RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing System

(ABM)

User Manual

Version 2.6
January 2010

Preface

The Third Party Billing System (ABM) is designed to automate the creation of a claim with existing RPMS visit data. ABM has a flexible design that accommodates billing to a specific payer's requirements or a unique contractual agreement. Third Party Billing enables the selection of a primary billing entity, the billing of any secondary insurers, and back-billing for services.

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1.0   Introduction

The Third Party Billing System (ABM) is designed to automate the creation of a claim using existing RPMS data. In ABM, the user can:

- Edit files and claims.

- Print a UB-92, UB-04, CMS-1500, NCPDP or ADA Dental form.

- Create an electronic 837 HIPAA Version 4010 X12 file.

- Print bills for Medicare, Medicaid, private insurance, and non-beneficiary (self-pay) patients.

- Export claims in the HIPAA-compliant 837 format.

ABM also supports the RPMS Accounts Receivable (BAR) application.

Using ABM, the user can:

- Create claims manually or automatically.

- Generate multiple forms for the same claim and Year 2000-compliant electronic media claims.

- Override a manual cancellation, and the Claim Generator will create a new claim with the same claim number.

Because patients can be seen as an outpatient and an inpatient on the same day, the ABM package combines these visits into one inpatient claim. This eliminates billing two separate visits on one day for which only one is paid (the first one that reaches the insurer.) All billable items are placed on ONE claim per inpatient stay.

ABM has a flexible design that accommodates billing to a specific payer's requirements or a unique contractual agreement. The user may select a primary billing entity, re-bill any secondary insurers, and back-bill for physician inpatient services.

ABM provides the use of coverage types to prevent non-reimbursable billing. Error checking prevents submission of erroneous bills, and the user can define the conditions for the error checking. The user may also associate all prescribed medications with a dispense fee that is automatically added to the drug cost.

Finally, ABM allows generation of a separate bill for each page of the Claim Editor, making it possible to generate professional component bills that must be on a separate form but are sent to the same payer. Depending on the settings, ABM will automatically split the professional component claim for Medicare.

In ABM visits are *orphaned* when they are not linked to a complete Patient Care Component (PCC) visit. This type of visit can occur when another RPMS package linked to PCC performs a service as a separate visit (e.g., a patient may go to the Lab to get blood drawn) creating an unknown purpose of visit (POV) and/or provider. ABM creates a claim if the ordering provider is available (and ensures the provider is billable before creating a claim); the POV can be left blank.

Using complete fee schedules for all applicable Common Procedural Terminology (CPT) codes and Revenue Codes allows the ABM system to better identify the level of care during a patient visit and provide more accurate billing.

In the ABM system, the user can also designate and sequence International Classification of Diseases – 9th revision (ICD9) diagnosis and procedure information. Separate line items for middle days of care accommodate different levels of care on different days. Lab links allow capture of CPT codes for panels and atomic tests from Patient Care Component (PCC) lab, micro, and path files.

> **Note:** For the data to be transferred to Third Party Billing, Lab 5.2 must be installed and operational.

1.1   New in Version 2.6

Version 2.6 of the Third Party Billing system allows for the integration of Code Set Version. This process uses the Veterans Administration's ICD-9, CPT-4 and HCPCS code sets which will allow for future enhancement within the clinical applications and provide new functionality associated with using these codes. Other changes to Version 2.6 include the function to close claims along with a report of closing activity.

A new supervisor key has been added for those canceling a claim. Users selected to cancel claims must be provided a key. Reference the Installation Guide for additional information.

Along with these enhancements to the system, any issues which were reported to the RPMS Helpdesk and resolved are included in this release. Also, any prior releases to the software in Version 2.5 are included.

1.2   Third Party Billing Data Flow
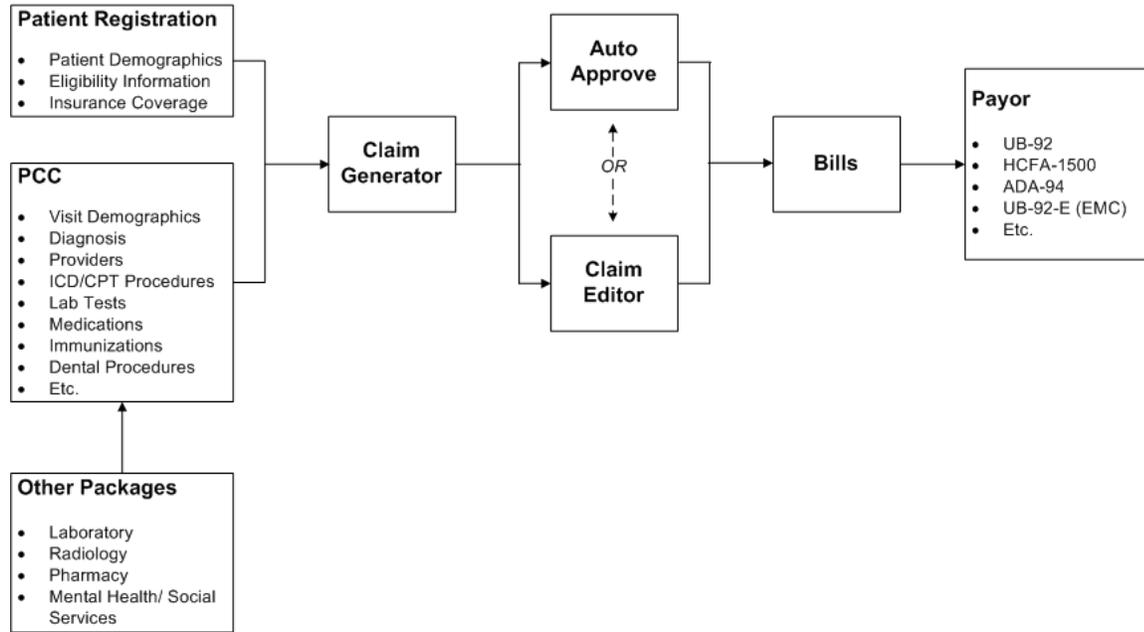
Figure 1-1: Third party billing data flow

2.0   System Navigation

2.1   Security and User Identification

The site manager controls login procedures and access to the system, ensuring that only authorized personnel gain entry to the system or access to confidential information stored in the database. Site managers are responsible for assigning access and verification codes only to those authorized to use the Third Party Billing system.

NEVER REVEAL YOUR ACCESS CODE TO ANYONE ELSE.

If the user believes someone else is using their access code to gain unauthorized entry to the system, they must inform their supervisor.

2.2   Starting an RPMS Session

2.3   Login/Logout Procedures

If nothing displays on the user's screen when turning on the terminal, press the Enter key. Within a few seconds, the following prompt should appear on the screen:

```
(system-prompt) Login:
```

Figure 2-1: System prompt for login

The **Access code** and **Verify code** identify the user to the RPMS system, enabling the system to take the user directly to menus he/she normally works with.

To login, follow these steps:

1. At the system prompt, type user name and password.

2. At the Access Code prompt, the user should type their RPMS access code and press the Enter key.

Nothing will appear on the screen while the user types. This is to prevent anyone from learning the user's access code by watching them log onto the system.

3. At the Verify Code prompt, type the RPMS verification code and press the Enter key.

After a few seconds, the system displays the primary menu. This is a top-level menu, which is based on the user's assigned Access code.

> **Note:** If an unfamiliar menu displays on the screen, contact a supervisor or site manager at once.
>
> **Important:** When the menu displays, make sure the keyboard is in the Caps Lock position. When Caps Lock is on, the word *lock* displays at the top of the screen.

To logout, follow these steps:

1. Return to the active RPMS menu option prompt and press the Enter key.

2. Continue pressing the Enter key at each prompt, until to the Third Party Billing Master Menu prompt displays.

2.4   Standards and Conventions

The Resource and Patient Management System (RPMS) has established certain terms and operating procedures (conventions) for the Third Party Billing system. The following sections provide a brief discussion of those conventions.

Read the following explanations, and refer to the keyboard, to insure that each of the keys and command functions are being correctly identified.

2.4.1   Keyboard Entry

The keyboard has two main sections:

- The left section of the keyboard has several special keys and symbols. Use this section of the keyboard and its special keys and symbols.

- The right section contains a keyboard similar to a 10-key adding machine.

Use either the numeric keypad or the numeric keys on the keyboard to type numbers.

If an incorrect response is typed, the system beeps to alert the user to the error. A message following the beep displays the type of error, and a second message requests the correct information.

2.4.2   Use Capital Letters Only

When entering data onto the system, type all letters and words in
CAPITAL LETTERS.

Set up the terminal to type only capital letters by pressing the Caps Lock key.
When Caps Lock is on, the word *lock* displays at the top of the screen.

> **Note:** The Caps Lock key has no effect on the numeric keys.

2.4.3   Key Usage

Enter (Return) Key: Press the Enter key to indicate the end of an entry, such as a
number or a word. Press the Enter key each time a response to a computer prompt is
required. To return to the previous menu screen, press the Enter key.

Backspace Key: The Backspace key moves the cursor to the left and deletes
characters every time it is pressed

Space Bar: Use the Space bar to reuse a previous response. For example, when
prompted to make a selection from a menu of choices, press the Space bar and press
the Enter key.

Caret (^): Use the caret (^), also known as the "up-hat," a special control character,
to exit from a particular activity or data entry sequence. Typing the caret at any
prompt will usually take the user back to the preceding prompt or menu level. The
caret can be used to exit from long data displays such as vendor lists that usually
involve many screens.

To use caret, press the Shift key and the number 6 key (Shift+6) on the keyboard.

Hold Screen (F1 Key): Use the Hold Screen (F1) key to temporarily halt the
scrolling display of data on the terminal screen. Pressing F1 once halts the display,
allowing the user to read the information on the screen. Pressing F1 a second time
resumes the scrolling of the data.

The F1 key is located in the upper left corner of the top row of the keyboard.

> **Important:**   Never leave your terminal with the Hold Screen key
>   in hold position.

Note that in some RPMS applications, the display terminal beeps and stops when
information comes on the screen. To continue to the next screen of information, press
the Enter key. To stop, type a caret (**^**) and press the Enter key.

Special Delete Character (@): Use the "at" symbol (@) to delete an existing entry in a file. After selecting the record or field the user wants to delete, type the @ symbol.

To use the @ symbol, press the Shift key and the number 2 key (Shift+2) on the keyboard.

Note that the system prohibits deletion of certain records or deletion of data contained in certain fields.

2.4.4   Text Editing

Certain RPMS data entry fields use the FileMan Text Editor. For those fields, use FileMan Text Editor conventions to enter new data or change the existing data.

Of specific interest is the Replace...With convention that allows the user to replace letters, words, or a *string* of words in a field. To change a part of a text string, the system displays a prompt and the current value. This is followed by the "Replace" prompt, where changes can be typed.

For example,

```
NAME: JOHN JACOB JINGLEHAEMER SMITH
REPLACE:
```

Figure 2-2: FileMan text editor "REPLACE" prompt

At the "Replace" prompt, type the text to be replaced. For example,

```
NAME:  JOHN JACOB JINGLEHAEMER SMITH
REPLACE: AE
```

Figure 2-3: FileMan text editor "WITH" prompt

At the "With" prompt, type the replacement text. For example,

```
REPLACE: AE WITH EI
```

Figure 2-4: FileMan text editor "REPLACE" prompt with replacement data

The system then displays the corrected data.

```
NAME: JOHN JACOB JINGLEHEIMER SMITH
```

Figure 2-5: FileMan text editor "REPLACE" prompt with corrected data

Pressing the Enter key at the "Replace" prompt ends the correction process.

2.4.5   Text Replacement Conventions

Text sequences may be one or more characters long. For example, consider the following:

ABC...XYZ (the string beginning with the character sequence ABC and ending with the character sequence XYZ), where typing

- **ABC...** replaces the text string beginning with the character sequence ABC to the end of the line.

- **...XYZ** replaces the text string beginning at the start of the line and ending with the sequence XYZ.

- **END** adds text at the end of existing text.

> **Note:** The replacement text may be blank, which will erase
>   specified text. Type a question mark (**?**) for online help
>   with the **Replace With** function.

2.4.6   RPMS Online Help

Special help displays are available for most menu options and data entry prompts. Typing **?** at the "Select . . . Option" prompt displays information related to the current option, where

Typing	Displays
A single question mark (**?**)	A list of all options accessible from the current option.
Two question marks (**??**)	A list of all accessible options and their formal names
Three question marks (**???**)	A brief description for each option in a menu.
A single question mark (**?**) followed by an option name	Extended help, if available, for that option

2.4.7   Previous and Default Responses

Some computer prompts display either a single slash (/) or a double slash (//) at the end of the prompt.

If the prompt displays a single slash, type a new response or type a response previously accepted by the system. Press the Space Bar and the Enter key to enter a previously accepted response. Names or dates are examples of responses entered using this method.

If the prompt contains a default value and a double slash, accept the default value by pressing the Enter key.

For example, in response to the following prompt, press the Enter key to accept the default, YES. In the following prompt, type **N** (No) and press the Enter key to enter a No response.

```
DO YOU WISH TO CONTINUE? YES//.
```

Figure 2-6: Example showing default value

2.4.8   Date and Time Conventions

When a system prompt requires a specific date and/or time, the information may be entered in the following ways.

Date:

At the Date prompt:

- Type **TO** (uppercase letters) to use the current date.

- Type **T+** (plus sign) followed by a number to use the date that equals the current date plus the number. For example, if the current date is October 5, T+15 = October 20.

- Type **T-** (minus sign) followed by a number to use the date that equals the current date minus the number. For example, if the current date is May 23, T-10 = May 13.

To enter a specific date, use one of the following formats:

> Month DD, YYYY
> DD Month, YYYY
> MM-DD-YY
> MM/DD/YY

Choose the format that is easiest to use, and use it consistently.

Time:

The system default is set to times that fall between the hours of 6:00 AM to 6:00 PM.

For example, if the user types **3** at the "Time" prompt it will convert to 3:00 PM. If the user types **9** at the prompt, it will convert to 9:00 AM. If the user needs to type a time after 6:00 PM then PM must be added.

Date/Time:

Any valid combination of date and time may be entered by using a date format, an @ symbol, and the time. For example, if the current date is May 20, 2006 and the user wants to make an entry using that date and a time of 3:00 PM, use one of the following formats:

- 5/20/04 @ 3

- 05-20-04 @ 3:00 PM

- T @ 3:00

2.5   RPMS Online Help

RPMS provides special help displays for most menu options and data entry prompts, as follows:

Type	To display
One question mark (**?**)	A list of all options accessible from the current option.
Two question marks (**??**)	A list of all accessible options and their formal names
Three question marks (**???**)	A brief description for each option in a menu.
A single question mark followed by an option name (**?OPTION**)	Extended help, if available, for that option

3.0   Main Menu

The Third Party Billing System **Main Menu** contains security locks on all options that allow data manipulation or export. Whether a particular user has access to an option is at the discretion of the Site Manager.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-++
         |            THIRD PARTY BILLING SYSTEM - VER 2.6          |
         +                         Main Menu                       +
         |                         sitename                        |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-++
         User: LASTNAME, FIRSTNAME        DD MMM YYYY HH:MM [AM|PM]

   EDTP    Add/Edit Claim Menu
   MGTP    Claim/Bill Management Menu
   RPTP    Reports Menu
   PRTP    Print Bills Menu
   TMTP    Table Maintenance Menu
   ELTP    Eligibility Menu
   PPTP    Payment Posting
   EMTP    Electronic Media Claims
   SSTP    Set Site
              -----------------------
    UCSH    Cashiering Options ...

 Select Third Party Billing System Option:
```

Figure 3-1: Third party billing Main Menu

To select a Third Party Billing Main Menu option

At the prompt, type enough of the option synonym or name to uniquely identify it and press the Enter key.

For example, typing **TM** uniquely identifies the Table Maintenance Menu option.

An effort has been made to provide unique menu option synonyms, which are easy to remember, to enable the user to *jump* from the current menu directly to an option in another menu without navigating through the menu tree.

To jump between Third Party Billing menus and options, type a caret (**^**) and the synonym of the option you want at the prompt.

3.1   Main Menu Entrance Checks

3.1.1   Review Site Parameters Notice

When the Third Party Billing system is first implemented, the following message displays on the Main Menu screen:

```
SITE PARAMETERS have not yet been reviewed. Access to the Claim Editor is
prevented until they are! The Site Parameters can be reviewed through the
Table Maintenance Menu.
```

Figure 3-2: Notice to review site parameters

This message continues to appear on the Main Menu until the Site Parameters file has been reviewed. For information on Site Parameters, see the Site Parameter Maintenance (SITM) option located in Table Maintenance.

3.1.2   Claim Generator Status

Upon entering the Third Party Billing system, ABM examines the successful operation of the nightly Claim Generator. If the Claim Generator has not run in more than a day, ABM displays the following message on the main menu to notify the user of the appropriate action to take.

```
WARNING: The Claim Generator has not run since Jan. 19, 2006.
Contact your Site Manager to investigate this problem.
```

Figure 3-3: Claim generator status message

3.1.3   UFMS Messages

Facilities designated as being an Indian Health Service federal facility that submit files to the finance system (UFMS) can see a variety of messages. Non-federal locations may see these messages, but need to know they are not responsible for transmitting to UFMS.

3.1.3.1   Open Cashiering Sessions Pending Review

A cashiering session must be opened by billing technician prior to performing billing functions. Options such as editing a claim, opening, closing, canceling a claim or canceling a bill are captured by the open session.

The following message will appear if a session has been kept open for greater than one day.

```
WARNING: Open cashiering sessions exist that should be reconciled for UFMS
```

Figure 3-4: Warning message for open cashiering session

This should be an indication to the user that a session has been opened and must be closed. It is suggested to close sessions daily after all billing activity has been completed.

Once the opened session is closed, the warning message will not display.

3.1.3.2   Closed Sessions Waiting to be Transmitted

It is suggested that sessions are closed daily after billing activity has been completed. If a session has been closed by the billing technician, the system will display the following message.

```
WARNING: Cashiering sessions are closed and awaiting export to UFMS
```

Figure 3-5: Warning message for closed cashiering session

This means the cashiering sessions are ready to transmit to the finance system. Once the session has been transmitted, the message will not display. Non-federal locations will not transmit but will reconcile their sessions. Once the sessions have been reconciled, the warning message will not display.

3.2   Exit Messages

As long as the billing technician is logged into the Third Party Billing system, all activity is tracked. If the user exits the billing options or exits out of RPMS, the system will display the following message.

```
Select Third Party Billing System Option:

NOTE: You are still logged into your cashiering session.  To Close
      your session select Cashiering Options (UCSH) then Cashiering Sign In/
      Sign Out (CIO).

Enter RETURN to Continue:
```

Figure 3-6: Exit billing options or exit RPMS system message

This notifies the technician that he/she is still logged into an open session. If the technician has completed all billing activity, he/she should log out of Cashiering Mode. At times, it may be necessary to log out of RPMS or the billing options. If it is necessary to logout of RPMS or the billing options, the exit message may be displayed, but can be ignored if the technician continues to bill.

4.0   Add/Edit Claim Menu (EDTP)

Main Menu > EDTP

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |           THIRD PARTY BILLING SYSTEM - VER 2.6       |
        +                  Add/Edit Claim Menu                 +
        |                 INDIAN HEALTH HOSPITAL               |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                      8-DEC-2009 9:00 AM


   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

Select Add/Edit Claim Menu Option:
```

Figure 4-1: Add/Edit Claim Menu

The Add/Edit Claim menu options include:

- CG1P. To start the Claim Generator for a specified patient.

- EDCL. To edit data for a specified claim

- LOOP. To edit data for all claims meeting specified exclusion parameters

- NEW. To add a new claim manually

- RBCL. To rebuild a specified portion of the claim with data from the Patient Care Component (PCC) system.

- CKCL. To display the list of eligibility for the visit and to notify the user the reason the claim did not generate for certain insurers.

Claim creation can be done manually (using the NEW option) or automatically. In automatic mode, the claim generator checks visits nightly against the eligibility files and creates a claim for each match, using the visit information.

4.1   Prior to Entering the Claim Editor

If the site has the option to use the cashiering function turned on, the user will see the following when entering the Claim Editor.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |            THIRD PARTY BILLING SYSTEM - VER 2.6          |
          +                      Edit Claim Data                    +
          |                    INDIAN HEALTH HOSPITAL               |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                     10-AUG-2009 2:31 PM

Select CLAIM or PATIENT: 30726  DEMO,JOHN
             Clm:30726  05-12-2009 DENTAL        DENTAL         INDIAN HOSP
                   ARIZONA MEDICAID                    In EDIT Mode
Correct Claim? YES//

* * YOU MUST SIGN IN TO BE ABLE TO PERFORM BILLING FUNCTIONS! * *

Enter RETURN to Continue:
```

Figure 4-2: Message user sees when entering claim editor

This message indicates that the user must sign into Cashiering Mode to be able to edit or approve the claim. This message will appear until the user signs into a cashiering session.

4.2   Claim Editor Pages

You can modify claim data, using the Claim Editor. The Claim Editor is comprised of multiple pages, where each page contains a different category of data. The following table lists the category of data for each claim page.

Table 4-1: Claim Pages and Data Category

Claim Page	Category of Data
0	Claim Summary
1	Claim Identifiers
2	Insurers
3	Questions
3A	Ambulance Questions
4	Provider Data
5A	Diagnosis (ICD)
5B	ICD Procedures
6	Dental Services (ADA)
7	Inpatient Data
8A	Medical Services (CPT)
8B	Surgical Procedures (CPT)
8C	Revenue Code
8D	Medications

Claim Page	Category of Data
8E	Laboratory Services (CPT)
8F	Radiology Services (CPT)
8G	Anesthesia Services (CPT)
8H	Misc Services (HCPCS)
8I	Inpatient Dental (ADA)
8J	Charge Master
8K	Ambulance Page
9A	Occurrence Codes
9B	Occurrence Span Codes
9C	Condition Codes
9D	Value Codes
9E	Special Program Codes
9F	Remarks

To navigate through the Claim Editor pages, use one of the following Add/Edit Claim menu (EDTP) options:

- Use the Claim Generator, One Patient (CG1P) option to edit claim data one patient at a time

- Use the Claim Editor Loop (LOOP) option to cycle through claims that are awaiting approval.

Both of these options use the claim editor commands.

4.3   Claim Editor ACTION Commands

Each page of the Claim Editor includes an associated set of editing commands. For each page, the "Desired ACTION" prompt is followed by a list of the valid commands for that page within parentheses. For example,

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

Figure 4-3: Claim editor "Desired ACTION" prompt

To view descriptions of the editing ACTION commands

At the "Desired Action" prompt, type a question mark (**?**) and press the Enter key.

For example,

```
Desired ACTION (View/Appr/Next/Jump/Quit): N//? <Enter>

  Choose from one of the following actions:

    Edit - Edit Information in the Current Screen
    Add  - Add a new Entry to a Page
    Seq  - Modify the Priority Sequence
    Pick - Select Insurer to Bill
    View - Display Detailed Information
    Appr - Approve Claim for Billing
    Pend - Pend the claim and enter Pend Status
    Jump - Jump to a desired Edit Screen
    Next - Go on to the Next Edit Screen
    Back - Backup to the Previous Edit Screen
    Quit - Stop Editing the Data of this Claim
    Del  - Delete on Existing Entry
    Mode – Change mode of Export for this page

  Enter First Character of the Desired Action.
```

Figure 4-4: Menu list for "Desired ACTION"

4.3.1   Claim Editor Page Navigation

Use the following Claim Editor Action commands to navigate through the claim pages.

Use	To
Next	Display the next page (Default)
Back	Display the previous page
Jump	Display a specific page
Quit	Exit the claim

4.3.2   Jump Command

Use the Jump Action command (J) to display a specific page. For example,

```
Desired ACTION (View/Appr/Next/Jump/Quit): N//J <Enter>

Desired SCREEN (0/1/2/3/4/5/7/8/9): ?? <Enter>

 0 - Claim Summary
 1 - Claim Identifiers
 2 - Billing Entities
 3 - Questions
 4 - Provider Data
 5 - ICD Diagnosis/Procedures
 7 - Inpatient Data
 8 - Worksheet Data (CPT)
 9 - UB-82 Info (Occurrence, Condition, Sp. Prog, Remarks)

 Enter the Number of the Desired Screen.

