTS
      EXISTS
11    DISABLED BENEFICIARY BUT             DISABLED BENEFICIARY BUT NO LGHP
      NO LGHP
12    PAYER CODE                           PAYER CODE
13    PAYER CODE                           PAYER CODE
14    PAYER CODE                           PAYER CODE
```

Figure 2-43:Display of UB-92 Codes Listing

For a complete list of the code set, reference the UB-04 Manual published by the American Hospital Association.

Appendix A Additional Fields Sent to Accounts Receivable (BAR)

Updates have been made to the utility that 'passes' data to Accounts Receivable upon approval of a claim into a bill. At this time, the user will not be able to see any of this data but changes will be made to Accounts Receivable to pull this information.

1. Bill Type
2. Manual/split claim indicator
3. Export mode
4. Procedure coding method
5. Master Tax ID if populated
6. Ambulance fields (.1212 thru .129)
    a. .1212 Type of Transport (set of codes)
    b. .1213 Transported To/For (set of codes)
    c. .1214 Point of Pickup Modifier (set of codes)
    d. .1215 Medical Necessity Ind (set of codes; 'Y' for Yes; 'N' for No)
    e. .1216 Dest Modifier (set of codes)
    f. .122 Point of Pickup Origin
    g. .123 Point of Pickup Address
    h. .124 Point of Pickup City
    i. .125 Point of Pickup State (State pointer)
    j. .126 Point of Pickup Zip
    k. .127 Destination (variable pointer – Patient/Location/Vendor)
    l. .128 Covered Mileage
    m. .129 Non-Covered Mileage
7. Approving Official
8. Date/Time Approved
9. Original Bill Amount .27
10. Flat Rate Amount .28
11. Line Item Control# - Flat Rate
12. Dental fields .43 thru.47

    a. .43 Number X-Rays Included
    b. .44 Orthodontic Related (1 for Yes; 0 for No)
    c. .45 Orthodontic Placement Date
    d. .46 Prothesis Included (1 for Yes; 0 for No)
    e. .47 Prior Placement Date

13. Case Number
14. Resubmission (Control) Number
15. Admit/discharge fields .51 thru .54
    a. .51 Admit Type (pointer to 3P Codes)
    b. .511 Referral Number
    c. .512 Prior Authorization Number
    d. .52 Admission Source/Newborn Code (pointer to 3P Codes)
    e. .525 Newborn Days
    f. .53 Discharge Status (pointer to 3P Codes)
    g. .54 PSRO Approval Code (pointer to 3P Codes)
16. Admitting diagnosis
17. Admission Date .61
18. Admission Hour .62
19. Discharge Date .63
20. Discharge Hour .64
21. Non-covered days .66
22. Release of Information and Assignment of Benefits dates
    a. .711 Release of Information Date
    b. .712 Assignment of Benefits Date
23. Worker's comp/TP Liability - .713 thru .727
    a. .713 Property/Casualty Claim Number
    b. .714 Hearing/Vision RX Date
    c. .715 Start Disability Date
    d. .716 End Disability Date
    e. .717 Date Last Worked

f. .718 Date Auth to return to work
g. .719 Assumed Care Date
h. .72 Service Date To – already done before this spec
i. .721 Relinquished Care Date
j. .722 Prop/Casualty Dt 1st Contact
k. .723 Patient Paid Amount
l. .724 Spinal Manipulation Cond Code (set of codes)
m. .725 Prop/Casual Patient ID (set of codes)
n. .726 Prop/Casual Patient Number
o. .727 Acute Manifestation Date

24. Covered days
25. .74 Release of Information (set of codes)
26. Assignment of Benefits
27. Accident state
28. Injury date
29. EXP35 FL17 provider type .825
30. Accident type (set of codes)
31. Accident hour
32. Ecodes from .857 thru .859
    a. .857 E-code
    b. .858 E-code (2)
    c. .859 E-code (3)
33. Date of first symptom
34. Date of first consultation
35. All referring provider fields (.88 thru .889)
    a. Referring Physician .88
    b. Referring Physician ID Qualifier .884
    c. Referring Physician ID NO. .885
    d. Referring Physician Person Class .886
    e. Referring Physician Provider Class .887

    f. Referring Physician Taxonomy Code .888
    g. Referring Provider NPI .889

36. Date of similar symptom
37. Employment related
38. Date last seen
39. Supervising provider
40. Delayed reason code (pointer to 3P Codes)
41. In-house CLIA
42. Ref lab CLIA
43. Pre-payment amount
44. HCFA 1500-B line 19 10
45. PCC Visit date/time and status
46. Insurer, including status and priority
    a. .01 INSURER (MP9999999.18'X), [0;1]
    b. .011 REPLACEMENT INSURER (P9999999.18'), [0;11]
    c. .02 PRIORITY (NJ2,0), [0;2]
    d. .03 STATUS (S), [0;3]
    e. 11 COVERAGE TYPE (Multiple-9002274.401311), [11;0]
        i. .01 COVERAGE TYPE (M*P9999999.65'X), [0;1]
47. ICD Diagnosis Fields (17 multiple)
    a. Diagnosis Code
    b. Priority
    c. Present on Admission Indicator
48. ICD Procedure Fields (19 multiple)
    a. .01 ICD Procedure
    b. .02 Priority
    c. .03 Date of Service
    d. .04 Provider Narrative
49. Provider Multiple
    a. Provider Type

50. Claim form line items
    a. Whatever is in the .01 field, assuming it's a CPT, HCPCS, DRUG, ADA, or Revenue Code
    b. CPT code from where it isn't in the .01 field (like where a CPT is linked to a drug)
    c. CPT Narrative
    d. NDC that is entered on the line item
    e. Modifiers
    f. Lab results
    g. CLIA numbers
    h. Export mode by line item, if populated

Acronym List

Acronym	Term Meaning
ADA	American Dental Association
AHA	American Hospital Association
CLIA	Clinical Laboratory Improvement Amendment of 1988
CMS	Centers for Medicare and Medicaid Services
CMS-1500	Centers for Medicare and Medicaid Services Claim Form, Version 1500
CPT	Current Procedural Terminology
DEA	Drug Enforcement Administration
ESRD	End Stage Renal Disease
FL	Form Locator
HCPCS	Healthcare Common Procedure Coding System
HFS	Host File Server
IHS	Indian Health Service
NDC	National Drug Code
NPI	National Provider Identifier
RPMS	Resource and Patient Management System
SNOW	Service Now
SOGI	Sexual Orientation-Gender Identity
THP	Tribal Health Program
UB-04	Uniform Billing Claim Form, version 2004
UFMS	Unified Financial Management System
VA	Veterans Administration

Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS IT Service Desk.

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