Desired SCREEN (0/1/2/3/4/5/7/8/9): 4 <Enter>
```

Figure 4-5: Using jump action command to display provider data screen

Typing **J2** at the "Desired ACTION" prompt displays the Page 2 Edit screen.

Jumping to pages that are suffixed with an alphabetic character (e.g., 8D Medication
Page) can be accomplished by following the Jump command with the appropriate
alpha character (e.g., J8D).

4.3.3   Add and Delete Commands

The Add and Delete Action commands are available on all pages that allow
multiple entries.

Add Command

To add an entry, select the Add command and respond to all prompts
for required fields.

Delete Command

To delete an item on any page except Page 4 (Provider), select the Delete command
and type the sequence number of the entry to be removed. For example,

```
Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N//D <Enter>

Sequence Number to DELETE: (1-3): 2 <Enter>

Do you wish 550.93 DELETED? NO <Enter>
```

Figure 4-6: Example showing use of delete command

To delete an item on the Provider page, select the Delete command and type the name of the provider to be removed.

4.3.4   Edit Command

Use the Edit Action command to modify existing data, either by selecting a particular field number or a sequence number for a series of fields.

On pages that contain different data element fields, a number enclosed by brackets [ ] precedes each field. To edit a specific field, type the number of the desired field at the prompt, and press the Enter key.

The following example illustrates how to select fields for editing.

```
Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//E <Enter>

Desired FIELDS: (1-11): 1-11//6-8,11 <Enter>

[6] Discharge Date.........: OCT 12,2009// <Enter>
[7] Discharge Status Code..: 01// <Enter>
[8] Discharge Hour.........: 14// <Enter>
[11] PRO Approval Code.....: 05// <Enter>
```

Figure 4-7: Example showing use of edit command

In this example, fields 6, 7, 8, and 11 were selected.

Pages that contain multiple fields with a varying number of entries that can be added or deleted are preceded by a sequence number. Selecting a sequence number allows the user to alter all of the editable data within multiple fields.

To edit only one field or only the fields associated with a multiple sequence number, the Edit command can be completed in a single step by combining the Edit command and the field number (e.g., type E4 to edit field 4).

4.3.5   Mode Command

The Mode Action command is available **only** on Page 8 of the Claim Editor, where each type of procedure may have a different mode of export.

4.3.6   Pending Command

The Pending Action command is available **only** on Page 0 of the Claim Editor, and this command allows the user to place the claim into pending status. The claim is pending until it is approved.

4.3.7   Sequence, Approve and Pick Commands

The Sequence, Approve, and Pick Action commands are available for specific Claim Editor Pages.

- Sequence is used on DIAGNOSIS (PAGE 5A).

- Approve is used on the CLAIM SUMMARY (PAGE 0).

- Pick is used on INSURERS (PAGE 2).

Examples of using these commands can be found in their respective sections.

4.3.8   View Command

Use the View Action command to obtain additional information, and to display errors, warnings, and corrective actions.

Additionally, the View command on PAGE 0 (CLAIM SUMMARY) can be used to print out an entire claim including any claim errors (if the claim was created automatically), a listing of the original Patient Care Component (PCC) or Ambulatory Patient Care (APC) visit, or the health summary.

For example,

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

Select one of the following:

   1          DETAILED CLAIM LISTING
   2          ERROR LISTING ONLY
   3          PCC VISIT DISPLAY
   4          HEALTH SUMMARY

Enter DESIRED REPORT: 2// <Enter> ERROR LISTING ONLY

Output DEVICE:
```

Figure 4-8: Using the View command

In this example, the desired listing is displayed on screen (by pressing the Enter key at the "Output DEVICE" prompt or sent directly to a system printer.

> **Note:** View options 3, PCC Visit Display, and 4,
> Health Summary, are not available when claims
> are entered manually.

4.3.9   Viewing Errors and Warnings

For the claim to be approved for billing, either the condition that is causing the error message to occur will have to be resolved or the error will have to be downgraded to a warning.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE E   ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                          Claim Number: 31390
............................ (ERROR LISTING) ..............................
Release of Information..: NO  Assignment of Benefits..: NO
WARNING:191 - OP VISIT(S) WITHIN 72 HOURS OF ADMISSION
-------------------------------------------------------------------------------
                         PAGE 2 - INSURER INFORMATION

  ERROR:225 - Insurer missing TIN number (1)
-------------------------------------------------------------------------------
                         PAGE 3 – QUESTIONS

WARNING:058 - RELEASE OF INFORMATION UNOBTAINED
WARNING:059 - ASSIGNMENT OF BENEFITS UNOBTAINED
WARNING:230 - Clinic is ER and Admitting Dx is missing
-------------------------------------------------------------------------------
                         PAGE 4 - PROVIDER INFORMATION

  ERROR:115 - PROVIDER'S LICENSURE NUMBER UNSPECIFIED
WARNING:170 - MEDICARE/MEDICAID PROVIDER NUMBER UNSPECIFIED FOR PROVIDER(S)
```

Figure 4-9: ERROR LISTING (PAGE E)

To display the corrective action for an error or warning:

At the "Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION" prompt, type the number associated with the error or type a narrative description, and press the Enter key.

For example,

```
 ==========================================================================
    Fatal ERRORS Exist a Bill can not be Generated until they are Resolved!
 ==========================================================================

 Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired): 58

                  (WARNING:58 RELEASE OF INFORMATION UNOBTAINED)


 --------------------------------------------------------------------------
 Corrective Action:   If the Patient signed the Release of Information form than
                      [J]ump to the Questions Page (3) and [E]dit the field to
                      be 'YES'.
 --------------------------------------------------------------------------

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

Figure 4-10: Example of displaying corrective actions

If an error or warning condition occurs, its corresponding message is displayed at the bottom of the applicable page.

All errors must be resolved before the claim can be approved. Warnings messages are displayed only for information purposes, and do not prevent claims from being approved. Errors and warnings can be defined through the Error Codes menu.

4.4   PAGE 0 - CLAIM SUMMARY

Use CLAIM SUMMARY (PAGE 0) to view an abbreviated summary of key information in the claim. This page is particularly useful when billing Medicare or Medicaid because the majority of the information necessary to approve a claim is displayed here.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,SYLVIA       [HRN:1122]                    Claim Number: 31560
............................ (CLAIM SUMMARY) ...............................

_____ Pg-1 (Claim Identifiers) _____ Pg-5A (Diagnosis) _____
Location..: INDIAN HOSP                 | 1) HYPERTENSION
Clinic....: INTERNAL MEDICINE           | 2) NOSEBLEED
Visit Type: INPATIENT                   |_____ Pg-8 (CPT Procedures) ____
Bill From: 06-03-2009 Thru: 06-05-2009  | 1) CONTROL OF NOSEBLEED
_____ Pg-2 (Billing Entity) _____| 2) INITIAL HOSPITAL CARE
BCBS OF NEW MEXICO             ACTIVE    | 3) SUBSEQUENT HOSPITAL CARE
NON-BENEFICIARY PATIENT        PENDING   | 4) EMERGENCY DEPT VISIT
_____ Pg-3 (Questions) _____| 5) HOSPITAL DISCHARGE DAY
Release Info: YES   Assign Benef: YES   | 6) ARTERY X-RAYS, HEAD & NECK
Emrg Related: YES                       | 7) COMPLETE CBC, AUTOMATED
_____ Pg-4 (Providers) _____| 8) URINALYSIS, NONAUTO W/SCOPE
 Attn: BURNEY,DWIGHT W                   | ***additional procedures exist***
                                        |_____
WARNING:191 - OP VISIT(S) WITHIN 72 HOURS OF ADMISSION
---------------------------------------------------------------------------
     *** Claim File ERRORS exist use the VIEW command to list them. ***

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

Figure 4-11: Example of CLAIM SUMMARY (PAGE 0)

The PROCEDURE TYPE (PAGE 8) displayed on this page will vary (ICD, CPT, or ADA) depending on the type of visit and the primary insurer's billing requirements.

4.4.1   Claim Data Checks

Before the system displays the CLAIM SUMMARY (PAGE 0), it performs checks for errors and eligibility.

```
...<<< Processing, Claim Error Checks >>>...

...<<< Checking Eligibility Files for Potential Coverage >>>...
```

Figure 4-12: System performing errors and eligibility check

The error check scans all pages in the claim for errors. If errors are found, the user is notified and the claim is put in an un-approvable status, pending resolution of the errors.

Eligibility data is also checked to make sure that it is consistent with the patient's registration information. If the claim data is inconsistent, the appropriate insurer(s) will be added or deleted (in active or pending status) accordingly. The claim data is adjusted to reflect the patient's current eligibility. If no eligibility is found in the Patient Registration system, the user is not allowed to edit the claim.

4.4.2   IHS Pharmacy-Automated Dispensing Interface System Alerts

This functionality applies to sites that have purchased the Omnicell or Pcommercial off-the-shelf software (COTS) systems. The IHS Pharmacy AutomDispensing Interface System sends information from the COTs system to RPMS when medications are dispensed from the Pharmacy COTs system. This information is stored in the I H S HL7 SUPPLY INTERFACE file. When a claim is edited, if there are medications and/or supplies on file for the dates covered by the claim, the billing technician will be able to review the medications/supplies, and decide which ones should be added to the claim.

When entering the claim editor, the user sees the following prompts notifying them that supply or pharmacy data exists. The user should review and decide if any items can be billed:

```
              ...<< Processing, Claim Error Checks >>...Release of
Information.
.: YES                              From: 06/13/2007Assignment of Benefits..: Y
ES                                       From: 06/13/2007

        ...<< Checking Eligibility Files for Potential Coverage >>...


There are SUPPLIES/MEDS on file that may need to be added to this claim.

PATIENT: DEMO,JOHN  VISIT DATE: OCT 14,2009  TO: OCT 14,2009

Beginning Date for Supply/Med Charges:  OCT 14,2009//

Ending Date for Supply/Med Charges:  DEC 8,2009//



 Supply Charges              Dec 08, 2009 10:01:49       Page:   1 of   1
                3P NUM: 31683
              PATIENT: DEMO,JOHN
       ADMIT/VISIT FROM: OCT 14,2009  TO: OCT 14,2009
                                           TRANCODE/       REV/
SUPPLY/MED NAME                QUAN    PRICE  NDC        HCPC  DEPT CLAIM NO.
-------------------------------------------------------------------------------
1  MOTRIN                       2     2.40  0001233449        250 31683
   OCT 14,2009                               0009-7387-02




_____
      - Previous Screen   Q Quit   ?? for More Actions
SEL  Select Supply Charges             EDIT Edit Items
Select ACTION: Quit//
```

Figure 4-13: Prompts notifying billing technician of supply or pharmacy data

The system displays the charges. The user can select charges, edit items or quit out of the screen.

4.4.2.1 Selecting Items to Import to Claim

Not all items that appear may be considered billable on the claim. The billing technician will need to review all items and decide what should be included. To add to the claim,

- Type **SEL** to select one supply charge entry.

- Type the number of the entry to include on the claim.

- The system will ask the user to confirm the addition of this charge to the claim. Type **YES** to allow the charge entry to appear in the claim editor. The charge will show up on the appropriate page, depending on the type of charge.

```
SEL  Select Supply Charges              EDIT Edit Items
Select ACTION: Quit// SEL
Select Charges to add or edit:  (1-1): 1
Charge these supplies/meds to Claim/Bill 31683 ? NO// YES
```

Figure 4-14: Selecting items to include on a claim

4.4.2.2 Editing Items

The user may elect to edit the item prior to importing it to the claim. This may occur if there is missing data that needs to be completed. In the example below, the HCPCS code is missing. If the item can be linked to a HCPCS code, the billing technician can edit and add the HCPCS code.

```
SEL  Select Supply Charges              EDIT Edit Items
Select ACTION: Quit// EDIT
Select Charges to add or edit:  (1-1): 1
 _____
        | ITEM NUMBER.....: 1                                           |
        | ITEM NAME.......: MOTRIN                                      |
        | UNIT PRICE......: 2.40                                        |
        | TRANSACTION CODE: 000123344959                               |
        | MEDICATION......: IBUPROFEN 800MG TAB                        |
        | HCPCS CODE......:                                            |
        | REVENUE CODE....: 250                                        |
 _____
Exit     Save      Refresh

Enter a command or '^' followed by a caption to jump to a specific field.


COMMAND:                                  Press <PF1>H for help    Insert
```

Figure 4-15: Example showing missing HCPCS code

To edit the supply charge, select the charge and then select the item to edit. The following fields can be edited:

- Unit Price. Price to be charged for the supply charge.

- Transaction Code. Used to reference the supply charge in the COTS system. This does not import to the claim editor but is used as a reference code for the billing technician.

- Medicaid. Used to indicate the Medication. This entry comes from the DRUG file. If the supply is not a medication, this may be left blank.

- HCPCS Code. Used to reference the HCPCS code associated with this supply charge.

- Revenue Code. Used to associate the revenue code to the supply charge.

When the charge is imported, it must be accessed in the claim editor.

4.4.3   Claim Approval

Claims can only be approved from the CLAIM SUMMARY (PAGE 0), and only when all of the pages in the claim are error free.

```
                    ***** UB-04 CHARGE SUMMARY *****

Active Insurer: MAILHANDLERS BENEFIT PLAN


                                       Revn           Total
            Description                Code   Units   Charges
-----------------------------------------------------------------------
ROOM-BOARD/SEMI              │ 260.00   0120     9    2,340.00
PHARMACY                     │          0250            46.77
EMERG ROOM                   │          0450            50.00
                                                     --------
TOTAL CHARGES                           0001         2,436.77

              ***** CMS-1500 (08/05) CHARGE SUMMARY *****

Active Insurer: MAILHANDLERS BENEFIT PLAN


                                            Corr
 Charge Date        POS TOS  Description    Diag    Charge      Qty
-----------------------------------------------------------------------
01-28-2009 01-28-2009 23 1    99281           1     385.00       1
01-28-2009 01-28-2009 23 4    71010   26      1      99.00       1
                                                  ----------
           TOTAL CHARGE                             484.00




Active Insurer: MAILHANDLERS BENEFIT PLAN

                         Previous                              Bill
      Form      Charges  Payments   Write-offs   Non-cvd      Amount
   ---------- ---------- ---------- ---------- ---------- ----------
 CMS-1500 (08/05)   484.00     0.00       0.00       0.00     484.00
 UB-04            1,073.00   321.91      26.07       0.00     725.02
                 ========= ========= ========= ======== ========
                 1,557.00   321.91      26.07       0.00    1209.02

Do You Wish to APPROVE this Claim for Billing? YES <Enter>

Transferring Data. . . .
  Bill Number 1001A Created.  (Export Mode: UB-04)
  Bill Number 1001B Created.  (Export Mode: CMS-1500)
```

Figure 4-16: Approval Summary screen

If the user approves the claim, one or more bills are created (depending on whether multiple forms are specified). After the claim is approved, it is closed to further editing until a payment is posted on the bill or the bill is canceled. If using the Accounts Receivable (BAR) application, the claim is closed to further editing until the bill is rolled back to ABM from the BAR system. The created bills are put in a status awaiting export (printing).

For bills being sent to Medicare, the professional component can be suppressed if a contract provider was the attending or operating provider and the patient has Part B coverage.

The following example illustrates how covered and non-covered charges will be presented on the UB-04 form for flat rate billing.

```
                    ***** UB-04 CHARGE SUMMARY *****
                               Revn           Total       Non-cvd
          Description          Code   Units   Charges      Charges
---------------------------------------------------------------------
ALL INCL R&B/ANC               400.00  100   14  5,600.00    1,200.00
                                                  --------
TOTAL CHARGES                          001        5,600.00

NOTE: The Professional Component (HCFA-1500) can be suppressed because a Contract
Provider is designated as either the attending or operating physician.
Do you want to Generate the Professional Component? Y// <Enter>
```

Figure 4-17: UB-04 Form flat rate billing example

To contrast the difference between normal flat rate billing and billing Medicare for ambulatory surgery, see the following example.

```
                    ***** UB-04 CHARGE SUMMARY *****
                               Revn              Total    Non-cvd
Description                    Code    Units     Charges  Charges
---------------------------------------------------------------------
ALL INCLUSIVE RATE         |49515  0519    1       76.00     0.00
                           |15931  0519    1        0.00
                                   ------           -------
TOTAL CHARGES                      0001             76.00
```

Figure 4-18: UB-04 Form Medicare ambulatory surgery billing example

In Figure 4-18, the CPT codes have a different charge in the Medicare Ambulatory Fee Schedule because of arrangements made with the Centers for Medicare/Medicaid Services (CMS). This is the format that IHS is required to use. If the user is billing for ambulatory surgery from a locally established Medicaid fee schedule (or other negotiated rate insurer), the charges from the fee schedule will be used.

4.4.4   Coordination of Benefit Page

The Coordination of Benefit Page (COB) allows the billing technician to bill secondary insurers when using the export mode for Electronic Data Interchange of the HIPAA 837 format.

4.4.4.1   Accessing the Coordination of Benefit Page

To use the Coordination of Benefit (COB) page,

- One of the insurers must have a Status of Complete, indicating that the insurer's payment was received, posted, and rolled back from the Accounts Receivable system.

- The Mode of Export must be approved to an 837 format.

Based on these conditions, the COB page will be available from Page 0 of the claim in the Claim Editor.

When the user is ready to bill the claim to the secondary payer, typing **A** to Approve the claim, displays a Summary Charge screen. For example,

```
 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 0 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN: 12345]              Claim Number: 29904
............................ (CLAIM SUMMARY) ............................

_____ Pg-1 (Claim Identifiers) _____ Pg-4 (Providers)_____
Location..: INDIAN HOSP              | Attn: ALEXIS,ALEXANDRA
Clinic....: GENERAL                  |
Visit Type: OUTPATIENT               |
Bill From: 02-08-2007 Thru: 02-08-2007 |
                                     |_____ Pg-5A (Diagnosis)_____
_____ Pg-2 (Billing Entity) _____| 1) SPRAIN OF FOOT NOS
MAIL HANDLERS BENEFIT PLAN     COMPLETE|
NEW MEXICO MEDICAID            ACTIVE  |
                                     |
_____ Pg-3 (Questions) _____|_____ Pg-5B (ICD Procedures) _____
Release Info: YES   Assign Benef: YES  |
                                     |
_____|_____

Desired ACTION (View/Appr/Pend/Next/Jump/Quit): N// A <Enter>


                 ***** 837 INST (UB) CHARGE SUMMARY *****

Active Insurer: NEW MEXICO MEDICAID


                                 Revn              Total         Non-cvd
          Description            Code    Units    Charges        Charges
------------------------------------------------------------------------------
OTHER CLINIC            | 242.00        0519     1      242.00           0.00
                                                     ---------
      TOTAL CHARGE                      0001            242.00
```

Figure 4-19: Example of the Summary Charge Page

After the user has reviewed the Charge Summary information, pressing the Enter key (to continue) displays the COB page. For example,

```
.......................(PRIOR PAYMENTS/ADJUSTMENTS).....................

Payment Amount....: (    364.00)        ORIGINAL BILL AMOUNT:      562.00
Deductible Amount.: (    100.00)        Current Charges.....:      242.00
Co-pay/ins Amount.: (     25.00)        Current Bill Amount.:      198.00
Write Off.........:       0.00
Non-Covered Amount: (     73.00)
Penalty Amount....:       0.00
Grouper Allowance.:       0.00
Refund............:       0.00
Payment Credits...:       0.00


[1] INSURER: MAIL HANDLERS BENEFIT PLAN PRIORITY ORDER: 1  STATUS: COMPLETED
       PAYMENT: (    364.00)
    ADJUSTMENT: (    100.00) [13] DEDUCTIBLE      [29] Deductible Amount
    ADJUSTMENT: (     25.00) [14] CO-PAY          [27] Co-Payment Amount
    ADJUSTMENT: (     73.00) [4] NON PAYMENT      [21] Chrgs Excd Max All

[2] INSURER: NEW MEXICO MEDICAID        PRIORITY ORDER: 2    STATUS: ACTIVE
----------------------------------------------------------------------------
ERROR: STANDARD ADJUSTMENT CODE NOT ENTERED FOR ADJUSTMENT
----------------------------------------------------------------------------

Desired ACTION (Add/Edit/Quit): Q//
```

Figure 4-20: Example of COB screen

The COB page displays Account Receivable transactions, as follows:

- The left column displays account receivable adjustment categories.

- The right column displays the claim's original bill amount and current charges. The Current Bill Amount field displays the sum of the deductible and co-insurance amounts from the primary insurer plus the non-covered amount.

- The lower half of the COB page displays billable insurers and claim status codes.

4.4.4.2   Using the Coordination of Benefit Page

The COB page was designed to bill secondary insurers electronically. EDI claims require HIPAA Standard Adjustment Reason Codes to be compliant. The first step is to edit the Standard Adjustment Reason Codes. The COB page will display the following error message automatically:

```
ERROR: STANDARD ADJUSTMENT CODE NOT ENTERED FOR ADJUSTMENT.
```

Figure 4-21: Automatic error message on the COB Page

> **Note:** Some facilities have their own RPMS adjustment types.
> These facility-specific types are not mapped to any HIPAA
> Standard Adjustment Reason (SAR). In such a case, the
> user should try to find a HIPAA SAR that corresponds as
> closely as possible to their facility-specific adjustment type.
> An error message will still appear because the RPMS
> mapping is not correct, but this will not affect the
> submission of the bill.

At the "Desired ACTION" prompt, enter the Edit option and select the insurer who
has a Completed claim status. The system displays a further break down of account
receivable transactions. Standard Adjustment Reason Codes are assigned to all
adjustments, at this time.

Begin by selecting one of the numbered adjustment transactions and responding
to the "AMOUNT," "ADJUSTMENT CATEGORY," and "ADJUSTMENT TYPE"
prompts. At the "STANDARD REASON" prompt, refer to the Standard Adjustment
Reason Codes List to select the appropriate HIPAA code for this
adjustment transaction.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN: 12345]                    Claim Number:  29904
.......................(PRIOR PAYMENTS/ADJUSTMENTS).......................

Payment Amount....: (    364.00)        ORIGINAL BILL AMOUNT:     562.00
Deductible Amount.: (    100.00)        Current Charges.....:     242.00
Co-pay/ins Amount.: (     25.00)        Current Bill Amount.:     198.00
Write Off.........:        0.00
Non-Covered Amount: (     73.00)
Penalty Amount....:        0.00
Grouper Allowance.:        0.00
Refund............:        0.00
Payment Credits...:        0.00

[1] INSURER: MAIL HANDLERS BENEFIT PLAN PRIORITY ORDER: 1  STATUS: COMPLETED
       PAYMENT: (    364.00)
    ADJUSTMENT: (    100.00) [13] DEDUCTIBLE      [29] Deductible Amount
[1]
    ADJUSTMENT: (     25.00) [14] CO-PAY          [27] Co-Payment Amount
    ADJUSTMENT: (     73.00) [4] NON PAYMENT      [21] Chrgs Excd Max All

[2] INSURER: NEW MEXICO MEDICAID         PRIORITY ORDER: 2    STATUS: ACTIVE
---------------------------------------------------------------------------
ERROR: STANDARD ADJUSTMENT CODE NOT ENTERED FOR ADJUSTMENT
---------------------------------------------------------------------------

Desired ACTION (Add/Edit/Quit): Q// E <Enter>E

Which insurer are you editing:  (1-2): 1 <Enter>
Ok, let's edit MAIL HANDLERS BENEFIT PLAN

  [1] PAYMENT         364.00
  [2] ADJUSTMENT     -100.00   [13]DEDUCTIBLE        [29]Deductible Amount
  [3] ADJUSTMENT      -25.00   [14]CO-PAY            [27]Co-Payment Amount
  [4] ADJUSTMENT      -73.00   [4]NON PAYMENT        [21]Chrgs Excd Max All
Which transaction:  (1-4): 2 <Enter>
AMOUNT:  (-242-242): -100// <Enter>
ADJUSTMENT CATEGORY: 13// <Enter>  DEDUCTIBLE
ADJUSTMENT REASON: 29// <Enter>  Deductible Amount
STANDARD REASON: 1 <Enter>
```

Figure 4-22: Example of using the COB page (1 of 3)

On completion, the Standard Adjustment Reason code display to the right of the chosen adjustment transaction.

Entering a Standard Adjustment Reason Code

When entering a Standard Adjustment Reason Code for an adjustment transaction, the system prompts the user to specify whether the amount should be billed to the secondary insurer. The "Do you want to include in secondary balance?" prompt requires a Yes or No response.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN: 12345]                     Claim Number:  29904
...................... (PRIOR PAYMENTS/ADJUSTMENTS) ........................

Payment Amount....: (    364.00)        ORIGINAL BILL AMOUNT:     562.00
Deductible Amount.: (    100.00)        Current Charges.....:     242.00
Co-pay/ins Amount.: (     25.00)        Current Bill Amount.:     198.00
Write Off.........:          0.00
Non-Covered Amount: (     73.00)
Penalty Amount....:          0.00
Grouper Allowance.:          0.00
Refund............:          0.00
Payment Credits...:          0.00

[1] INSURER: MAIL HANDLERS BENEFIT PLAN PRIORITY ORDER: 1  STATUS: COMPLETED
      PAYMENT: (     364.00)
   ADJUSTMENT: (     100.00) [13] DEDUCTIBLE     [29] Deductible Amount    [1]
   ADJUSTMENT: (      25.00) [14] CO-PAY         [27] Co-Payment Amount    [3]
   ADJUSTMENT: (      73.00) [4] NON PAYMENT     [21] Chrgs Excd Max All

[2] INSURER: NEW MEXICO MEDICAID        PRIORITY ORDER: 2    STATUS: ACTIVE
----------------------------------------------------------------------------
ERROR: STANDARD ADJUSTMENT CODE NOT ENTERED FOR ADJUSTMENT
----------------------------------------------------------------------------

Desired ACTION (Add/Edit/Quit): Q// E <Enter>

Which insurer are you editing:  (1-2): 1 <Enter>
Ok, let's edit MAIL HANDLERS BENEFIT PLAN

  [1] PAYMENT        364.00
  [2] ADJUSTMENT    -100.00   [13]DEDUCTIBLE       [29]Deductible Amount   [1]
  [3] ADJUSTMENT     -25.00   [14]CO-PAY           [27]Co-Payment Amount   [3]
  [4] ADJUSTMENT     -73.00   [4]NON PAYMENT       [21]Chrgs Excd Max All
Which transaction:  (1-4): 4 <Enter>
AMOUNT:  (-242-242): -73//<Enter>
ADJUSTMENT CATEGORY: 4// <Enter>  NON PAYMENT
ADJUSTMENT REASON: 21// <Enter>  Chrgs Excd Max Allowable Amt
STANDARD REASON: 42 <ENTER>
Do you want to include in secondary balance? Y// N <Enter>  No
```

Figure 4-23: Example of using the COB page (2 of 3)

Based on the Standard Adjustment Reason Codes assigned to the adjustment transaction, the Current Bill Amount field will either remain the same or the amount will reflect any changes made. The current bill amount is the amount being requested for reimbursement from the secondary insurer.

In Figure 4-23, the user did not request reimbursement for the
Non-Covered Amount ($73.00). The reimbursement is for the Deductible
Amount ($100) plus the Co-Pay Amount ($25). As a result, the Current Bill
Amount changed from $198 to $125 (See Figure 4-24).

For example,

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN: 12345]                      Claim Number:  29904
....................... (PRIOR PAYMENTS/ADJUSTMENTS) .......................

Payment Amount....: (    364.00)        ORIGINAL BILL AMOUNT:     562.00
Deductible Amount.: (    100.00)        Current Charges.....:     242.00
Co-pay/ins Amount.: (     25.00)        Current Bill Amount.:     125.00
Write Off.........:         0.00
Non-Covered Amount: (     73.00)
Penalty Amount....:         0.00
Grouper Allowance.:         0.00
Refund............:         0.00
Payment Credits...:         0.00

[1] INSURER: MAIL HANDLERS BENEFIT PLAN PRIORITY ORDER: 1  STATUS: COMPLETED
      PAYMENT: (    364.00)
   ADJUSTMENT: (    100.00) [13] DEDUCTIBLE    [29] Deductible Amount    [1]
   ADJUSTMENT: (     25.00) [14] CO-PAY        [27] Co-Payment Amount    [3]
   ADJUSTMENT: (     73.00) [4] NON PAYMENT    [21] Chrgs Excd Max All  [42]

[2] INSURER: NEW MEXICO MEDICAID        PRIORITY ORDER: 2    STATUS: ACTIVE
-----------------------------------------------------------------------------

Desired ACTION (Add/Edit/Quit): Q//
```

Figure 4-24: Example of using the COB page (3 of 3)

After all errors have been cleared, the user will determine if the

- Current Bill Amount is correct, and

- Standard Adjustment Reason Codes are accurate.

If the user is satisfied with changes applied, typing **Q** (Quit) or pressing the Enter key
displays the "Do You Wish to APPROVE this Claim for Billing?" prompt to approve
the claim for billing to the secondary insurer. Typing **Yes** creates the bill.
For example,

```
Desired ACTION (Add/Edit/Quit): Q// <Enter>

Do You Wish to APPROVE this Claim for Billing? YES <Enter>

Transferring Data....

Bill Number 3431B Created.  (Export Mode: 837 PROF (HCFA))
```

Figure 4-25: Example showing bill creation

DRG Reimbursements Billed to Secondary Insurance

The following example demonstrates a claim reflecting a Diagnosis Related Group (DRG) reimbursement being billed to the secondary insurance carrier.

When the user is ready to bill the claim to the secondary payer, type **A** at the "Desired ACTION" prompt to approve the claim. This will display a Summary Charge screen. For example,

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 0 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN: 12345]                    Claim Number:  29904
............................. (CLAIM SUMMARY) .............................

_____ Pg-1 (Claim Identifiers) _____ Pg-4 (Providers)_____
Location..: INDIAN HOSP               | Attn: ALEXIS,ALEXANDRA
Clinic....: GENERAL                   |
Visit Type: INPATIENT                 |
Bill From: 02-01-2007 Thru: 02-05-2007|
                                      |_____ Pg-5A (Diagnosis)_____
_____ Pg-2 (Billing Entity) _____| 1) CARDIAC ARREST
MAIL HANDLERS BENEFIT PLAN    COMPLETE|
MEDICARE                      ACTIVE  |
NEW MEXICO MEDICAID           PENDING |
                                      |_____ Pg-5B (ICD Procedures) _____
_____ Pg-3 (Questions) _____|
Release Info: YES   Assign Benef: YES |
_____|_____

Desired ACTION (View/Appr/Pend/Next/Jump/Quit): N// A <Enter>

                ***** 837 INST (UB) CHARGE SUMMARY *****

Active Insurer: MEDICARE


                                Revn            Total       Non-cvd
        Description             Code    Units   Charges      Charges
------------------------------------------------------------------------
ALL INCL R&B            |1660.00   0101      4    6,640.00       0.00
                                                 ---------
        TOTAL CHARGE            0001            6,640.00
```

Figure 4-26: COB example of DRG reimbursement billed to secondary (1 of 4)

After the user has reviewed the Charge Summary information, pressing the Enter key (to continue) displays the COB page. For example,

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:12345]                         Claim Number: 29904
........................ (PRIOR PAYMENTS/ADJUSTMENTS).....................

Payment Amount....: (   4968.00)        ORIGINAL BILL AMOUNT:    4265.00
Deductible Amount.:        0.00         Current Charges.....:    6640.00
Co-pay/ins Amount.:        0.00         Current Bill Amount.:       0.00
Write Off.........:        0.00
Non-Covered Amount:        0.00
Penalty Amount....:        0.00
Grouper Allowance.:      703.00
Refund............:        0.00
Payment Credits...:        0.00


1] INSURER: MAIL HANDLERS BENEFIT PLAN PRIORITY ORDER: 1   STATUS: COMPLETED
      PAYMENT: (   4968.00)
   ADJUSTMENT:       500.00  [16] GROUPER ALLOWANCE[93] DRG Weight
   ADJUSTMENT:       203.00  [16] GROUPER ALLOWANCE[93] DRG Weight

[2] INSURER: MEDICARE                   PRIORITY ORDER: 2     STATUS: ACTIVE
           COVERAGE TYPE: PART A

[3] INSURER: NEW MEXICO MEDICAID        PRIORITY ORDER: 3    STATUS: PENDING
------------------------------------------------------------------------------
ERROR: STANDARD ADJUSTMENT CODE NOT ENTERED FOR ADJUSTMENT
------------------------------------------------------------------------------

Desired ACTION (Add/Edit/Quit): Q//
```

Figure 4-27: COB Example of DRG reimbursement billed to secondary (2 of 4)

At the "Desired ACTION" prompt,

- Type **E** (Edit) and press the Enter key.

- Select the insurer who has a Completed claim status.

For this example, the DRG adjustment for a $500 deductible is selected for reimbursement.

```
Desired ACTION (Add/Edit/Quit): Q// E <Enter>

Which insurer are you editing:  (1-3): 1 <Enter>
Ok, let's edit MAIL HANDLERS BENEFIT PLAN

  [3] PAYMENT        4968.00
  [1] ADJUSTMENT      500.00   [16]GROUPER ALLOWANCE[93]DRG Weight       [68]
  [2] ADJUSTMENT      203.00   [16]GROUPER ALLOWANCE[93]DRG Weight       [68]
Which transaction:  (1-3): 1 <Enter>
AMOUNT:  (-6640-6640): 500// <Enter>
ADJUSTMENT CATEGORY: 16// 13 <Enter>  DEDUCTIBLE
ADJUSTMENT REASON: 93// 29 <Enter>  Deductible Amount
STANDARD REASON: 1 <Enter>
Do you want to include in secondary balance? Y// Y <Enter>  Yes
```

Figure 4-28: COB Example of DRG reimbursement billed to secondary (3 of 4)

When entering a Standard Adjustment Reason Code for an adjustment transaction, the system prompts the user to respond if this amount should be billed to the secondary insurer. The "Do you want to include in secondary balance?" prompt requires a Yes or No response.

Based on the Standard Adjustment Reason Codes applied to the selected adjustment, the Current Bill Amount changed from $0.00 to $500.00, the amount requested for reimbursement from the secondary insurer.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN: 12345]                    Claim Number: 29904
........................ (PRIOR PAYMENTS/ADJUSTMENTS)........................

Payment Amount....: (   4968.00)       ORIGINAL BILL AMOUNT:   4265.00
Deductible Amount.:       500.00       Current Charges.....:   6640.00
Co-pay/ins Amount.:         0.00       Current Bill Amount.:    500.00
Write Off.........:         0.00
Non-Covered Amount:         0.00
Penalty Amount....:         0.00
Grouper Allowance.:       203.00
Refund............:         0.00
Payment Credits...:         0.00

[1] INSURER: MAIL HANDLERS BENEFIT PLAN PRIORITY ORDER: 1  STATUS: COMPLETED
      PAYMENT: (   4968.00)
   ADJUSTMENT:       500.00  [13] DEDUCTIBLE     [29] Deductible Amount  [1]
   ADJUSTMENT:       203.00  [16] GROUPER ALLOWANCE[93] DRG Weight       [68]

[2] INSURER: MEDICARE                  PRIORITY ORDER: 2   STATUS: ACTIVE
            COVERAGE TYPE: PART A

[3] INSURER: NEW MEXICO MEDICAID       PRIORITY ORDER: 3   STATUS: PENDING
------------------------------------------------------------------------
Desired ACTION (Add/Edit/Quit): Q//
```

Figure 4-29: COB example of DRG reimbursement billed to secondary (4 of 4)

If the user is satisfied with changes applied, typing **Q** (Quit) or pressing the Enter key displays the prompt to approve the claim for billing to the secondary insurer. Typing **Yes** creates the bill.

4.5   PAGE 1 - CLAIM IDENTIFIERS

Unless the claim contains errors, use the Next command on PAGE 0 to skip the
CLAIM IDENTIFIERS (PAGE 1).

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                        Claim Number: 31390
........................... (CLAIM IDENTIFIERS) ...........................

                 [1] Clinic.............: EMERGENCY MEDICINE
                 [2] Visit Type.........: EMERGENCY ROOM
                 [3] Bill Type..........: 131
                 [4] Billing From Date..: 07/27/2008
                 [5] Billing Thru Date..: 07/27/2008
                 [6] Super Bill #.......:
                 [7] Mode of Export.....: 837 PROF (HCFA)
                 [8] Visit Location.....: INDIAN HEALTH HOSPITAL


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

Figure 4-30: CLAIM IDENTIFIERS (PAGE 1) example

4.5.1   Displaying the CLAIM IDENTIFIERS (PAGE 1)

To display the CLAIM IDENTIFIERS (PAGE 1):

- Use the Jump command, or

- Use the Back command from Page 2.

To edit a field on PAGE 1, select the Edit command and designate the field(s)
to be altered.

4.5.2   Viewing PAGE 1 Information

Using the View command on this page displays information about the patient's employer, the facility where the visit occurred, the National Provider Identifier for the facility, and the ASUFAC (Area, Service Unit, Location code) for the location where the visit occurred. For example,

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1   ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                         Claim Number: 31390
........................ (IDENTIFIER - VIEW OPTION) ........................

Patient.: DEMO,JOHN (123567)                 Sex.: M    DOB..: 01-01-1950
          12345 RESOURCE LANE                Home Phone......: 999 999 9999
          ALBUQUERQUE, NM  87999             Marital Status..: MARRIED

   Employer...: SILVER STATE CONSTRUCTION    Empl. Status..: RETIRED
                                             Work Phone....:


------------------------------------------------------------------------------
Facility: INDIAN HEALTH HOS                  Tax Number..: 85-9999999
          INDIAN HEALTH HOSP                 Phone.......: 505 555-0000
          PO BOX 99999                       NPI.........: 9999999999
          ALBUQUERQUE, NM  87999             ASUFAC......: 232101
------------------------------------------------------------------------------
WARNING:075 - EMPLOYER LOCATION UNSPECIFIED
------------------------------------------------------------------------------

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

Figure 4-31: IDENTIFIER – VIEW OPTION (PAGE 1) information example

If an error or warning condition exists, it is given an error/warning number. Typing the error/warning number at the "Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION" prompt displays instructions for correcting the problem.

4.6   PAGE 2 - INSURERS

Use INSURERS (PAGE 2) to:

- View the patient's current billable resources.

- Display the active mode of billing.

- Select the entity to bill.

For example,

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                         Claim Number: 31388
............................. (INSURERS) ................................

To: TRAILBLAZER HEALTH ENT.LLC         Bill Type...: 111
     12800 INDIAN SCHOOL RD, NE        Proc. Code..: ICD9
    ALBUQUERQUE, NM  87222             Export Mode.: 837 INST (UB)
    (888)763-9836                      Flat Rate...: 1726.00
...........................................................................
MSP STATUS AS OF MAY 16, 2006: NOT MSP ELIGIBLE
...........................................................................


           BILLING ENTITY              STATUS        POLICY HOLDER
     ============================== ==========  ============================
[1]   MEDICARE                       ACTIVE      DEMO,JOHN
[2]   MISSISSIPPI MEDICAID           PENDING     DEMO,JOHN
[3]   EMPLOYERS DENTAL SERVICES      PENDING     DEMO,ALICIA
---------------------------------------------------------------------------
WARNING:075 - EMPLOYER LOCATION UNSPECIFIED
--------------------------------------------------------------------

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

Figure 4-32: Billing entities (PAGE 2) edit screen example

The INSURERS (PAGE 2) contains two sections:

- The first section displays demographic information about the active billing entity and the mode of billing, as defined for that entity in the Visit Type section of the Insurer file.

- The second section shows a listing of all billable resources for the patient and his/her current billing status and policyholder. This information is derived from the Patient Registration application.

Only one entity can be billed at a time. Selecting the entity to bill is the billing technician's responsibility.

The sequence in which the entities are initially presented is determined by the most common hierarchical order for coordination of benefits. For example, the Claim Generator will attempt to present accident insurance as primary, if the visit was marked *accident-related* in PCC and the relationship to policyholder was flagged as *accident/tort-related* in Patient Registration.

The billing mode corresponds to the entity setup in the Insurer file (under Table Management). In Figure 4-33, hospital services will be billed at a flat rate of $215.00 on an 837 Institutional electronic claims format, and the procedures will be coded in an ICD format.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DOE,JANE  [HRN:756312]                          Claim Number: 31684
............................... (INSURERS) ...............................

To: TRAILBLAZER HEALTH ENT.LLC          Bill Type...: 131
     12800 INDIAN SCHOOL RD, NE         Proc. Code..: ICD9
    ALBUQUERQUE, NM  87222              Export Mode.: 837 INST (UB)
    (888)763-9836                       Flat Rate...: 215.00
..........................................................................
```

Figure 4-33: Billing mode for inpatient Medicare example

To change how an insurer is billed, make the necessary modifications to the insurer's record. For more information on setting up the insurer's billing mode, see the Add/Edit Insurer option located in Table Maintenance.

4.6.1   Picking the Insurer

Use the Pick command to select the insurer to bill. For example,

```
Desired ACTION (Pick/View/Next/Jump/Back/Quit): N//P <Enter>

Sequence Number of Payer to BILL:  (1-3): 2

BLUE CROSS OF CALIFORNIA is Currently the Billing Source!

Do you wish to bill NEW MEXICO MEDICAID? YES <Enter>
```

Figure 4-34: PAGE 2 Pick command example

Picking an insurer to bill makes the insurer the active billing entity, changes the billing mode to correspond accordingly, and changes the status of all other insurers to pending.

4.6.2   Viewing Active Insurer, Policy, and Policyholder Information

Use the View command to obtain information about the active insurer, policy, or policyholder. For example,

```
Desired ACTION (Pick/view/Next/Jump/Back/Quit):  N// V <Enter>
Sequence Number to VIEW:  (1-3):  1
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT, JANE  [HRN:5824]           Claim Number: 635
..................... (INSURER - VIEW OPTION) ...................

Insurer..: PRINCIPAL FINANCIAL             Phone....: (800)826-1820
Prov. No.:                                 Contact..:
----------------------------------------------------------------
Policy Number....: 10010001-01             Coverage(s).....:
Group Name.......: SELF                    Group Number....: 2398743
   Elig date.....: JAN 01, 1994            Elig end date..:
----------------------------------------------------------------
Policy Holder.: PATIENT,JANE               Relationship..: SELF
              4321 GREEN STREET            Home Phone....: 555 555 5555
              DENVER, CO   33333

   Employer...: PRESBYTERIAN HEALTH PLAN   Empl. Status..: FULL-TIME
              PO BOX 27845                 Work Phone....:
              ALBUQUERQUE, NM  87125
----------------------------------------------------------------

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

Figure 4-35: View command INSURER – VIEW OPTION (PAGE 2) example

4.6.3   Adding, Deleting PAGE 2 Information

The Add and Delete commands are available only when the Accident or Employment Related field is set to YES on QUESTIONS (PAGE 3). When available, these commands enable the user to change the billable entities in the claim, so that an insurer other than the patient's third party resources can be billed (e.g., Worker's Compensation).

4.7   PAGE 3 - QUESTIONS

Use QUESTIONS (PAGE 3) to include additional miscellaneous billing information,
so that it can be exported to the billing entities. For example, Figure 4-36 shows how
a subset would be displayed for editing.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3   ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT,JR  [HRN:2]               Claim Number: 29734
.......................... (QUESTIONS) ............................

 [1] Release of Information..: YES
 [2] Assignment of Benefits..: YES
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.:
 [6] Special Program.........: YES  EPSDT/CHAP        Referral: S2
 [7] Blood Furnished.(pints).: NO
 [8] PRO Approval Number.....:
 [9] Type of Admission.......:  2  URGENT
[10] Source of Admission.....:  1  PHYSICIAN REFERRAL
[11] Discharge Status........: 01  DISCHARGE TO HOME
[12] Admitting Diagnosis.....:

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

Figure 4-36: QUESTIONS (PAGE 3) example

The set of questions displayed is dependent on the established mode of export. The
following list includes all questions that may be displayed in the QUESTIONS page:

1. Release of Information

2. Assignment of Benefits

3. Accident Related

4. Employment Related

5. Emergency Room Required

6. Special Program

7. Outside Lab Charges

8. Blood Furnished (pints)

9. Date of First Symptom

10. Date of Similar Symptom

11. Date of First Consultation

12. Referring Physician

13. Revenue Code/Charge

14. Case No. (External ID)

15. Medicaid Resubmission Number

16. Radiographs Enclosed

17. Orthodontic Related

18. Init Prosthesis Placed

19. Prior Authorization No

20. HCFA-1500B Block 19

21. Type of Admission

22. Source of Admission

23. Patient Status

24. Admitting Diagnosis

25. Supervising Provider (Form Locator 19) & Date Last Seen

26. Date of Last X-Ray

27. Referral Number

28. Prior Authorization Number

29. Homebound Indicator

30. Hospice Employed Provider

31. Delayed Reason Code

32. Number of Enclosures

33. Other Dental Charges

34. Reference Lab CLIA Number

35. In-House CLIA Number

Answering any of these questions is optional.

Only the Release of Information and Assignment of Benefits fields have an associated error or warning condition. If the visit type for the claim is anything other than Inpatient, the "Release of Information" and "Assignment of Benefits" prompts will correspond to entries in the Patient Registration system. In the previous example, registration information is listed as a visit date range.

> **Note:** Editing these fields will update the registration information and all existing and subsequent non-inpatient claims for that patient.

If the claim is created automatically from PCC data, some of the questions may be answered already (e.g., Accident, Employment Related, Emergency Room Utilized, and Special Program).

If the patient's file indicates that the visit was accident/employment-related (Accident Related or Employment Related fields), the Billing Entities page allows the user to add or delete insurers. Under these conditions it may be desirable to bill an entity (e.g., Worker's Compensation) other than the patient's third party resources.

If an entry is specified in the Outside Lab Charges field and the affiliation of the Billing Facility is 638, the unit charge amount on the CPT Laboratory Page (8E) will be editable. It is the user's responsibility to ensure that the charges entered on the Laboratory page equal the outside lab charge entered on this page.

The Revenue Code/Charge field can be used to present a special charge (supplies, equipment, ambulance, etc.), to be included in the bill. When billing Medicare for intraocular lenses during an ambulatory surgery visit, the Revenue Code 274 should be entered along with the corresponding invoice amount of the IOL.

Answering questions on this page can also trigger entries in other pages automatically.

- If the Emergency Room Utilized field is set to YES, the Admission Type and Admission Source fields on PAGE 7 will be set to Emergency and Emergency Room, respectively.

- If the Accident Related field is set to YES and if the Export Mode is in a UB-04 or 837 Institutional format, PAGE 9A will contain the appropriate Occurrence Code.

- If the Employment Related field is set to YES and if the Export Mode is on a UB-92, PAGE 9C will contain the appropriate Condition Code.

- If the Special Program field is set to YES and if the Export Mode is on a UB-92, PAGE 9E will contain the designated Special Program.

4.8   PAGE 4 - PROVIDER DATA

Use PROVIDER DATA (PAGE 4) to designate the attending and operating providers and to display the providers' numbers and disciplines.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT   [no HRN]                  Claim Number: 1
............................. (PROVIDER DATA) .....................

        PROVIDER                 NUMBER     DISCIPLINE
        ====================     ==========  ========================
(attn)  MEDICAL,DOCTOR           NM-877687   PHYSICIAN
(oper)  WELBY,MARCUS             MI-299834   PHYSICIAN

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

Figure 4-37: PROVIDER DATA (PAGE 4) example

To designate the attending or operating provider, a selection must be made from the Provider File.

> **Note:** Presently, the Third Party Billing system allows only one attending provider and one operating provider.

If the claim was generated automatically from PCC data, the providers will already be established. The Primary Provider in PCC is typically the Attending Provider.

If no entries exist on MEDICAL SERVICES (PAGE 8A), a minimal level of service entry will automatically be triggered when a physician is added as the attending provider and the visit type is not inpatient or dental.

4.8.1   Adding a Provider

Use the Add Command to add the attending and operating providers.

> **Note:** Although more than one attending or one operating provider cannot be designated, the user may designate the same person as both operating and attending provider.

To add a provider:

1. At the "Desired ACTION" prompt, type **A** and press the Enter key.

2. At the "Select Provider" prompt, type the provider's name or initials and press the Enter key.

3. At the "Provider Status" prompt, type the desired option (A, O, or R) and press the Enter key. The default is Operating (O).

For example,

```
Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//A <Enter>

Select Provider: WELBY,MARCUS

     Select one of the following:

          A          Attending
          O          Operating
          T          Other
          F          Referring
          R          Rendering
          P          Purchased Service
          S          Supervising

Provider Status: O// <Enter> Operating
```

Figure 4-38: Adding a provider example

4.8.2   Viewing Provider Information

Use the View command on the PROVIDER VIEW OPTION page to display information about the Attending and Operating providers, and to list all providers entered through the Patient Care Component (PCC) system.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [no HRN]                Claim Number: 1
.................... (PROVIDER VIEW OPTION) ......................

Attn Prov..: MEDICAL,DOCTOR              Phone #....:
Discipline.: PHYSICIAN                   MCR/MCD #..: NM-12345
Affilliation: IHS                        DEA #......: AB1234567
NPI.........: 1234567802                 Provider Taxonomy:207Q00000X


------------------------------------------------------------------
         ***** Provider Information Entered Through PCC *****
PRI      PROVIDER                             DISCIPLINE
=== ================================  =======================
 P  GIVER,GREAT CARE                         PHYSICIAN
 S  MARCUS,WELBY                             PHYSICIAN
------------------------------------------------------------------
```

Figure 4-39: Viewing provider (PAGE 4) information example

4.8.3   Display if NPI Only Field Selected

If the Active Insurer entry (Page 2 of the Claim Editor) holds an NPI Usage of NPI Only, the user will see the following display on PAGE 4:

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:9999]                    Claim Number: 29732
.......................... (PROVIDER DATA) ..........................

            PROVIDER                 NPI            DISCIPLINE
    ========================== ============ =====================
(attn)  DOCTOR,ALEXANDRA         1234567890    PHYSICIAN

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

Figure 4-40 : Example of PROVIDER DATA (PAGE 4) when NPI Only field is selected

This type of display indicates that the NPI will be submitted to the payer. As a result, the NPI must be entered for the provider. Users should see this screen if they are to send only the NPI to the payer.

4.8.4   Display if NPI & Legacy Number Field Selected

If the Active Insurer entry (Page 2 of the Claim Editor) holds an NPI Usage of NPI and Legacy, the user will see a display similar to the following display on PAGE 4.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:9999]                    Claim Number: 29838
.......................... (PROVIDER DATA) ..........................

            PROVIDER            NPI         NUMBER       DISCIPLINE
        ================= ========== =========== ===============
(attn)  DOCTOR,ALEXANDRA    1234567890   NM-001393    PHYSICIAN

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

Figure 4-41: Example of PROVIDER DATA (PAGE 4) when NPI & Legacy Number
                        is selected

This type of display indicates that both the NPI and the Legacy (Current provider Number) will be submitted to the insurer. Users should see this when they are in the implementation phase of submitting NPI. This is the phase where both the NPI and Legacy Number can be submitted.

4.8.5   PAGE 4 – PROVIDER DATA Displays if Legacy Only Field is Selected

If the Active Insurer entry (PAGE 2 of the Claim Editor) contains an NPI Usage of Legacy Only or if the field is blank, the user will see a display similar to the following display on PAGE 4 (PROVIDER DATA).

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:45630]               Claim Number: 29837
.......................... (PROVIDER DATA) ..........................

            PROVIDER               NUMBER           DISCIPLINE
        ========================  ===========  ====================
(attn)  DOCTOR,ALEXANDRA            NM-001234    PHYSICIAN

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

Figure 4-42: Example of PROVIDER DATA (PAGE 4) when Legacy Only field is selected

This is the criteria used for the Provider (Legacy) Number assignment:

1. If the Payer Assigned Provider Number has been entered for the provider, the payer assigned provider number is used.

2. If the billing entity is Medicare, and a Medicare number has been entered for the Provider, the Medicare number is used. If there is no Medicare number but a UPIN number has been entered, the UPIN is used. If no Medicare or UPIN number has been entered, then the default, PHS000, is used.

3. If the billing entity is Medicaid and a Medicaid number has been entered for the provider, the Medicaid number is used. If no Medicaid number has been entered, then the claim editor will display error number 170 (Medicare/Medicaid Provider Number Unspecified for Providers).

4. If the provider has a state license for the state where the visit occurred, the state license number is used. This number is located in the provider file. If no state license number has been entered, the UPIN number from the Provider file is used.

For Medicare Part B Only

The provider number entered in the Insurer file will appear on the claim if the insurer is Medicare and the visit type is 999 (Professional Component). The provider number for this entity is entered into the Insurer File in Table Maintenance.

4.9   PAGE 5A - DIAGNOSIS

Use DIAGNOSIS (PAGE 5A) to select and manipulate the visit diagnosis information. This page displays the hierarchical sequence number, the ICD code, its description, and the provider's narrative for each diagnosis. E-codes may also be displayed if linked to a diagnosis code.

Displaying both the ICD description and the provider's narrative provides the user a means to ensure data entry accuracy through comparison. The user can control whether the page presents a short or long version of the ICD description by editing the Site Parameters file.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 5A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                         Claim Number: 30675
............................... (DIAGNOSIS) ...............................

BIL    ICD9
SEQ    CODE  - Dx DESCRIPTION        PROVIDER'S NARRATIVE
===    ========================      ==============================
 1    366.04 - NUCLEAR NONSENILE         NUCLEAR CATARACT
 2    550.02 - BILATERAL INGUINAL        BILAT INGUINAL HERNIA W/ GANG
               HERNIA WITH GANGRENE

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

Figure 4-43: DIAGNOSIS (PAGE 5A) screen example

If the claim is created from PCC data, the diagnosis and corresponding provider's narrative will already be entered in the order designated by the provider.

The provider's narrative will be presented on the bill and should be comprehensible to an outside entity (internal abbreviations removed, etc.).

> **Note:** Altering data in the claim system that was obtained from
> PCC will not impact the original PCC data.

4.9.1   Adding a Diagnosis

Before the user can add a diagnosis to the claim, he/she must select the diagnosis from the ICD Diagnosis file. Diagnoses are selected from the file using a lookup program that finds entries contained in the diagnostic narrative, based on words that are independent of order or punctuation.

Keywords (or abbreviations) established for the ICD Diagnosis file that are partially matched by words in the input narrative are considered a lookup match. To obtain a listing of ICD keywords, see the PCC data entry operator.

```
Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N// A <Enter>

======================= ADD MODE - DIAGNOSIS  =======================
Select Diagnosis: BILAT INGUINAL HERNIA GANGRENE <Enter>
( BILAT/BILATERAL GANGRENE HERNIA/HERNIATED/HERNIATION INGUINAL/INGUINALE)

The following matches were found:

   1: 550.02 (BILAT ING HERNIA W GANG)
       BILATERAL INGUINAL HERNIA, WITH GANGRENE

   2: 550.03 (RECUR BIL ING HERN-GANG)
       RECURRENT BILATERAL INGUINAL HERNIA, WITH GANGRENE

   3: 550.12 (BILAT ING HERNIA W OBST)
       BILATERAL INGUINAL HERNIA, WITH OBSTRUCTION, WITHOUT MENTION GANGRENE

Select 1-3: 1 <Enter>

Select PROVIDER NARRATIVE: BILAT ING HERNIA W GANG// <Enter>  BILATERAL INGUINAL
HERNIA WITH GANGRENE

 =-=-=-= The Diagnosis has been Added. =-=-=-=
```

Figure 4-44: Adding a diagnosis example

> **Note:** In this example, the default value for the Provider's
> Narrative is the short version of the ICD narrative. If it is
> inconsistent with the Provider's Narrative or unclear, it
> should be modified.

4.9.2   Deleting a Diagnosis

The Delete command can be used to delete diagnosis data by specifying the sequence
number of the diagnosis to be removed.

```
Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N//D1 <Enter>

Do you wish 550.01 DELETED? YES
```

Figure 4-45: Deleting a diagnosis example

As a safeguard, the user will be prompted if the ICD Code entry is to be deleted prior
to the system removing the entry specified.

4.9.3   Viewing Additional Diagnosis Information

Use the View command on the DIAGNOSIS VIEW OPTION page to display the
PCC diagnosis information for the visit, including the cause of injury and modifiers
(if the claim was automatically created from PCC data).

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 5A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                         Claim Number: 30675
......................... (DIAGNOSIS VIEW OPTION) .........................

            ***** DIAGNOSIS INFORMATION ENTERED THROUGH PCC *****
PRI ICD CD       PROVIDER'S NARRATIVE                     CAUSE OF INJURY
=== ====== =============================== ===========================
 S  784.0  HEADACHE
 S  786.2  COUGH
--------------------------------------------------------------------------

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

Figure 4-46: Viewing diagnosis information example

If PCC data entry activity occurs after the claim has been edited, the claim will not be automatically updated. Instead, the system will display a warning that PCC data entry activity occurred, advising the user to investigate the visit. In this situation, the View command is a useful tool for determining what changes have occurred to the PCC data.

4.9.4 Re-Sequencing a Diagnosis

Use the Sequence command to change the order in which the diagnosis is presented during export. The Sequence command is useful for Diagnostic Related Group (DRG) billing, when the diagnosis order influences the rate of collection.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 5A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                         Claim Number: 30675
.............................. (DIAGNOSIS) ...............................

BIL   ICD9
SEQ   CODE        Dx DESCRIPTION                    PROVIDER'S NARRATIVE
=== ======= ========================= ===================================
 1  784.0   HEADACHE                  HEADACHE
 2  786.2   COUGH                     COUGH


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

        If you need to change the current billing order then
        enter the sequence numbers above in the desired order
        separated by commas.

        NOTE: If the billing sequence is different from that noted
              in the file then a Physcian's Attestation is required!

Enter the desired billing sequence: 1,2// 2,1 <Enter>
```

Figure 4-47: Re-sequencing a diagnosis example

> **Note:** If the diagnosis sequence is altered to maximize billing, an
> attestation signed by the provider that coincides with the
> claim must be on file in the patient's chart.

4.10   PAGE 5B - ICD PROCEDURES

ICD PROCEDURES (PAGE 5B) is accessible only when the Procedure Coding
method is ICD.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 5B  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                        Claim Number: 30675
............................ (ICD PROCEDURES) ............................

BIL SERV    ICD0
SEQ DATE    CODE - PROCEDURE DESCRIPTION            PROVIDER'S NARRATIVE
=== =====   ================================   ===========================
 1  CHARGE DATE: 10/25/2008
            13.19 - INTRACAPSUL LENS EXT NEC     INTRACAPSUL LENS EXT NEC
 2  CHARGE DATE: 10/25/2008
            53.00 - UNILAT ING HERN REP NOS      UNILAT ING HERN REP NOS


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

Figure 4-48: ICD procedure data (PAGE 5B) screen example

The same actions can be performed on this page as are performed on
DIAGNOSIS DATA (PAGE 5A) See Section 4.9.

4.10.1   PAGE 6 - DENTAL SERVICES

Use DENTAL SERVICES (PAGE 6) to select and modify dental information for a visit. For example,

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 6  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                          Claim Number: 30726
........................... (DENTAL SERVICES) ............................

    VISIT                                            ORAL OPER
    DATE                 DENTAL SERVICE              CAV  SITE SURF
CHARGE
    ===== ========================================= ==== ==== ====  ======
[1] 05/12 0120 PERIODIC ORAL EVALUATION - ESTABLISHED                41.07
[2] 05/12 1205 TOPICAL FLUORIDE WITH PROPHY-ADULT                    94.63
[3] 05/12 2120 AMALGAM - TWO SURFACES, PRIMARY        L    3     OB  133.00
                                                                     ======
                                                                    $268.70


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

Figure 4-49: Dental data (PAGE 6) screen example

Dental procedures use American Dental Association (ADA) codes and specify tooth and surface. If the claim was automatically created by the Dental application, all dental information should have already been entered.

As Figure 4-49 shows, if a dental service is tooth-specific and the operative site or surface data is missing, an error or warning message is displayed on the screen.

4.10.2   Adding a Dental Service

When adding a dental procedure, consider the following:

- There is no keyword lookup utility associated with the Dental file. When selecting/adding dental codes, type the desired ADA code at the prompt.

- Dental Codes can be selected only if they have a corresponding entry in the active Dental Fee Schedule.

- The date of service must be entered in the standard FileMan date format.

- The "Operative Site:" and "Surface:" prompts appear only if the dental procedure is tooth-specific.

- Operative site assignments must be selected from the Operative Site file. By entering the tooth number, a narrative description, or the operative site code the system should be able to locate the operative site data.

- The surface code is a one-to-five character combination of the letters O, M, D, B,L F, and I.

To add a dental procedure for PAGE 6:

1. At the "Desired Action" prompt, type **A** and press the Enter key.

2. At the "Select ADA Code" prompt, type the ADA code and press the Enter key.

3. At the "Date of Service" prompt, type the date the dental service was performed and press the Enter key. The default date of service is the current date.

4. If applicable,

   a. At the "Operative Site" prompt, enter the operative site information and press the Enter key.

   b. At the "Surface" prompt, type the surface location code and press the Enter key.

   For example,

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N// A
Select ADA CODE: 2940 <Enter>   FILLING (SEDATIVE)

DATE OF SERVICE: 06/15/2006// 04/26/2006 <Enter>

OPERATIVE SITE: 20D  DECIDUOUS SECOND MOLAR,MAND LEFT     K    20D

SURFACE: DB <Enter>


                  DIAGNOSES
      Seq   ICD9
      Num   Code                 Diagnosis Description
      ===  ======   ==========================================
       1   V72.2    DENTAL EXAMINATION
UNITS: 1// <Enter>
CHARGE: 40//
```

Figure 4-50: Adding a dental service example

4.11   PAGE 7 - INPATIENT DATA

Use INPATIENT DATA (PAGE 7) to enter hospitalization information for a claim. When a claim is created, the majority of the fields on PAGE 7 are completed automatically. For example,

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 7  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                           Claim Number: 30699
............................ (INPATIENT DATA) ............................

[1] Admission Date...: 02-11-2009      [2] Admission Hour....: 08
[3] Admission Type...: 02 (URGENT)
[4] Admission Source.: 02 (CLINIC REFERRAL)
[5] Admitting Diag...: 540.0 (ACUTE APPENDICITIS W/ GENERALIZED PERITONITIS)

[6] Discharge Date...: 02-13-2009      [7] Discharge Hour....: 16
[8] Discharge Status.: 01 (DISCHARGE TO HOME)
[9] Service From Date: 02-11-2009      [10] Service Thru Date: 02-13-2009
[11] Covered Days...: 2               [12] Non-Cvd Days...:
[13] Prior Auth Number.....: 12345678901234567890
------------------------------------------------------------------------------
WARNING:146 - PSRO AUTHORIZATION NUMBER NOT SPECIFIED
------------------------------------------------------------------------------

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

Figure 4-51: INPATIENT DATA (PAGE 7) screen example

The hospital code fields are saved to reflect the most normal condition, unless the claim contains PCC data that indicates otherwise.

If the user adds or edits data on this page and no entries exist on the Medical Services page, the level of service entries will be established automatically for the day of admission, each subsequent inpatient day, and the day of discharge.

4.11.1   Editing Admission Type

The Admission Type, Newborn Days, and Admission/ Newborn Code fields have a relationship that is dependent on what is entered at the "Admission Type" prompt.

If the Admission Type is set to Newborn (01),

- The "Newborn Days:" prompt displays, requiring an entry.

- The "Admission/Newborn Code:" prompt displays, requiring an entry.

If this field already contains an admission code, the system deletes the existing code and prompts you for a newborn code.

For example,

```
Desired ACTION (Edit/Next/View/Jump/Back/Quit): N// E3 <Enter>

[3] Admission Type..........: 01// <Enter> NEWBORN
[3a] Newborn Days...........: 4 <Enter>
[4] Admission/Newborn Code..: NORMAL BIRTH <Enter>
```

Figure 4-52: Designating admission type as newborn example

In addition, the system adds a Nursery Room entry and a Delivery Room entry to the Accommodations page. The nursery room entry equals the number of days entered at the "Newborn Days" prompt.

If the admission type is designated as anything other than Newborn (01), the "Newborn Days" prompt does not appear, and the "Admission/Newborn Code:" prompt requires an admission code. If the field already contains a newborn code, the system deletes the existing code and prompts for a new entry. No delivery room or nursery room entries appear on the ACCOMMODATIONS PAGE.

4.11.2   Newborn Days and Flat Rate Billing

If newborn days are designated on the claim and the billing mode is flat rate, an additional charge for the newborn is added to the bill. The following example illustrates how this additional charge appears.

```
                ***** UB-92 CHARGE SUMMARY *****
                                    Revn             Total      Non-cvd
          Description               Code   Units    Charges     Charges
---------------------------------------------------------------------
ALL INCLUSIVE RATE        |400.00    100      4    1,600.00        0.00
NURSERY                   |400.00    170      3    1,200.00
                                                   --------
TOTAL CHARGES                        001           2,800.00
```

Figure 4-53: Example of impact of newborn days on flat rate billing

In this example, the mother had four inpatient days and the newborn had only three.

4.12   PAGE 8A - MEDICAL SERVICES

Use MEDICAL SERVICES (PAGE 8A) to collect and modify medical data for a specific visit. The CPT codes used on this page are restricted to those listed in the Medicine section of the CPT manual.

Note: The CMS-1500 and 837 Professional export mode allows up to three modifiers to be appended to the CPT code. If this form (or mode) is indicated, the system prompts for multiple modifiers when editing CPT coded entries. This occurs on all appropriate CPT-coded pages.

The professional component entries are screened to prevent data entry error. For example, if the visit type is outpatient, the hospital level service entries are not selectable and vise-versa.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8A   ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                        Claim Number: 31389
Mode of Export: 837 PROF (HCFA)
........................... (MEDICAL SERVICES) ...........................

     REVN                                              UNIT      TOTAL
     CODE          CPT - MEDICAL SERVICES              CHARGE QTY  CHARGE
     ==== ========================================== ====== === =========
[1]  CHARGE DATE: 07/27/2008 (DOCTOR,TRUDEL-R)
     0960 99221 INITIAL HOSPITAL CARE                 137.00  1    137.00
[2]  CHARGE DATE: 07/28/2008 (DOCTOR,TRUDEL-R)
     0960 99231 SUBSEQUENT HOSPITAL CARE               72.00  1     72.00
[3]  CHARGE DATE: 07/27/2008 (DOCTOR,TRUDEL-R)
     0960 99232 SUBSEQUENT HOSPITAL CARE               99.00  1     99.00
                                                             ==========
                                                              $308.00
---------------------------------------------------------------------------
  ERROR:122 - PROCEDURE(S) MISSING CORRESPONDING DIAGNOSIS(SES) (1)
---------------------------------------------------------------------------

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

Figure 4-54: MEDICAL SERVICES (PAGE 8A) screen example

If the claim is created using PCC data, the Level of Service entries are established as follows.

- If the Level of Service is specified in PCC with a corresponding CPT code, that CPT code is used.

- If the Level of Service is **not** specified in PCC with a corresponding CPT, the following criteria is used:

  - If the visit type is outpatient and the attending or operating provider is a physician, the claim will contain the CPT code 99211 (established patient, minimal service). This function can be turned off in the Site Parameters, "Set Prof. Comp. Automatically" prompt.

  - If the visit type is inpatient, the following three entries will be created for the claim:

    1) CPT code 99238 (Hospital discharge day management) - one unit

2) CPT code 99221 (Initial hospital care, brief) - one unit

3) CPT code 99231 (Subsequent hospital care, brief) - units equal to the inpatient days minus two

> **Note:** These entries can also be triggered by editing either the Provider or Inpatient pages.

If any of the automatically created entries are incorrect, they must be edited and corrected so that the page accurately reflects the medical portion of the visit.

4.12.1   Adding a Medical Service

Before adding a medical service (CPT code), the user must select the associated CPT code from the CPT file. CPT entries are selected using the same lookup program that is used to select an ICD diagnosis or procedure. However, keywords (or abbreviations) have not been provided for the CPT file. It is recommended that the local site establish keywords that are appropriate for the site.

The "Modifier" prompts allow the user to include information about abnormal service circumstances in the file. The modifiers that can be selected are restricted to those specified as usable in the Medicine section of the *CPT Manual*.

A selected modifier may influence the amount billed for a specified item. For example, if modifier 52 (Reduced Services) is selected, the system prompts the user for the reduced charge.

When adding a Medical Service entry to this page, consider the following:

- Up to three modifiers are allowed per service.

If the Export mode is CMS-1500 or 837-P for Page 8A,

  - A corresponding diagnosis must be associated with every service.
  - The user is allowed to choose any existing diagnosis for the visit. If the proper diagnosis is not available on this page, it can be entered on Page 5A.
- The "Medical Procedure SERVICE FROM DATE/TIME" prompt, and the "Medical Procedure SERVICE TO DATE/TIME" prompt defaults to the visit date. In the following example, the visit date is 02/11/2009. To accept the default, press the Enter key; or type a different visit date and press the Enter key.

- The "Medical Procedure Units" prompt defaults to the value 1. To accept the default, press the Enter key; or type a different number of units and press the Enter key.

- The "Medical Procedure PLACE OF SERVICE" prompt is used to override the default Place of Service values for the charge being entered. This is intended to only override the POS values of one charge.

- The "SERVICE LINE PROVIDER TYPE" prompt is used when a payer needs the Rendering provider identified along with the charge submitted. This is usually sent with the 837 Professional formats and prints the provider identifiers on the CMS-1500 Block 24J. Ordering provider can be used if the payer wishes to see who the ordering provider is for the charges. This is mainly used in Durable Medical Equipment (DME) billing.

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


=============== ADD MODE - MEDICAL SERVICES  ===============
Select Medical Service (CPT Code): 92270    ELECTRO-OCULOGRAPHY
       ELECTRO-OCULOGRAPHY WITH INTERPRETATION AND REPORT
          ...OK? Yes//   (Yes)


Select 1st MODIFIER: 24   Unrelated Evaluation and Management Service by the
 Same Physician During a Postoperative Period
          ...OK? Yes//   (Yes)


Select 2nd MODIFIER:


                   DIAGNOSES
       Seq   ICD9
       Num   Code              Diagnosis Description
       ===  ======   ==========================================
        1   540.0    AC APPEND W PERITONITIS
        2   571.3    ALCOHOL LIVER DAMAGE NOS
        3   427.31   ATRIAL FIBRILLATION

Enter Principle Corresponding DX: 1  540.0    1
Enter Other Corresponding DX (carriage return when done): 3  427.31   1,3
Enter Other Corresponding DX (carriage return when done):

   Medical Procedure SERVICE FROM DATE/TIME: 02/11/2009//   (FEB 11, 2009)
   Medical Procedure SERVICE TO DATE/TIME: 02/11/2009//   (FEB 11, 2009)
   Medical Procedure UNITS: 1//

   Medical Procedure PLACE OF SERVICE: 21//        INPATIENT HOSPITAL
Select SERVICE LINE PROVIDER: DOCTOR,TRUDEL//       TD
   SERVICE LINE PROVIDER TYPE: RENDERING//

 =-=-=-= The Medical Service (CPT Code) has been Added. =-=-=-=
```

Figure 4-55: Adding a medical service (CPT Code) example

4.13   PAGE 8B - SURGICAL PROCEDURES

The user can specify the surgical procedures performed during the patient's visit on the SURGICAL PROCEDURES page. The CPT codes allowed for use on PAGE 8B are restricted to those listed in the surgical section of the CPT manual.

If a CMS-1500 is to be used for export, PAGE 8B prompts the user for the corresponding diagnosis for each procedure (required). In all other export scenarios, descriptions of the CPT Codes will be displayed instead of a "Corresponding Diagnosis" prompt. The user is also prompted for the provider number if the system requires it.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8B  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                        Claim Number: 31389
Mode of Export: 837 PROF (HCFA)
.......................... (SURGICAL PROCEDURES) ..........................

BIL   SERV   REVN   CORR   CPT
SEQ   DATE   CODE   DIAG   CODE        PROVIDER'S NARRATIVE   UNITS   CHARGE
===   =====  ====   ======  =====================================  ========
 1   CHARGE DATE: 07/29/2008 (WELBY,MARCUS-R)
            ****  2,1     61490-50 INCISE SKULL FOR SURGERY     1   4,992.00
 2   CHARGE DATE: 07/29/2008 (WELBY,MARCUS-R)
            ****  6       42650-22 DILATION OF SALIVARY DUCT    1      87.00
                                                                   =========
                                                                   $5,079.00

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

Figure 4-56: SURGICAL PROCEDURES (PAGE 8B) screen example

If PAGE 8B is displayed the procedure information was entered by CPT code. The user may choose to code procedures using the CPT or the ICD method. If the user chose the ICD procedure coding method, PAGE 5B will contain procedure information and PAGE 8B will not appear.

If a procedure is marked with an asterisk in the CPT manual, a warning message will appear on the screen, and alert the user to follow the rules that govern the billing of these procedures. The rules for billing this type of procedure can be found in the CPT manual.

When the insurer requires that the provider number be displayed on the HCFA, **MD** *must* be entered in the 24K Block for that visit type, through the Table Maintenance option.

4.13.1   Adding Surgical Procedures

Before adding a surgical procedure, the user must select the procedure from the CPT file. CPT procedures are selected using the same keyword lookup utility that is used to select an ICD diagnosis or procedure. However, keywords (or abbreviations) have not been provided for the CPT file. It is recommended that the local site establish keywords that are appropriate for the site.

> **Note:** Only CPT codes that have a corresponding entry in the current fee schedule may be selected.

The "Modifier" prompt allows the user to include information about abnormal service circumstances in the file. The modifiers the user can select are restricted to those specified as usable in the Surgical section of the *CPT Manual*.

When adding a surgical procedure, consider the following:

- Up to three (3) modifiers may be appended to the CPT code.

The following modifier, when used on this page, will alter the fee schedule amount by the factor indicated:

Code	Description	Factor*
52	REDUCED SERVICES	?

*A question mark (?) in the Factor column indicates that the modifier could affect the charge for a procedure, but that the modified charge is based on a formula and is maintained by the sites.

If modifier 52 (Reduced Services) is selected, the system prompts for the reduced charge.

```
Select 3rd MODIFIER: 52        Reduced Services
         ...OK? Yes//   (Yes)

Reduced CHARGE:  (0-4992): 4992//
```

Figure 4-57: Reduced CHARGE prompt

- The text contained in the Provider's Narrative field is presented on the bill and, if necessary, should be modified so that it is understandable to an outside entity.

- The "Corresponding Diagnosis" prompt displays only when the Export mode is CMS-1500. This field allows the selection of an ICD code that is restricted to what is currently entered on the DIAGNOSIS page (5A).

- The "Date of Service" prompt defaults to the encounter date value. To accept the default, press the Enter key; or type a different date and press the Enter key.

- The "Number of Units" prompt defaults to the value 1. To accept the default, press the Enter key, or type a different number of units and press the Enter key.

- The "Surgical Procedure Place of Service" prompt is used to override the default Place of Service values for the charge being entered. This is intended to only override the POS values of one charge.

- The "Service Line Provider" prompt is used when a payer needs the Rendering provider identified along with the charge submitted. This is usually sent with the 837 Professional formats and prints the provider identifiers on the CMS-1500 Block 24J. Ordering provider can be used if the payer wishes to see who the ordering provider is for the charges. This is mainly used in Durable Medical Equipment (DME) billing.

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

=============== ADD MODE - SURGICAL PROCEDURES ===============
Select Surgical (CPT Code): 61490    INCISE SKULL FOR SURGERY
       Craniotomy for lobotomy, including cingulotomy ...OK? Yes//   (Yes)

Select 1st MODIFIER: 51       Multiple Procedures
         ...OK? Yes//   (Yes)

Select 2nd MODIFIER:

Select PROVIDER NARRATIVE: INCISE SKULL FOR SURGERY//


                     DIAGNOSES
        Seq   ICD9
        Num   Code               Diagnosis Description
        ===   ======   ============================================
         1    458.8    OTHER SPECIFIED HYPOTENSION
         2    428.0    CONGESTIVE HRT FAILURE UNSPEC
         3    305.1    TOBACCO USE DISORDER
         4    427.31   ATRIAL FIBRILLATION
         5    784.7    EPISTAXIS
         6    V58.61   LONG-TERM USE ANTICOAGULANTS
         7    562.10   DIVERTICULOSIS COLON W/O HEM
         8    386.00   MENIERE'S DISEASE NOS
         9    401.9    HYPERTENSION NOS

Enter Principle Corresponding DX: 8  386.00    8
Enter Other Corresponding DX (carriage return when done): 9  401.9   8,9
Enter Other Corresponding DX (carriage return when done):

   Surgical Procedure SERVICE FROM DATE/TIME: 07/27/2008  (JUL 29, 2008)

   Surgical Procedure SERVICE TO DATE/TIME: 07/27/2008  (JUL 29, 2008)
   Surgical Procedure UNITS: 1//

   Surgical Procedure PLACE OF SERVICE: 21//        INPATIENT HOSPITAL
Select SERVICE LINE PROVIDER: DOCTOR,TRUDEL        TD

 =-=-=-= The Surgical (CPT Code) has been Added. =-=-=-=
```

Figure 4-58: ADD – MODE SURGICAL PROCEDURES screen

4.13.2   Contract Attending or Operating Provider Charges

If the attending or operating provider is a contract provider,

The "Do you want a Zero Charge for this Procedure (Y/N)?" prompt displays if the following are true:

- The Visit Location from the Location file must contain the affiliation of Tribe.

- The attending or operating provider must be designated a contract provider based on the affiliation recorded in the New Person file for the provider.

For example,

```
Either the Attending or Operating Provider's affiliation is Contract,
depending upon local policy, procedures done by a Contract provider may be
unbillable.

Do you want a Zero Charge for this Procedure   (Y/N)?
```

Figure 4-59: "Do you want a Zero Charge for this Procedure (Y/N)?" prompt

If the user types **YES** at this prompt, the charge for the procedure will be zero instead of the corresponding charge in the fee schedule.

4.13.3   Viewing the Surgical Information

Use the View command on the SURGICAL PAGE to display the procedure information for the PCC visit from which the claim was created.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 5B  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                          Claim Number: 31389
........................... (PROCEDURE VIEW OPTION) ...........................


              ***** PROCEDURE INFORMATION ENTERED THROUGH PCC *****
VISIT         ICD0
DATE    PRI   CODE - PROCEDURE DESCRIPTION       PROVIDER'S NARRATIVE
=====   ===   =============================   ==============================
07/27/2008
        P    13.19    INTRACAPSUL LENS EXT NEC  CATARACT REPAIR
--------------------------------------------------------------------------
WARNING:163 - NO CORRESPONDING CPT CODE FOR AN ICD PROCEDURE ENTERED THRU
PCC
--------------------------------------------------------------------------

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

Figure 4-60: Display of additional surgical information by using the View command

If PCC data entry activity occurs *after* the claim has been edited, the claim will not be updated automatically. Instead, a warning will appear advising the user that PCC data entry activity occurred and that the visit should be investigated. In this situation, the View command is a useful tool for determining what changes have occurred to the PCC data.

4.14   PAGE 8C – REVENUE CODE

The REVENUE CODE field specifies the room and board charges and/or other charges related to a revenue code. If the Approved Stay Days value does not equal the Days of Stay value, an error condition occurs and a warning message is displayed. For example,

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 8C  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                            Claim Number: 31389
Mode of Export: 837 INST (UB)
.............................. (REVENUE CODE) ................................

                                                               TOTAL
     REVENUE CODE                 CPT     CHARGE    DAYS   UNITS    CHARGE
     =========================    ===     ======    ====   =====    =========
[1]  CHARGE DATE: 07/27/2008
     0120 ROOM-BOARD/SEMI                 725.00      4       4      2,900.00
[2]  CHARGE DATE: 07/29/2008
     0360 OR SERVICES                     573.00      0       1        573.00
[3]  CHARGE DATE: 07/27/2008
     0981 PRO FEE/ER              99283   1220.00     0       1      1,220.00
[4]  CHARGE DATE: 07/29/2008
     0200 INTENSIVE CARE OR (ICU)         1196.00     1       1      1,196.00
                                                    ====           =========
                                                      5            $5,889.00

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

Figure 4-61: REVENUE CODE (PAGE 8C) screen example

Only certain entries on PAGE 8C account for Days of Stay. Although the Nursery, Delivery Room, and Operating Room entries are unit-oriented, these entries do increment the Days of Stay value.

A CPT code may be entered for each revenue code used. This is mainly to indicate the level of service when reporting for charges such as the E & M of the Emergency Room.

During claim creation or INPATIENT DATA (PAGE 7) edits, entries are created automatically on the REVENUE CODE page. A Semi-Private Room & Board entry will be established with the units equal to the number of covered days.

If the CPT procedures entered indicate childbirth or if newborn days have been specified,

* A Nursery Room entry is created with units equal to the number of newborn days.

* A Delivery Room or an Operating Room entry is created (depending on whether the CPT code indicates a normal or cesarean childbirth) with a unit of one (1).

4.14.1   Resolving Covered Days, Days of Stay Inconsistencies

When using the View command on the REVENUE CODE page, the information displayed is from INPATIENT DATA (PAGE 7). This allows the user to resolve an inconsistency error between the Covered Days field value and the Days of Stay field value.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8C   ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                            Claim Number: 30699
Mode of Export: UB-04
......................... (PAGE 8C - VIEW OPTION) .........................

Admission Date: 02-11-2009              Bill From Date: 02-11-2009
Discharge Date: 02-13-2009              Bill Thru Date: 02-13-2009


        Covered Days..: 2      Non-Cvd Days..:
--------------------------------------------------------------------------

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

Figure 4-62: Viewing room & board information to resolve covered days,
days of stay inconsistencies

4.14.2   Adding Revenue Codes

Before adding a revenue code, the code from the Revenue Code file must be selected. At the "Select REVENUE CODES" prompt, type the Revenue code or description.

The Unit Charge default value is the charge stored in the Revenue Code file. If this charge is not correct, it should be modified.

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

Select REVENUE CODES: 360        OR SERVICES      GENERAL CLASSIFICATION
UNITS: 1 <Enter>
UNIT CHARGE: 573// <Enter>
CPT CODE:<Enter>
DATE/TIME: 08/21/1990 <Enter>
```

Figure 4-63: Adding revenue codes example

4.15   PAGE 8D - MEDICATIONS

Use MEDICATIONS (PAGE 8D) to collect and modify the record of drugs dispensed to the patient during the visit. The medications available for selection are restricted to those entries that exist in the Drug file at each site. The Drug file is maintained by the pharmacy and should reflect all locally prescribed take-home drugs.

If the claim was created automatically and the RPMS Pharmacy system is running, all prescribed drugs for the visit will already be entered.

If the NDC Code for a selected drug has been entered in the Drug file, it displays to the left of the drug name.

> **Note:** Altering the medication information on this page does not affect the data in the Pharmacy system. Over-the-Counter (OTC) drugs may be entered on this page, if the drug exists in the Drug file and the ABM fee table.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 8D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHNNY  [HRN:112244]                    Claim Number: 31732
Mode of Export: CMS-1500 (08/05)
.............................. (MEDICATIONS) ...............................

    REVN   CHARGE                                    DAYS          TOTAL
    CODE   DATE              MEDICATION              SUPPLY  QTY   CHARGE
=============================================================================
[1]  0250  10/24/2009@15:00    Rx:289029
     53746-0131-05    IBUPROFEN 400MG TAB              5      25     5.35
[2]  0250  10/24/2009@15:00    Rx:289030
     59911-5874-01    METHOTREXATE 2.5MG TAB          25      30    15.62
[3]  0250  10/24/2009@15:00    Rx:289031
     00332-1171-09    PENICILLIN VK 250MG TAB          5      20     5.36
[4]  0250  10/24/2009@15:00    Rx:289032
     <NO NDC>         AMPICILLIN 250MG CAP             7      30     6.44
                                                                 ========
     TOTAL                                                        $32.77

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

Figure 4-64: MEDICATIONS (PAGE 8D) screen example

Since the Pharmacy system manages the drug costs, it is extremely important that the pharmacists keep the drug cost information up to date so that Billing accurately reflects the true costs. In addition to the drug cost on file, a dispense fee will be charged automatically for each drug prescribed.

The Service Line Provider may be entered when a payer needs the Rendering provider identified along with the charge submitted. This is usually sent with the 837 Professional formats, and prints the provider identifiers on the CMS-1500 Block 24J. Ordering provider can be used if the payer wishes to see who the ordering provider is for the charges. This is mainly used in Durable Medical Equipment (DME) billing.

4.15.1 Adding a Medication

Before adding a medication to a claim, a selection must be made from the Drug file by entering the name of the drug at the "Select DRUG GENERIC NAME" prompt.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A <Enter>
Select DRUG GENERIC NAME: PENICILLIN G POTASSIUM <Enter>  PEN-G POTASSIUM 5MIL.UNIT
VIAL
          AM051
Is this entry an IV? NO// <Enter>
REVENUE CODE: 250// <Enter>   PHARMACY     GENERAL CLASSIFICATION
DATE/TIME: 03/31/2006// <Enter>  (MAR 31, 2006)
Units (at $1.075 per unit): 20 <Enter>
Times Dispensed (at $10 per each time dispensed) : 1// <Enter>


                    DIAGNOSES
      Seq   ICD9
      Num   Code               Diagnosis Description
      ===   ======   ================================================
       1    431.     INTRACEREBRAL HEMORRHAGE
       2    471.0    POLYP OF NASAL CAVITY

Enter Principle Corresponding DX: 1 <Enter>  431.
Enter Other Corresponding DX (carriage return when done): <Enter>
```

Figure 4-65: Adding a medication example

If the encounter Visit Type is 111 (Inpatient) or 831 (Ambulatory Surgery), the system asks if this drug is an IV. The default value is NO.

For non-IV medications,

- The Revenue Code default value is 250. If this is not the correct revenue code, a different value can be entered.

- The Date/Time default value is the encounter visit date. If this is not the correct date, a different value can be entered.

- The Units field has no default value. The number of units must be entered.

- The unit charge is obtained automatically from the Drug file, and is not editable through the Claim Editor. However, the IV Price Per Unit field can be modified as needed. The amount of the modified charge will be stored on the claim but does not update the Drug File.

- The Times Dispensed default value is one (1). If this is not the correct number of times dispensed, a different value can be entered.

- The dispense fee is obtained automatically from the fee schedule, and is not editable through the Claim Editor.

4.15.2 Adding an IV Medication

If the selected medication is an IV, the system prompts for the following information:

- The IV Price Per Unit has a default value which is obtained automatically from the Drug file. If this is not the correct price per unit, enter the correct amount.

> **Note:** The value entered here becomes the unit charge value.

- The Revenue Code default value for IV medications is 260. If this is not the correct revenue code, a different value can be entered.

- The IV Type requires an entry. Possible values are Piggyback, Admixture, Hyperal, Syringe, or Chemotherapy.

- For IV Additive, make a selection from the IV Additive file.

- For IV Solution, make a selection from the IV Solution file.

- The IV Narrative requires a brief description (maximum = 10 characters) or Notes.

- The Date/Time default value is the encounter visit date. If this is not the correct date, a different date can be entered.

- For Units enter the number.

The unit charge is the value entered for the IV Price Per Unit. If this is incorrect, change the value of the IV Price Per Unit.

- The Times Dispensed default value is one (1). If this is not the correct number of times dispensed, a different value can be entered.

The dispense fee is obtained automatically from the fee schedule and is not editable through the Claim Editor.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A <Enter>
Select DRUG GENERIC NAME: MAGNESIUM CITRATE SOLN.            GA202
Is this entry an IV? NO// YES <Enter>
IV Price per Unit:  (0-9999): .95// 100.76 <Enter>
REVENUE CODE: 260//          IV THERAPY     GENERAL CLASSIFICATION
IV TYPE: P <Enter>  PIGGYBACK
IV ADDITIVE: <Enter>
IV SOLUTION: <Enter>
IV NARRATIVE: TEST <Enter>
DATE/TIME: 03/31/2006// <Enter>  (MAR 31, 2006)
Units (at $100.76 per unit): 2 <Enter>
Times Dispensed (at $ per each time dispensed) : 1// <Enter>


                      DIAGNOSES

      Seq   ICD9
      Num   Code              Diagnosis Description
      ===  ======   ========================================
       1   431.      INTRACEREBRAL HEMORRHAGE
       2   471.0     POLYP OF NASAL CAVITY

Enter Principle Corresponding DX: 2 <Enter>  471.0   2
Enter Other Corresponding DX (carriage return when done): <Enter>
```

Figure 4-66: Adding IV medications example

4.15.3 Viewing Medications

The View command displays a list of all prescribed medications on the visit date. If the visit is inpatient, the View command displays a list of all drugs prescribed by the pharmacy between the admission and discharge dates.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHNNY  [HRN:112244]                    Claim Number: 31732
Mode of Export: CMS-1500 (08/05)
......................... (MEDICATION VIEW OPTION) .........................

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


Rx#     Drug                                Qty    Issued    Last Fill  Rem
------------------------------------------------------------------------
289029  IBUPROFEN 400MG TAB                 25    10-24-200910-24-2009 (4)
          NDC#: 53746-0131-05
289030  METHOTREXATE 2.5MG TAB              30    10-24-200910-24-2009 (5)
          NDC#: 59911-5874-1
289031  PENICILLIN VK 250MG TAB             20    10-24-200910-24-2009 (0)
          NDC#: 332-1171-09
289032  AMPICILLIN 250MG CAP                30    10-24-200910-24-2009 (0)
          NDC#:
------------------------------------------------------------------------

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

Figure 4-67: View of medications prescribed example

> **Note:** If drugs were prescribed that are **not** contained in the claim, the user must check that those drugs are not involved with a different claim before including them on the current claim.

4.16 PAGE 8E - LABORATORY SERVICES

Use LABORATORY SERVICES (PAGE 8E) to specify laboratory tests performed in conjunction with a visit. The entries on this page are designated by CPT code. The allowable CPT codes are restricted to those listed in the Laboratory section of the *CPT Manual*. For a CPT code to be selectable, it must also have a corresponding entry in the Laboratory section of the current fee schedule.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8E   ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHNNY  [HRN:112244]                       Claim Number: 31732
Mode of Export: CMS-1500 (08/05)
.......................... (LABORATORY SERVICES) ..........................

     REVN                                              UNIT        TOTAL
     CODE          CPT - LABORATORY SERVICES          CHARGE QTY   CHARGE
     ==== ========================================== ====== === =========
[1]  CHARGE DATE: 10/24/2009 (DOCTOR,TRUDEL-R)
     0300 85025 COMPLETE CBC W/AUTO DIFF WBC           30.00  1      30.00
[2]  CHARGE DATE: 10/24/2009 (DOCTOR,TRUDEL-R)
     0300 84550 ASSAY OF BLOOD/URIC ACID               19.00  1      19.00
[3]  CHARGE DATE: 10/24/2009
     0300 82140 ASSAY OF AMMONIA                       47.00  1      47.00
                                                                 ==========
                                                                     $96.00
------------------------------------------------------------------------------
WARNING:174 - LABORATORY ACTIVITY IS ASSOCIATED WITH THE PCC VISIT
------------------------------------------------------------------------------

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

Figure 4-68: LABORATORY SERVICES (PAGE 8E) screen example

If the Laboratory application is installed and running, the Third Party Billing system obtains the laboratory information automatically and creates orphan labs.

When adding a laboratory test, the Revenue Code default value depends on the CPT selected.

The CLIA Number will also be tagged to each charge. The In-House CLIA Number will be used unless the charge has a -90 modifier. If so, the Reference Lab CLIA Number will be used for all charges that contain a -90 modifier.

The Modifiers field can be used for a laboratory test to identify an unusual circumstance. The modifiers allowed for selection are restricted to those specified as usable in the Laboratory section of the CPT Manual. A modifier may influence the amount billed for the item it modifies.

The unit charge corresponds to the current fee schedule and cannot be altered through the Claim Editor.

The service line provider may be entered when a payer needs the rendering provider identified along with the charge submitted. This is usually sent with the 837 Professional formats, and prints the provider identifiers on the CMS-1500 Block 24J. Ordering provider can be used if the payer wishes to see who the ordering provider is for the charges. This is mainly used in Durable Medical Equipment (DME) billing.

4.16.1   Viewing the Laboratory Page

The View command displays the laboratory information entered through the Patient Care Component (PCC). The message, "Laboratory Test Information Entered Through PCC," indicates that the laboratory data is associated with the PCC visit from which the claim was created. The View option displays the visit date, the CPT code associated to the alb test, the description of the test, the lab accession number, and the results.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8E   ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHNNY  [HRN:112244]                      Claim Number: 31732
Mode of Export: CMS-1500 (08/05)
........................ (LABORATORY VIEW OPTION) ........................


           ***** LABORATORY TEST INFORMATION ENTERED THROUGH PCC *****
VISIT
DATE   CPT   LAB DESCRIPTION(IEN)                    Lab accession#    Results
=====  =====  =================================  =================  =======
10/24  85025 CBC(1177)                               HE 1208 1
10/24        WBC(1)                                  HE 1208 1         24
10/24        RBC(2)                                  HE 1208 1         5
10/24        HEMOGLOBIN(3)                           HE 1208 1         13
10/24        HEMATOCRIT(4)                           HE 1208 1         20
10/24        MCV(5)                                  HE 1208 1         60
10/24        MCH(6)                                  HE 1208 1         60
10/24        MCHC(7)                                 HE 1208 1         50
10/24        RDW(416)                                HE 1208 1         30
10/24        PLATELET COUNT(9)                       HE 1208 1         60
10/24        MPV(10)                                 HE 1208 1         43
10/24        GR%, AUTO(1247)                         HE 1208 1         10
10/24        LY%, AUTO(558)                          HE 1208 1         60
10/24        MO%, AUTO(1248)                         HE 1208 1         20
10/24        EOS%, AUTO(9020)                        HE 1208 1         1
10/24        BASO%, AUTO(9021)                       HE 1208 1         05
10/24  84550 URIC ACID(182)                          CH 1208 5         60
10/24  82140 AMMONIA(206)                            CH 1208 6         50
--------------------------------------------------------------------------
WARNING:174 - LABORATORY ACTIVITY IS ASSOCIATED WITH THE PCC VISIT
--------------------------------------------------------------------------

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

Figure 4-69: Viewing PCC laboratory data example

> **Note:** The information displayed from PCC includes the lab tests ordered for the visit. This may not correspond to the actual lab tests performed. Thus, to accurately bill laboratory procedures, review the lab activity listed in the patient's chart.

4.17   PAGE 8F - RADIOLOGY SERVICES

Use RADIOLOGY SERVICES (PAGE 8F) to specify the radiology tests performed in conjunction with the visit. The entries on this page are designated by CPT code. Allowable CPT codes are restricted to those contained in the Radiology section of the CPT Manual. For a CPT code to be selectable, it must also have a corresponding entry in the Radiology section of the current fee schedule.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8F  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHNNY  [HRN:112244]                      Claim Number: 31732
Mode of Export: CMS-1500 (08/05)
........................... (RADIOLOGY SERVICES) ...........................

      REVN                                            UNIT       TOTAL
      CODE          CPT - RADIOLOGY SERVICES          CHARGE QTY  CHARGE
      ==== =========================================  ====== === =========
[1]   CHARGE DATE: 10/24/2009 (DOCTOR,TRUDEL-R)
      **** 71034-26 CHEST X-RAY AND FLUOROSCOPY       143.00  1    143.00
[2]   CHARGE DATE: 10/24/2009 (DOCTOR,TRUDEL-R)
      **** 70210 X-RAY EXAM OF SINUSES                 41.00  1     41.00
                                                                ==========
                                                                  $184.00

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

Figure 4-70: RADIOLOGY SERVICES (PAGE 8F) screen example

Currently, the Third Party Billing system interfaces with the Radiology system. However, radiology tests entered directly into PCC (using CPT procedure codes) will also be included in the claim.

When adding a radiology test to the patient's file, the Revenue Code default value corresponds to the selected CPT. Modifiers can be added to radiology tests to identify unusual circumstances. Allowable modifiers are listed in the Radiology section of the CPT Manual. A modifier may influence the billed amount for a radiological test.

The Unit Charge value is in the current fee schedule, and cannot be altered through the Claim Editor.

The Service Line Provider may be entered when a payer needs the Rendering provider identified along with the charge submitted. This is usually sent with the 837 Professional formats, and prints the provider identifiers on the CMS-1500 Block 24J. Ordering provider can be used if the payer wishes to see who the ordering provider is for the charges. This is mainly used in Durable Medical Equipment (DME) billing.

4.18   PAGE 8G - ANESTHESIA SERVICES

Use ANESTHESIA SERVICES (PAGE 8G) to specify the anesthesia services performed in conjunction with the patient's visit. The entries on this page are designated by CPT code. Allowable CPT codes are restricted to those listed in the Anesthesia section of the CPT Manual.

For a CPT code to be selectable, it must have a corresponding entry in both the Anesthesia section of the current fee schedule and SURGICAL PROCEDURES (PAGE 8B). Therefore, ANESTHESIA SERVICES (PAGE 8G) is skipped unless data has been entered on SURGICAL PROCEDURES (PAGE 8B). ANESTHESIA SERVICES (PAGE 8G) will also be skipped if the anesthesia services performed have been coded **unbillable** for the specified visit type.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8G  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT,JR  [HRN:2]                      Claim Number: 29734
Mode of Export: HCFA-1500 Y2K
.......................... (ANESTHESIA SERVICES) ..........................

     REVN                                                          TOTAL
     CODE          CPT - ANESTHESIA SERVICES                MIN    CHARGE
     ==== ================================================= === ========
[1]  **** 01214-P1 ANESTH, HIP ARTHROPLASTY                  75     280.00
            (DOCTOR,TRUDEL-R)
           Start Date/Time: 10-OCT-2006 11:00 AM
            Stop Date/Time: 10-OCT-2006 12:15 PM

                                                            ==========
                                                               $280.00


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

Figure 4-71: ANESTHESIA SERVICES (PAGE 8G) screen example

When billing Medicare, the anesthesia charge is a sum of the base and time charges where,

- The base charge corresponds to that in the current fee schedule and cannot be altered through the Claim Editor.

- The time charge is derived from a table that uses the elapsed time of the operation as a parameter.

The units are restricted to one (1). If multiple units are necessary, use the CHARGE MASTER page.

For payers other than Medicare, the base charge of the Anesthesia CPT code will be used regardless of the units of time used.

When the insurer requires the provider number for the CMS-1500, the system prompts for the name or number of the provider.

The Service Line Provider may be entered when a payer needs the Rendering provider identified along with the charge submitted. This is usually sent with the 837 Professional formats, and prints the provider identifiers on the CMS-1500 Block 24J. Ordering provider can be used if the payer wishes to see who the ordering provider is for the charges. This is mainly used in Durable Medical Equipment (DME) billing.

Currently, Third Party Billing does not obtain anesthesia information from an Anesthesia package automatically. If the anesthesia data is entered in the Patient Care Component (PCC) system (using a new mnemonic) it will be included in the claim.

4.18.1   Adding Anesthesia Services

When adding an anesthesia service, a CPT code must be used. To obtain a list of available CPT codes, type a double question mark (**??**) at the "Select Anesthesia:" prompt.

This list corresponds to the entries on SURGICAL PROCEDURES (PAGE 8B). If no entries exist on the SURGICAL PROCEDURES page, no anesthesia services can be added.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A <Enter>

=============== ADD MODE - ANESTHESIA SERVICES ===============
Select Anesthesia (CPT Code): ?? <Enter>

Choose from:
   42650    DILATION OF SALIVARY DUCT
            DILATION SALIVARY DUCT
   61490    INCISE SKULL FOR SURGERY
            CRANIOTOMY FOR LOBOTOMY, INCLUDING CINGULOTOMY

Select Anesthesia (CPT Code): 61490 <Enter>        INCISE SKULL FOR SURGERY
       CRANIOTOMY FOR LOBOTOMY, INCLUDING CINGULOTOMY
         ...OK? Yes// <Enter>  (Yes)

Select MODIFIER: <Enter>

                    DIAGNOSES
       Seq  ICD9
       Num  Code              Diagnosis Description
       ===  ======   =========================================
        1   431.     INTRACEREBRAL HEMORRHAGE
        2   471.0    POLYP OF NASAL CAVITY

Enter Principle Corresponding DX: 1 <Enter>  431.   1
Enter Other Corresponding DX (carriage return when done): <Enter>

   Anesthesia REVENUE CODE: 370// <Enter>
   Anesthesia START DATE/TIME: N  (MAR 19, 2006@10:58)
   Anesthesia STOP DATE/TIME: MAR 19, 2006@12:08  (MAR 19, 2006@12:08)

   Anesthesia OBSTETRICAL?: No <Enter>
```

Figure 4-72: Adding an anesthesia service example

Modifiers can be added to an anesthesia service to identify an unusual circumstance. The modifiers allowed for selection correspond to those specified as usable in the Anesthesia section of the CPT Manual. Modifiers available for selection on this page may or may not influence the amount billed for that item.

If the anticipated Export mode is CMS-1500, a corresponding diagnosis must be specified for each service selected. If the desired diagnosis is not available as a choice, the user must return to PAGE 5A of the Claim Editor and enter it.

The "REVENUE CODE" prompt displays only if the Export mode is UB-92, UB-04, UB-92-E, or 837 Instituational formats, and has a default value of 370. If professional services are to be billed separately, those services identified with Revenue Code 963 (Anesthesiologist, Professional Fee) will be on the Professional Component (CMS-1500).

For each anesthesia service entered, the system prompts for a start and stop date/time. These fields are used to compute automatically the time charge.

If the service is obstetric-related, type **YES** at the "Anesthesia Obstetrical?" prompt. A Yes value in this field will also affect the total charge.

4.19   PAGE 8H – MISC. SERVICES

Use MISC. SERVICES (PAGE 8H) to specify any miscellaneous services that were provided during the patient's visit. The entries on this page are **not** designated by HCFA Common Procedure Coding System (HCPCS) codes. CPT codes are allowed to be entered onto this page. The user selects a HCPCS code in the same way he or she would select a CPT code.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8H   ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHNNY  [HRN:112244]                        Claim Number: 31732
Mode of Export: UB-04
............................. (MISC. SERVICES) .............................

     REVN                                            UNIT       TOTAL
     CODE          HCPCS - MISC. SERVICES            CHARGE QTY  CHARGE
     ==== ========================================== ====== === =========
[1]  CHARGE DATE: 10/24/2009 (DOCTOR,TRUDEL-R)
     0270 A6230 Gauze > 48 sq in water/salne           5.95  3      17.85
[2]  CHARGE DATE: 10/24/2009
     0270 A4311 CATHETER W/O BAG 2-WAY LATEX         129.00  1     129.00
[3]  CHARGE DATE: 10/24/2009 (DOCTOR,TRUDEL-R)
     0530 A4580 CAST SUPPLIES (PLASTER)               99.00  1      99.00
                                                                ==========
                                                                  $245.85


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

Figure 4-73: MISC. SERVICES (PAGE 8H) screen

4.20   PAGE 8I - INPATIENT DENTAL SERVICES

Use INPATIENT DENTAL SERVICES (PAGE 8I) to specify any dental services performed during an inpatient stay. The entries on this page are designated by ADA codes. An ADA code is selected in the same way a CPT code is selected.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8I  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                          Claim Number: 31733
Mode of Export: ADA-2006
........................ (INPATIENT DENTAL SERVICES) ........................

    VISIT                                           OPER
    DATE          INPATIENT DENTAL SERVICE          SITE SURF   CHARGE
    ===== ============================================== ==== ===== ======
[1] 07/29  1350 SEALANT (PER TOOTH)                   O     B    47.00
                                                                =======
                                                                 $47.00
```

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

Figure 4-74: Example INPATIENT DENTAL SERVICES (PAGE 8I)

When adding entries to this page, the user must specify a corresponding diagnosis with the other inpatient dental services information.

4.21   PAGE 8J - CHARGE MASTER

Use CHARGE MASTER (PAGE 8J) to bill for any goods or services provided during the visit, including supplies. The item must exist in the Charge Master file to be entered on the claim. Revenue code, quantity, and total charge are displayed with the item description.

> **Note:** This page is a temporary solution for the billing of supplies until a facility level supply package can be developed.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8J  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                          Claim Number: 31733
Mode of Export: ADA-2006
.............................. (CHARGE MASTER) ..............................

     REVN                                                             TOTAL
     CODE                           ITEM                      QTY     CHARGE
     ========================================================================
[1]  CHARGE DATE: 07/27/2008
          EYE GLASS CASE                                       1       32.00
[2]  CHARGE DATE: 07/27/2008
          GAUZE                                               11        5.50
                                                                     ========
     TOTAL                                                             $37.50

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

Figure 4-75: CHARGE MASTER (PAGE 8J) screen example

4.21.1   Adding a Charge

To add a charge to the claim, make a selection from the Charge Master file, using a lookup program that finds entries based on item description or Universal Product Code (UPC).

> **Note:** If the item does not exist in the Charge Master file, it cannot be added to the claim.

- The Charge Date (date item was used) default value is the visit date.

- The Quantity default value is one (1). If the quantity is more than one, enter the correct quantity.

- The Unit Price, Revenue Code, and HCPCS Code default to the values associated with the item in the Charge Master file. If any value is different than the default, enter the correct value.

> **Note:** If the Unit Price, Revenue Code, or HCPCS Code is incorrect, go to the Charge Master file and correct the data there.

- The HCPCS code value is restricted to values existing in the CPT file.

A corresponding diagnosis is required, which can be selected from diagnosis entered on PAGE 5A.

```
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A <Enter>
Select 3P CHARGE MASTER ITEM DESCRIPTION: GAUZE
CHARGE DATE: 03/31/2006// T-10 <Enter>  (MAR 21, 2006)
QUANTITY: 1// 4 <Enter>
UNIT PRICE: 0// 3.42 <Enter>
REVENUE CODE: 272// <Enter>     STERILE SUPPLY     STERILE SUPPLIES
HCPCS CODE: A4202// <Enter>

DIAGNOSES
       Seq   ICD9
       Num   Code               Diagnosis Description
       ===   ======    ==========================================
        1    431.      INTRACEREBRAL HEMORRHAGE
        2    471.0     POLYP OF NASAL CAVITY

Enter Principle Corresponding DX: 1 <Enter> 431.   1
Enter Other Corresponding DX (carriage return when done): <Enter>

Enter RETURN to Continue: <Enter>
```

Figure 4-76: Adding an item to the CHARGE MASTER screen

4.22   PAGE 9 - UB-92 CODES

UB-92 CODES (PAGE 9) is the last section of the Claim Editor and contains the following six pages that are used to specify UB-92, UB-04 or 837 Institutional codes:

- OCCURRENCE CODES (PAGE 9A)

- OCCURRENCE SPAN CODES (PAGE 9B)

- CONDITION CODES (PAGE 9C)

- VALUE CODES (PAGE 9D)

- SPECIAL PROGRAM CODES (PAGE 9E)

- REMARKS (PAGE 9F)

If entries are made on any of these pages, the exported UB-92, UB-04 or 837 Institutional will reflect those entries.

The following example displays PAGE 9A. The remaining pages (9B-9E) are similar. Answering particular questions on QUESTIONS (PAGE 3) automatically triggers the entry of the appropriate codes.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                        Claim Number: 31388
............................ (OCCURRENCE CODES) ............................

      OCCR
      CODE                 OCCURRENCE DESCRIPTION                       DATE
      ====   ==================================================  ========
[1]   42     DATE OF DISCHARGE                                    08-02-2008


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

Figure 4-77: Example of OCCURRENCE CODES (PAGE 9A) screen

4.23   Claim Generator, One Patient (CG1P)

Main Menu > EDTP > CG1P

Use the One Patient CG1P option to generate claims for new PCC visits, for specified patients, one at a time. Although this is a batch process, under normal circumstances, it should produce a single claim within seconds. However, if the Claim Generator is not executed nightly, this option may take much longer.

To generate claims one patient at a time, follow these steps:

1. At the "Select Patient Name" prompt, type the name of the patient for whom the user wants to generate a claim.

If the system finds the patient's information in the RPMS database, the patient's additional information will appear below the "Select Patient Name:" prompt.

2. At the "Enter RETURN to continue or '^' to exit" prompt, do one of the following:

- To return to the Add/Edit Claim menu, type the caret (^).

- To continue generating claims for specific patients, press the Enter key.

At the Another Patient" prompt, do one of the following:

– To continue using the CGIP option, type **Y** (Yes) and repeat step 1.
– To exit this option, press the Enter key.

For example,

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |            THIRD PARTY BILLING SYSTEM - VER 2.6          |
        +                Claim Generator, One Patient              +
        |                   INDIAN HEALTH HOSPITAL                 |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                          13-NOV-2009 1:40 PM

Select PATIENT NAME: DEMO,JOHN <Enter>
                                       M 01-01-1950 XXX-XX-2222   IHH 123567

Claim generator queued for selected patient.
Enter RETURN to continue or '^' to exit:  <Enter>

Another patient? NO//
```

Figure 4-78: Claim generation for one patient

4.24   Edit Claim Data (EDCL)

Main Menu > EDTP > EDCL

Use the Edit Claim Data option to edit the data for a specific claim.

To edit a single claim, follow these steps:

1. At the "Select Add/Edit Claim Menu Option" prompt, type **EDCL**.

2. At the "Select Claim or Patient" prompt, type the claim number or a patient identifier (Name, HRN, SSN, DOB). If there are multiple matches, the system displays a list.

3. If there are multiple matches, type the number corresponding to the patient whose claim the user wants to edit at the "Choose" prompt. If multiple claims exist, the system displays a list of claims associated with that patient.

4. If there are multiple claims, type the number corresponding to the claim the user wants to edit at the "Select" prompt.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |            THIRD PARTY BILLING SYSTEM - VER 2.6          |
           +                     Edit Claim Data                     +
           |                  INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: TESTER,TEST                     13-NOV-2009 1:46 PM

Select CLAIM or PATIENT: DEMO,JOHN
                                     M 01-01-1950 XXX-XX-2222  IHH 123567


PATIENT:  DEMO,JOHN    M  01/01/1950  222-22-2222  HRN: 123567
=========================================================================

(1) Claim# 31683   10/14/2009 PROFESSIONAL COMPONENT  GENERAL
      INDIAN HOSP    MEDICARE                    Status: In EDIT Mode

(2) Claim# 31682   10/14/2009 OUTPATIENT              GENERAL
      INDIAN HOSP    MEDICARE                    Status: In EDIT Mode

(3) Claim# 31598   05/03/2009 DENTAL                  DENTAL
      INDIAN HOSP    EMPLOYERS DENTAL SERVICES    Status: Flagged as Billable

(4) Claim# 31390   07/27/2008 OUTPATIENT              EMERGENCY MEDICINE
      INDIAN HOSP    MISSISSIPPI MEDICAID         Status: In EDIT Mode

(5) Claim# 31389   07/27/2008 PROFESSIONAL COMPONENT  GENERAL
      INDIAN HOSP    MEDICARE                    Status: In EDIT Mode


Select 1 to 5: 3

        ...<< Processing, Claim Error Checks >>...Release of Information.
.: YES                            From: 06/13/2007Assignment of Benefits..:
YES                               From: 06/13/2007

        ...<< Checking Eligibility Files for Potential Coverage >>...

Release of Information..: YES   From: 06/13/2007Assignment of Benefits..: Y
```

Figure 4-79: Selecting a claim

The system displays a PAGE 0 summary of the claim the user has chosen to edit.

4.25   Claim Editor Loop (LOOP)

Main Menu > EDTP > LOOP

Use the Claim Editor Loop (LOOP) to edit a series of claims waiting for approval.
These are claims that are in the 'Flagged as Billable' or the 'In Edit Mode' status.
The number of claims to be selected for viewing and editing can be restricted by
entering exclusion parameters at the "Select ONE or MORE of the above
EXCLUSION PARAMETERS" prompt. When finished, press the Enter key at the
next "Select ONE or MORE of the above EXCLUSION PARAMETERS" prompt.
Regardless of the parameters selected, the oldest claim that holds the Flagged as
Billable or In Edit Mode status will display first.

For example,

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |            THIRD PARTY BILLING SYSTEM - VER 2.6          |
           +               Claim Editor Loop                       +
           |               INDIAN HEALTH HOSPITAL                   |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
             User: TESTER,TEST                       13-NOV-2009 2:02 PM

    EXCLUSION PARAMETERS Selected for RESTRICTING the CLAIM LOOPING to:
    ====================================================================

      Select one of the following:

            1            LOCATION
            2            BILLING ENTITY
            3            DATE RANGE
            4            VISIT TYPE
            5            CLINIC
            6            PROVIDER
            7            ELIGIBILITY STATUS
            8            RANGE OF PATIENTS

Select ONE or MORE of the above EXCLUSION PARAMETERS: 4 <Enter>  VISIT TYPE

Select 3P VISIT TYPE NAME: INPATIENT <Enter>

    EXCLUSION PARAMETERS Selected for RESTRICTING the CLAIM LOOPING to:
    ====================================================================
    - Visit Type........: INPATIENT

      Select one of the following:

            1            LOCATION
            2            BILLING ENTITY
            3            DATE RANGE
            4            VISIT TYPE
            5            CLINIC
            6            PROVIDER
            7            ELIGIBILITY STATUS
            8            RANGE OF PATIENTS

Select ONE or MORE of the above EXCLUSION PARAMETERS: 8 <Enter>  RANGE OF PATIENTS

Select RANGE OF PATIENTS to display:

Start with Patient Name: AAA <Enter>

Go to Patient Name: AAA// GZZ <Enter>

    EXCLUSION PARAMETERS Selected for RESTRICTING the CLAIM LOOPING to:
    ====================================================================
    - Visit Type........: INPATIENT
    - Range of Patients..: AAA thru GZZ

      Select one of the following:

            1            LOCATION
            2            BILLING ENTITY
            3            DATE RANGE
            4            VISIT TYPE
            5            CLINIC
            6            PROVIDER
            7            ELIGIBILITY STATUS
            8            RANGE OF PATIENTS

Select ONE or MORE of the above EXCLUSION PARAMETERS: <Enter>
```

```
LOOPING through CLAIMS with a Status of ROLLED-In Edit Mode....

          ...<< Processing, Claim Error Checks >>...Release of Information.
.: YESAssignment of Benefits..: YES

       ...<< Checking Eligibility Files for Potential Coverage >>...
```

Figure 4-80: Claim Editor Loop screen 1

The system displays the Claim Editor pages for all Inpatient claims waiting for approval that match the user's criteria. The last name of the patient selected ranges from A to G for billing.

When finished reviewing the claim information in the Claim Editor, type **Q** (Quit) at the "Desired ACTION" prompt. Before reviewing the next claim, the user is prompted to continue looping, delete the current claim, or quit the Loop option. For example,

```
Desired ACTION (View/Appr/Next/Jump/Quit): N// Q <Enter>

Select one of the following:

          1          CONTINUE LOOPING
          2          DELETE CLAIM
          3          QUIT

Desired ACTION: 1// <Enter>  CONTINUE LOOPING
```

Figure 4-81: Claim Editor Loop screen 2

The Delete Claim is selected, and the user is prompted to enter a Cancellation Reason.

```
Desired ACTION: 1// 2 <Enter>  DELETE CLAIM
WARNING: If you cancel this Claim it will be deleted and no further Editing
         or Approvals can occur.

Do you wish Claim Number 24595 DELETED (Y/N)? YES <Enter>

Cancellation REASON: 1 <Enter>  ORPHAN CLAIM CREATED IN ERROR

OK, the claim is being deleted...

Claim Number: 24595 has been Deleted!
```

Figure 4-82: Canceling a claim in the Loop option

4.26   Add New Claim (NEW) Manually

Main Menu > EDTP > NEW

Claims can be created automatically through the Claim Generator or manually, using the Add New Claim (NEW) option on the Add/Edit Claim (EDTP) menu.

To create a claim manually, follow these steps:

1. At the "Select PATIENT NAME" prompt, type the name of the patient for whom the user wants to add the claim, and press the Enter key.

If the system finds the patient's information in the database, the patient's additional information is displayed below the "Select PATIENT NAME" prompt.

2. Verify that the correct patient has been selected before continuing.

3. At the "Select CLINIC" prompt, type the clinic type code or name that corresponds to the clinic where the patient was seen.

The next prompt that is displayed depends on the response to the "Select CLINIC" prompt.

4. At the next prompt, type the date of the patient's visit (or the date that the patient was admitted if the visit was inpatient).

Before creating a claim, the system checks to make sure that the visit:

- Does not already exist

- Is covered by the patient's third party resources

For example,

```
              +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
              |           THIRD PARTY BILLING SYSTEM - VER 2.6        |
              +              Add New Claim (Manual Entry)             +
              |                 INDIAN HEALTH HOSPITAL                |
              +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
              User: TESTER,TEST                      13-NOV-2009 2:19 PM

Select PATIENT NAME....: DOE,JANE
                                         F 01-12-1937 XXX-XX-5555    IHH
756312
Select CLINIC..........: GENERAL// 01 <Enter>
Select VISIT TYPE......: OUTPATIENT// <Enter>
Enter ENCOUNTER DATE...:: (1/12/1937 - 11/13/2009): 10/5/2009 <Enter> (OCT
05, 2009)

Checking eligibility...

        ...<< Processing, Claim Error Checks >>...Release of Information.
.: YES                          From: 02/14/2005Assignment of Benefits..: NO

        ...<< Checking Eligibility Files for Potential Coverage >>...

Release of Information..: YES       From: 02/14/2005Assignment of
Benefits..: N
```

Figure 4-83: Add New Claim (Manual Entry) screen–verifying patient data

If visit data entered match data of an existing claim, the following shall occur:

- If a claim already exists with the same clinic code, visit type and date of service, the system will display the following.

```
Claim Number:  already exists with the Identifiers entered above!
     (NOTE: Use the EDIT CLAIM Option to Access Existing Claims)
Enter RETURN to continue or '^' to exit:
```

Figure 4-84: System display if claim has same clinic code

- If a claim already exists with the user entering the same visit date and a different clinic code or visit type, the system will display the claims for the user to determine if a new claim needs to be added.

```
The following Claims already exist for this Patient on this date:

Claim   Location                       Clinic              Visit Type
-------------------------------------------------------------------------
31682   INDIAN HEALTH HOSPITAL         GENERAL             OUTPATIENT
31683   INDIAN HEALTH HOSPITAL         GENERAL             PROFESSIONAL COMP

Do you wish to CONTINUE to ADD this Claim?
```

Figure 4-85: System display if claim has different clinic codes or visit types

- If no eligible third party resources are found for the patient, the user will need to enter the name of the insurer he/she wishes to bill. The system also displays "EMPLOYMENT RELATED" and "ACCIDENT TYPE" prompts. This allows the user to enter a manual claim for the patient.

For example,

```
Checking eligibility...

NOTE: Patient either has no 3rd Party Resources for the date of the visit or
the location/clinic is not billable for the insuring source.

Continue? NO// YES
Select INSURER to Bill // NEVERPAY
( NEVERPAY )
.
NEVERPAY INSURANCE                       - PO BOX 38738
                                           JERSEY CITY, NJ 84728
 OK? Y//

EMPLOYMENT RELATED (Y/N): N  NO
ACCIDENT TYPE:

           ...<< Processing, Claim Error Checks >>...Release of
Information.
.: NO Assignment of Benefits..: NO

       ...<< Checking Eligibility Files for Potential Coverage >>...
```

Figure 4-86: Manually adding a patient–unable to add

If the visit does not already exist in the system and the patient has third party resources on file, CLAIM SUMMARY (PAGE 0) of the Claim Editor displays.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN      [HRN:88888]                    Claim Number: 44860
............................. (CLAIM SUMMARY) .............................

_____ Pg-1 (Claim Identifiers) _____|_____ Pg-4 (Providers) _____
Location..: INDIAN HOSP                    | Attn:
Clinic....: GENERAL                        |
Visit Type: OUTPATIENT                     |
Bill From: 03-05-2006 Thru: 03-05-2006     |
_____ Pg-2 (Billing Entity) _____|_____ Pg-5A (Diagnosis) _____
ALLEGHANY CORP GRP             ACTIVE       |
NEW MEXICO CHIP                PENDING      |
MAIL HANDLERS BENEFIT PLAN     PENDING      |
_____ Pg-3 (Questions) _____|_____ Pg-8 (CPT Procedures) _____
Release Info: YES   Assign Benef: YES      |
                                           |
                                           |
                                           |
_____|_____
  ERROR:004 - CLAIM HAS NO CHARGES (PROCEDURES OR SERVICES) TO BILL
--------------------------------------------------------------------------
Desired ACTION (View/Appr/Next/Jump/Quit): N//
```

Figure 4-87: Manually adding a patient–ok to add

For more information on editing the claim data, see Section 3.2.

4.27   Rebuild Items from PCC (RBCL)

Main Menu > EDTP > RBCL

The Rebuild Items from PCC (RBCL) option on the Add/Edit Claim (EDT) menu
enable the user to delete certain pages of the claim and rebuild the page using only
PCC data. This function is helpful if a user accidentally edits the wrong claim.
Instead of deleting the changes item by item, the user can delete a single page or
series of pages and rebuild them with the correct patient's PCC data.

> **Note:** Use this option only on existing claims with a state of In
> Edit Mode.

To rebuild claim items from PCC data, follow these steps:

1. At the "Select 3P CLAIM DATA PATIENT" prompt, type the claim number or
   the patient name. If the user enters

   - A claim number (not manually entered), the PCC visit linked to the claim will
     be used to gather data to rebuild.

   - If the patient's name was entered, the user will also be prompted to specify a
     visit (claim).

2. At the "Do you wish to view PCC visit information before continuing?" prompt, type **YES** or press the Enter key to accept the default, No.

If the user types YES, the data is displayed for review.

3. At the "Enter subfile number or list of subfiles to clean out" prompt, type the number that corresponds to the Claim Editor page to rebuild. The user can enter

- A single number

- Series of numbers separated by commas

- Range of numbers

To rebuild as many pages as possible, type 13-46.

The Claim Generator is then queued for that patient.

4. At the "Enter RETURN to continue or '^' to exit" prompt, press the Enter key to continue, or type the caret (**^**) to exit and return to the Add/Edit Claim menu.

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            |              THIRD PARTY BILLING SYSTEM - VER 2.6         |
            +                     Rebuild Items from PCC                +
            |                     INDIAN HEALTH HOSPITAL                |
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            User: TESTER,TEST                         13-NOV-2009 2:55 PM

WARNING this option deletes the data from selected pages (subfiles) of the
claim file.  Then it looks to see if the data can be rebuilt from PCC.
For some pages there is no data in PCC.  For some the data may be missing.
The data will only be rebuilt if the information exists in PCC.

Select 3P CLAIM DATA PATIENT: DEMO,JOHN <Enter>
                                        M 01-01-1950 XXX-XX-2222    IHH
123567
     1  DEMO,JOHN        03-11-2008     INDIAN HEALTH HOSPITAL
     2  DEMO,JOHN        07-27-2008     INDIAN HEALTH HOSPITAL
     3  DEMO,JOHN        07-27-2008     INDIAN HEALTH HOSPITAL
     4  DEMO,JOHN        07-27-2008     INDIAN HEALTH HOSPITAL
     5  DEMO,JOHN        05-03-2009     INDIAN HEALTH HOSPITAL
CHOOSE 1-5: 5 <Enter>  DEMO,JOHN    05-03-2009     INDIAN HEALTH HOSPITAL
Do you wish to view PCC visit information before continuing? No// NO


                                        13  Insurer  (P-2)
15  APC Visit                           17  Diagnosis  (P-5A)
19  ICD Procedure  (P-5B)               21  Surgical Procedure  (P-8B)
23  Pharmacy  (P-8D)                    25  REVENUE CODE  (P-8C)
27  Medical Procedure  (P-8A)           33  Dental  (P-6)
35  Radiology  (P-8F)                   37  Laboratory  (P-8E)
39  Anesthesia  (P-8G)                  41  Providers  (P-4)
43  Misc. Services  (P-8H)              45  Charge Master  (P-8J)
47  AMBULANCE SERVICE  (P-8K)

Enter subfile number or list of subfiles to clean out:  (13-47): 41 <Enter>
Claim generator queued for selected patient.
Enter RETURN to continue or '^' to exit:
```

Figure 4-88: Rebuild items from PCC Screen

> **WARNING!**
>
> If the user tries to rebuild the claim data and there is no data for the
> patient in the PCC files, the information currently in the claim will
> be lost.
>
> If a claim is selected that is dated prior to the back-billing limit, the
> claim will be deleted, not rebuilt.
>
> The system will give a warning message prior to either of these
> errors occurring which will ask the user if they wish to continue.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |           THIRD PARTY BILLING SYSTEM - VER 2.6          |
        +              Rebuild Items from PCC                     +
        |                  INDIAN HEALTH HOSPITAL                 |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: LASTNAME, FIRSTNAME          DD MMM YYYY HH:MM [AM|PM]

WARNING this option deletes the data from selected pages (subfiles) of the
claim file. Then it looks to see if the data can be rebuilt from PCC.
For some pages, there is no data in PCC.  For some, the data may be missing.
The data will only be rebuilt if the information exists in PCC.

Select 3P CLAIM DATA PATIENT:    DOE,JOHN
                                        M 05-01-1950 553228866
The date of this claim is prior to the back-billing limit. As a result items
will not be rebuilt from PCC. If you continue, you can only delete items.

Do you wish to continue? No//
```

Figure 4-89: Rebuild claim prior to back-billing limit error message

4.28   Check Eligibility for a Visit (CKCL)

Main Menu > EDTP > CKCL

The Check Eligibility for a Visit option (CKCL) may be used when the billing
technician needs information on why the claim did not generate. The user must have
the Patient Name and the Date of Service to view the eligibility status.

To check the eligibility status, follow these steps:

1. At the "Select PATIENT NAME" prompt, type the name of the patient for whom
   the user wants to check eligibility and press the Enter key.

If the system finds the patient's information in the database, the patient's additional
information is displayed below the "Select PATIENT NAME" prompt.

2. Verify that the correct patient has been selected before continuing.

3. At the next prompt, type the date of the patient's visit (or the date that the patient
   was admitted if the visit was inpatient).

The system will display the list of eligible payers along with the reason listed as
unbillable. The user may use this information to review eligibility data in
Patient Registration or ensure the correct set up has been performed
in Table Maintenance.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |              THIRD PARTY BILLING SYSTEM – VER 2.6          |
         +              Check Eligibility for a Visit                +
         |                   INDIAN HEALTH HOSPITAL                  |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: TESTER,TEST                          13-NOV-2009 3:36 PM
Select PATIENT NAME: DEMO,JOHN
                                       M 01-01-1950 XXX-XX-2222    IHH 123567
Select VISIT: 5/3/2009    MAY 03, 2009
  partial match to:  MAY 03, 2009@08:00   DEMO,JOHN     INDIAN HEALTH HOSPIT
AL      AMBULATORY      DENTAL
        ...OK? Yes//   (Yes)




For patient DEMO,JOHN, for visit 05/03/2009@08:00
PRIORITY INSURER                       STATUS     REASON UNBILLABLE
------------------------------------------------------------------------
  3      EMPLOYERS DENTAL SER(104) BILLABLE
  4      MISSISSIPPI MEDICAID(433) BILLABLE
  99     MEDICARE(2)               UNBILLABLE (50)CLINIC DESIGNATED UNBILLAB
  99     CIMARRON SALUD(876)       UNBILLABLE (36)MEDICAID COVERAGE; VISIT O
  99     BCBS OF NEW MEXICO(903)   UNBILLABLE (37)PRIVATE INSURANCE; VISIT O

 REASON UNBILLABLE KEY:
   36 - MEDICAID COVERAGE; VISIT OUTSIDE ELIGIBILITY DATES (NE)
   37 - PRIVATE INSURANCE; VISIT OUTSIDE ELIGIBILITY DATES (NE)
   50 - CLINIC DESIGNATED UNBILLABLE FOR INSURER (NE)

Select PATIENT NAME:
```

Figure 4-90: Check Eligibility for a Visit screen

5.0   Claim/Bill Management Menu (MGTP)

Main Menu > MGTP

The Claim/Bill Management menu options enable the user to manipulate claims and bills.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |            THIRD PARTY BILLING SYSTEM - VER 2.6      |
        +                Claim/Bill Management Menu            +
        |                  INDIAN HEALTH HOSPITAL              |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                      31-AUG-2009 2:47 PM


   CLMG   Cancel Claim
   BIMG   Cancel an Approved Bill
   IQMG   Inquire about an Approved Bill
   MRMG   Merge Claims
   BKMG   Initiate Back Billing Check
   ADMG   Add a new BILL that was Manually Submitted
   EXMG   Export Inpatient Bill to Excel
   OCMG   Open/Close Claim
   RCCP   Recreate claim from PCC data
   SCMG   Split Claim

Select Claim/Bill Management Menu Option:
```

Figure 5-1: Claim/Bill Management Menu (MGMP option)

5.1   Cancel Claim (CLMG)

Main Menu > MGTP > CLMG

When a claim is unbillable or if the claim generated erroneously, it may be canceled. Removing unbillable or erroneous claims eliminates unnecessary entries for claim listings.

Once a claim is canceled, it is **permanently** removed, and no further editing or approval of that claim can occur. However, any bills already generated from the claim remain in the system. An audit trail is also established tracking the user who cancelled, the date/time cancelled, and the reason why it was cancelled.

To cancel a claim, follow these steps:

1. At the "Select CLAIM or PATIENT" prompt, type the claim number of patient's name.

When the system finds the claim the user selected, it displays additional information for that claim.

2. Review the claim information to make sure this is the claim the user wants to cancel.

3. At the "Correct Claim?" prompt do one of the following:

   - If the claim displayed is the correct claim, type **Y** (yes), press the Enter key, and continue to step 3.

   - If the claim displayed is not the claim the user wanted, type **N** (no), press the Enter key, and return to step 1.

4. At the "Do you wish Claim Number [*number*] DELETED?" prompt do one of the following:

   - To delete the claim, type **YES**, press the Enter key, and continue to step 3.

     If yes is selected, the system will require a cancellation reason to be entered. Please reference Appendix E for a complete list of codes.

   - If the user decides not to delete the claim, type **NO**, press the Enter key, and return to step 1.

The system displays the deletion progress, and when the deletion is complete, the "Select CLAIM or PATIENT:" prompt is displayed.

5. Do one of the following:

   - To delete another claim, return to step 1.

   - Press the Enter key to return to the Claim/Bill Management menu.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |          THIRD PARTY BILLING SYSTEM - VER 2.5        |
        +                     Cancel Claim                    +
        |                 INDIAN HEALTH HOSPITAL              |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                      31-AUG-2009 2:52 PM


Select CLAIM or PATIENT: 30726  DEMO,JOHN
          Clm:30726  05-12-2009 DENTAL    DENTAL          INDIAN HOSP
                ARIZONA MEDICAID                     In EDIT Mode
Correct Claim? YES// YES
WARNING: If you cancel this Claim it will be deleted and no further Editing
        or Approvals can occur.

Do you wish Claim Number 30726 DELETED (Y/N)? YES

Cancellation REASON: 2  DUPLICATE CLAIM CREATED

OK, the claim is being deleted...

Claim Number: 30726 has been Deleted!
```

Figure 5-2: Example of canceling a claim (CLMG option)

5.2   Cancel an Approved Bill (BIMG)

Main Menu > MGTP > BIMG

After a bill has been printed and all the errors are found, it can be canceled at this point, then corrected through the Claim Editor, and finally approved again for export.

When a bill is canceled, the claim that it was generated from (if it still exists) will be opened for editing.

Important:	Canceling a bill in ABM through this option will **NOT** cancel the bill in the Accounts Receivable system.

To cancel an approved bill, follow these steps:

1. At the "Select BILL to CANCEL" prompt, type the number of the bill the user wishes to cancel.

The system will display additional information about the bill on the screen.

2. Make sure that the correct bill has been selected.

> **Note:** If two bills were approved together (hospital bill
> and professional component), they will also be
> canceled together. Besides the normal confirmation prompt
> for ensuring that the bill selected is to be deleted, a
> second prompt will appear if the bill has already
> been exported (printed).

3. At the "Do you want to CANCEL all of these Bills?" prompt, type **Y** (Yes) or
   type **N** (No).

4. At the "Do you wish Bill Number [*number*] CANCELLED?" prompt type
   Y (Yes) or type **N** (No).

> **Note:** This prompt may or may not appear, depending on the
> export/ print status of the bill(s).

```
Select BILL to CANCEL: 109B <Enter>
            Visit: 04-07-1992 DENTAL         DENTAL     SELLS HOSP
             Bill: WISCONSIN MEDICAID     WI-MCD-DEN     176.00

The following Bills are all associated and can only be
CANCELED in a group manner: 109B,109A

Do you want to CANCEL all of these Bills (Y/N)? Y <Enter>  Yes

    **** Bill Number 109B was ALREADY PRINTED/EXPORTED! ****

Do you wish Bill Number 109B CANCELED (Y/N)? Y <Enter>  YES

Canceling...

Bill Number: 109B has been Canceled!
Bill Number: 109A has been Canceled!
```

Figure 5-3: Example of canceling an approved bill (BIMG option)

5.3   Inquire about an Approved Bill (IQMG)

Main Menu > MGTP > IQMG

At times, it is necessary to investigate the data contained in a bill. The Inquire about
an Approved Bill (IQMG) option enables the user to view every field in the bill that
contains data.

To view a bill, type the patient's name or the bill number at the "Select BILL or PATIENT:" prompt. If the user selects the bill by patient name (or other identifier) and there is more than one bill on file for the selected patient, the user will be prompted to select a specific bill before any bill data displays on the screen.

The Bill Inquiry option is particularly useful for determining why a bill did not print or why it printed in the manner that it did.

The following example displays a partial listing of the bill.

```
                          *** BILL FILE INQUIRY ***

================================================================================
BILL NUMBER: 31395A                        BILL TYPE: 131
  VISIT LOCATION: INDIAN HEALTH HOSPITAL
  BILL STATUS: BILLED                      PATIENT: DEMO,JANE
  EXPORT MODE: CMS-1500 (08/05)            VISIT TYPE: OUTPATIENT
  ACTIVE INSURER: NEVERPAY INSURANCE       PROCEDURE CODING METHOD: CPT
  CLINIC: EMERGENCY MEDICINE               APPROVING OFFICIAL: FAST,BILLER
  DATE/TIME APPROVED: SEP 10, 2008@07:48:59
  EXPORT STATUS: AWAITING TRANSFER TO AR
  EXPORT NUMBER: OCT 24, 2008              MASTER TAX ID#: 232101PRV
  BILL AMOUNT: 127                         INSURER TYPE: PRIVATE INSURANCE
  GROSS AMOUNT: 127                        *UNCOLLECTED BALANCE: 127
  ORIGINAL BILL AMOUNT: 0                  ADMISSION TYPE: 2
  ADMISSION SOURCE/NEWBORN CODE: 1         DISCHARGE STATUS: 01
  ADMISSION DATE: JUL 27, 2008             ADMISSION HOUR: 05
  DISCHARGE DATE: JUL 27, 2008             DISCHARGE HOUR: 05
  SERVICE DATE FROM: JUL 27, 2008          SERVICE DATE TO: JUL 27, 2008
  COVERED DAYS: 1                          RELEASE OF INFORMATION: YES
  ASSIGNMENT OF BENEFITS: YES
  RELEASE OF INFORMATION DATE: JUL 27, 2008
  ASSIGNMENT OF BENEFITS DATE: JUL 27, 2008
  EMERGENCY (Y/N): YES                     IN-HOUSE CLIA#: 12A3456789
  REFERENCE LAB CLIA#: THE REFERENCE LAB INC.
PCC VISIT: JUL 27, 2008@05:00             VISIT STATUS: P
INSURER: NEVERPAY INSURANCE               PRIORITY: 1
  STATUS: INITIATED                       PRIVATE INSURANCE MULTIPLE: 1
INSURER: NEW MEXICO MEDICAID              PRIORITY: 2
  STATUS: PENDING                         MEDICAID ELIG POINTER: DEMO,JANE
  MEDICAID MULTIPLE: 3080501
INSURER: BENEFICIARY PATIENT (INDIAN)     PRIORITY: 3
  STATUS: PENDING
DIAGNOSIS: 789.00                         PRIORITY ORDER: 1
  PROVIDER'S NARRATIVE: ABD PAIN
MEDICAL (CPT): 99283                      UNITS: 1
  UNIT CHARGE: 127.00                     CORRESPONDING DIAGNOSIS: 1
  SERVICE FROM DATE/TIME: JUL 27, 2008  DATA SOURCE: 18|2409|CPT
PROVIDER: DODGER,ROGER E                  TYPE: ATTENDING
PROVIDER: NURSE,NANCY                     TYPE: OTHER
UFMS TRANSMISSION DATE: SEP 10, 2008@07:52:03
  UFMS INVOICE NUMBER: 2321012321018321
================================================================================
```

Figure 5-4: Example of a display of bill information (IQMG option)

5.4   Merge Claims (MRMG)

Main Menu > MGTP > MRMG

The Merge Claims (MRMG) option enables the user to merge two or more claims into one claim. When the user merges claims, a new claim is created containing information from the merged claims. The user also has the option of deleting the merged claims after examining the newly created claim.

To merge two or more claims, follow these steps:

1. At the "Enter 1st claim" prompt, type the claim number for the first claim.

If the system finds a match, additional information from the claim file will be displayed so the selection can be verified.

2. At the "Enter 2nd claim" prompt, type the claim number for the second claim.

If the system finds a match, additional information from the claim file will be displayed so the selection can be verified.

3. At the "Enter 3rd claim:" prompt, do one of the following:

    - If the user is finished entering claims, press the Enter key and go to step 4.

    - Continue to add claims until finished, and then go to step 4.

4. At the "Proceed with merge?" prompt,

    - Type **Yes** to merge the selected claims, or

    - Type **No** to return to the Claim/ Bill Management Menu.

The system merges the selected claims and displays status messages during the merge process.

5. At the "Proceed to Claim Editor?" prompt,

    - Type **Yes** to edit the new claim through the Claim Editor, or

    - Press the Enter key for the default (No) to skip editing the new claim, and go to step 6.

6. At the "Delete claims merged from?" prompt,

    - Type **Yes** to delete the original claims that were merged, leaving only the new merged claim.

The system will display a status message after it deletes each claim.
The deleted claim will be marked with a cancelled claim status
of MERGED CLAIM.

- Press the Enter key to retain the original claims (they will not be deleted).

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |        THIRD PARTY BILLING SYSTEM - VER 2.6          |
          +                    Merge Claims                      +
          |                INDIAN HEALTH HOSPITAL                |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                     16-NOV-2009 8:29 AM

Enter 1st claim: 31682 <Enter> DEMO,JOHN   M 01-01-1950 XXX-XX-2222   IHH
123567


Enter 2nd claim: 31686 <Enter> DEMO,JOHN   M 01-01-1950 XXX-XX-2222   IHH
123567


Enter 3rd claim: <Enter>
PATIENT: DEMO,JOHN
   CLAIM #s: 31682  31686
2 claims selected.
Proceed with merge? YES <Enter>
Claim # 31687 created.

Merging selected claims to claim 31687
Claim # 31682 merged.
Claim # 31686 merged.

Cross referencing new claim # 31687

Proceed to Claim Editor? N// NO <Enter>
Delete claims merged from? N// YES <Enter>
Claim # 31682 deleted.
Claim # 31686 deleted.
```

Figure 5-5: Example of merging two or more claims (MRMG option)

> **Note:** The newly created claim is likely to require editing prior to
> claim approval.

5.5   Initiate Back Billing Check (BKMG)

Main Menu > MGTP > BKMG

At the initial implementation of this system, and periodically thereafter, it may be
desirable to scan all visits back to a specific date, to determine if they are billable.
The Initiate Back Billing Check option enables the user to accomplish this task.

> **Note:** A back billing check should be performed after changes to Table Maintenance have been made.

To initiate a back billing check, follow these steps:

1. At the "Do you wish to run this program?" prompt,

   - Type **Y** (Yes) to continue, or
   - Type **N** (No) to return to the Claim/Bill Management menu.

2. At the "Check all Visits back to (Date)" prompt, do one of the following

   - Type the date the system should search back to, or
   - Press the Enter key to accept the default date that is displayed.

   The system will automatically queue the one-time back billing check to run with the nightly claim generator.

3. At the "Enter RETURN to continue or '^' to exit" prompt,

   - Press the Enter key to continue, or
   - Type the caret (**^**) to return to the Claim/Bill Management menu.

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       |            THIRD PARTY BILLING SYSTEM - VER 2.6        |
       +               Initiate Back Billing Check             +
       |                   INDIAN HEALTH HOSPITAL              |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: TESTER,TEST                      16-NOV-2009 8:42 AM

     This program will cause the nightly claim generator to initiate
     a one time job of checking all visits back to the date specified.


Do you wish to run this program (Y/N)? YES <Enter>

Check all Visits back to (Date): 11-17-2005// 11/16/2008 <Enter>  (NOV 16,
2008)

OK, all visits will be checked back to 11-16-2008 during the nightly
claim generation process.

Enter RETURN to continue or '^' to exit: <Enter>
```

Figure 5-6: Example of initiating a back billing check of old visits (BKMG option)

5.6   Add a New Bill That Was Manually Submitted (ADMG)

Main Menu > MGTP > ADMG

If a bill was prepared and submitted by a mode separate from the Third Party Billing system, the accounting information should still be entered into the billing system so that it can be tracked and managed accordingly. The Add a New Bill That Was Manually Submitted (ADMG) option enables the user to manually input the accounting information from such bills into the Third Party Billing system.

When a bill is added using this option, its data will be transferred to the Accounts Receivable (BAR) package, payments can be posted for it, and the data will be used for all system reports.

Manually added bills have no alpha suffix.

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            |             THIRD PARTY BILLING SYSTEM - VER 2.6        |
            +        Add a new BILL that was Manually Submitted       +
            |                  INDIAN HEALTH HOSPITAL                 |
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            User: TESTER,TEST                       16-NOV-2009 8:54 AM

     NOTE: This program should only be utilized when an entry in the
           Accounts Receivable File is needed to reflect a bill that
           was manually prepared and submitted.

Proceed? NO// YES <Enter>

Patient........: DEMO,JOHN <Enter>
                                      M 01-01-1950 XXX-XX-2222  IHH 123567
Visit Type.....: 131 <Enter>  OUTPATIENT
Clinic.........: 01 <Enter>  GENERAL      01
Serv Date From.: 11/02/2009 <Enter>  (NOV 02, 2009)
Serv Date Thru.: NOV 2,2009// <Enter>
No. of Visits..: 1// <Enter>
Insurer........: NEVERPAY <Enter>( NEVERPAY )
.
NEVERPAY INSURANCE                    - PO BOX 38738
                                        JERSEY CITY, NJ 84728
 OK? Y//

Amount Billed..: 450.50 <Enter>

File Bill? NO// YES <Enter>
Bill # 31688 Filed.

Enter RETURN to continue or '^' to exit: <Enter>
```

Figure 5-7: Example of adding a bill manually (ADMG option)

The option is flexible enough to allow a payer to be used even if the patient does not contain that eligibility on file. If the user selects such a payer, the following message will be displayed. This is only to notify the user that the patient does not have eligibility for that insurance company.

```
DOE,JANE has NO ELIGIBILITY for MONEYBAGS INSURANCE on SEP 15, 2009
```

Figure 5-8: Display of payer used for patient with no eligibility on file

5.7   Flat Rate Adjustment (FRMG)

Main Menu > MGTP > FRMG

The Flat Rate Adjustment (FRMG) option enables the user to update flat rates for a specified insurer and visit type beginning on a specific date. Usually when flat rate changes occur, they are retroactive to a specific date. Claims that have already been billed must reflect the new charge, as Medicare and Medicaid will reimburse at the new rate.

The Flat Rate Adjustment (FRMG) option:

- Cancels the bill

- Re-approves the claim

- Creates a new bill to reflect the new flat rate

This option is date-sensitive to accommodate the billing of older accounts.

> **Note:** This option has been temporarily removed. It will be added
> back in a future release.

To make a flat rate adjustment to a bill, follow these steps:

1. At the "Select 3P INSURER" prompt, type the name of the insurer to adjust a flat rate.

2. At the "Select VISIT TYPE" prompt, type the visit type to apply the adjustment.

To view a list of available visit types, type two question marks (**??**) at the prompt.

3. At the "Enter a date" prompt, type the date of service to start applying the flat rate adjustment to.

4. At the "Proceed?" prompt, verify the information entered (steps 1-3) and

- Type **Y** (Yes) to begin the process, or

- Type **N** (No) to cancel the task and return to the Claim/Bill Management menu.

When the system finishes applying the flat rate adjustment, it displays the number of bills changed.

5. At the "Enter RETURN to continue or '**^**' to exit:" prompt, do one of the following:

- To adjust another flat rate, press the Enter key.

- To return to the Claim/Bill Management menu, type the caret (**^**).

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       |          THIRD PARTY BILLING SYSTEM - VER 2.6          |
       +                   Flat Rate Adjustment                 +
       |                        SELLS HOSP                      |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: LASTNAME, FIRSTNAME          DD MMM YYYY HH:MM [AM|PM]

This option will adjust the amount billed field for all claims for the insurer and
visit type you select beginning with the date you select to reflect a new flat rate.

The bills may then be re-loaded to the A/R system.

Select 3P INSURER:    NEW MEXICO MEDICAID <Enter>
Select VISIT TYPE:    INPATIENT <Enter>
Enter a date: T-10 <Enter>

I am going to adjust the amount billed field for all bills with visit date 15-MAR-
1997 or later for insurer NEW MEXICO MEDICAID, visit type 111.

NOTE: The flat rate for this insurer, visit type, and date is $420.

Proceed? NO// YES.<Enter>....

Finished - 5 bills changed.

Enter RETURN to continue or '^' to exit:
```

Figure 5-9: Adjusting flat rates

5.8   Open/Close Claim (OCMG)

Main Menu > MGTP > OCMG

The Open/Close Claim option enables the user to

- Re-open claims that are in a closed or complete status for editing, or

- Close claims that are in an open status.

To open a claim that has a Closed status, follow these steps:

1. At the "Select 3P CLAIM DATA PATIENT" prompt, type the name of the
   patient, who is associated with the claim the user wants to open.

   - If the system finds a match, additional claim information is displayed so that
     the selection can be verified.

   - If more than one claim matches the patient name entered, the user is prompted
     to select a claim from the list displayed.

2. At the "Re-open Claim?" prompt, do one of the following:

   - Type **Y** (Yes) to reopen the claim.

     The system reopens the claim for editing, and prompts the user
     for another patient name.

   - Type **N** (No) to cancel the task and return to the Claim/Bill
     Management menu.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
        +                     Open/Close Claim                    +
        |                   INDIAN HEALTH HOSPITAL                |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                          16-NOV-2009 9:44 AM

Select 3P CLAIM DATA PATIENT: 31687   DEMO,JOHN
                                      M 01-01-1950 XXX-XX-2222    IHH
123567
Current Claim Status is: Closed
Re-Open Claim? NO// YES

Claim # 31687 now in Edit Mode.

Select 3P CLAIM DATA PATIENT:
```

Figure 5-10: Example of opening a claim

Once a claim has been reopened, the user, the date/time the claim was reopened, and
the status will be recorded. This can be used for future reporting.

To close a claim that has an Open status, follow these steps:

1. At the "Select 3P CLAIM DATA PATIENT" prompt, type the name of the
   patient, who is associated with the claim the user wants to close.

   - If the system finds a match, additional claim information is displayed so that
     the selection can be verified.

- If more than one claim matches the patient name entered, the user is prompted to select a claim from the list displayed.

2. At the "Change Status to Complete? prompt, do one of the following:

- Type **Y** (Yes) to close the claim.

  A reason for closing the claim will need to be entered. Once entered, the system closes the claim, and prompts you for another patient name.

- Type **N** (No) to cancel the task and return to the Claim/Bill Management menu.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |            THIRD PARTY BILLING SYSTEM - VER 2.6        |
        +                     Open/Close Claim                   +
        |                  INDIAN HEALTH HOSPITAL                |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                        16-NOV-2009 9:18 AM

Select 3P CLAIM DATA PATIENT: 31687   DEMO,JOHN
                                      M 01-01-1950 XXX-XX-2222    IHH 123567
Current Claim Status is: Edit Mode
Change Status to Closed? NO// YES

CLOSED REASON: 24   INCORRECT CHARGES

Claim # 31687 Now in Status Closed.

Select 3P CLAIM DATA PATIENT:
```

Figure 5-11: Example of closing a claim

If a claim has been closed, the following will be displayed to the user the next time the claim is viewed within the claim editor:

```
(1)  Claim# 31687    10/14/2009 OUTPATIENT              GENERAL
     INDIAN HOSP    MEDICARE                     Status: Closed
```

Figure 5-12: Message displayed when claim is closed

The following message will also be displayed in the claim editor. This means that the user can only view the claim data, but can make no changes unless the claim is in an Open or in an Edit Mode status.

```
    Claim is CLOSED and therefore uneditable.
```

Figure 5-13: Message displayed in the claim editor

5.9   Recreate Claim from PCC Data (RCCP)

Main Menu > MGTP > RCCP

Use the Recreate Claim from PCC Data (RCCP) option to recreate claims that have been cancelled by the Claim Generator. This option requires the visit date for the patient.

> **Note:** To regenerate the claim immediately, use the Claim
> Generator, One Patient option (CG1P) on the Add/Edit
> Claim menu (EDTP). Be sure to wait a minute for the
> Claim Generator to finish before trying to edit the claim.

To recreate a claim from PCC data, follow these steps:

1. At the "Select PATIENT NAME" prompt, type the patient name associated with the claim that the user wants to recreate.

If more than one patient matches the selection, the system displays the list of matches and prompts the user to select the correct patient.

2. At the "Select VISIT" prompt, type the visit date for which the user wants to recreate the claim.

Additional information is displayed for the selected visit.

3. At the "OK?" prompt, do one of the following:

   - Type **Y** (Yes) to close the claim.

     The system queues the new claim to the claim generator, and prompts the user for another patient name.

   - Type **N** (No) to cancel the task and return to the Claim/Bill Management menu.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |               THIRD PARTY BILLING SYSTEM - VER 2.6          |
         +             Recreate claim from PCC data                    +
         |                  INDIAN HEALTH HOSPITAL                     |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: TESTER,TEST                         16-NOV-2009 10:30 AM

Select PATIENT NAME: 123567 <Enter>  DEMO,JOHN
                                       M 01-01-1950 XXX-XX-2222  IHH 123567

Select VISIT: 05/28/2009   MAY 28, 2009 <Enter>
  partial match to:  MAY 28, 2009@12:40   DEMO,JOHN      INDIAN HEALTH HOSPIT
AL     AMBULATORY      EMERGENCY MEDICINE
        ...OK? Yes// YES <Enter>  (Yes)


Claim will be created for this visit next time claim generator runs.
Select PATIENT NAME: <Enter>
```

Figure 5-14: Example of recreating a claim from PCC data

5.10   Split Claim (SCMG)

Main Menu > MGTP > SCMG

Use the Split Claim (SCMG) option to split certain ages or to split all pages of one claim into another, creating two claims. Any new claim created this way will be created with a status of IN EDIT MODE.

When splitting a claim, the section in the original claim that was moved to the new claim can be deleted. For example, if pharmacy charges must be billed to a separate entity, split off PAGE 8D to the new claim and then delete PAGE 8D from the original claim.

To split a claim to create two claims, follow these steps:

1. At the "Select CLAIM or PATIENT" prompt, type the claim number or the name of the patient associated with the claim the user wants to split.

Additional information is displayed for the matched claim so that you the selection can be verified.

2. At the "Move which section(s)?" prompt, type the code associated with the section the user wants to separate.

The system displays the selection for verification.

3. The system will redisplay "Move which section(s)?" prompt. Type another page to split. If no page is selected or needed, press the Enter key.

The system will allow the user to select different pages to move. After a page is selected, the system will display the selection for verification.

4. At the "Delete sections from original claim after move?" prompt, do one of the following:

- Press the Enter key to **keep** the section in the original claim.

- Type **Y** (Yes) to **delete** the section in the original claim.

5. At the "Enter RETURN to continue or '^' to exit" prompt, do one of the following:

- To select another claim to split, press the Enter key.

- To return to the Claim/Bill Management menu, type the caret (**^**).

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |           THIRD PARTY BILLING SYSTEM - VER 2.6          |
        +                       Split Claim                      +
        |                  INDIAN HEALTH HOSPITAL                 |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                      16-NOV-2009 10:40 AM

Select CLAIM or PATIENT: 31598  DEMO,JOHN
            Clm:31598  05-03-2009 DENTAL      DENTAL        INDIAN HOSP
                    EMPLOYERS DENTAL SERVICES      In EDIT Mode
Correct Claim? YES// YES

     Select one of the following:

          8A        MEDICAL
          8B        SURGICAL
          8C        REVENUE CODE
          8D        RX
          8E        LAB
          8F        RADIOLOGY
          8G        ANESTHESIA
          8H        HCPCS
          8I        INPATIENT DENTAL
          8J        CHARGE MASTER
          8Z        ALL

Move Which Section(s)? : 8D  RX

Selected: 8D

     Select one of the following:

          8A        MEDICAL
          8B        SURGICAL
          8C        REVENUE CODE
          8D        RX
          8E        LAB
          8F        RADIOLOGY
          8G        ANESTHESIA
          8H        HCPCS
          8I        INPATIENT DENTAL
          8J        CHARGE MASTER
          8Z        ALL

Move Which Section(s)? :

Delete sections from original claim after move? NO//

Claim # 31690 created.

Enter RETURN to continue or '^' to exit:
```

Figure 5-15: Example of splitting a claim to create two claims

6.0   Reports Menu (RPTP)

Main Menu > RPTP

The Reports Menu enables the user to generate various reports from the Third Party
Billing system.

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       |            THIRD PARTY BILLING SYSTEM - VER 2.6          |
       +                     Reports Menu                        +
       |                 INDIAN HEALTH HOSPITAL                  |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: TESTER,TEST                        16-NOV-2009 10:53 AM


   BRRP    Brief (single-line) Claim Listing
   DERP    Detailed Display of Selective Claims
   PRRP    Employee Productivity Listing
   BLRP    Bills Listing
   STRP    Statistical Billed-Payment Report
   PTRP    Billing Activity for a Specific Patient
   DXRP    Listing of Billed Primary Diagnosis
   PXRP    Listing of Billed Procedures
   CHRP    Charge Master Listing
   PARP    PCC Visit Tracking/Audit
   VPRP    View PCC Visit
   CCRP    Cancelled Claims Report
   CLRP    Closed Claims Report
   PCRP    Pending Claims Status Report

Select Reports Menu Option:
```

Figure 6-1: Claim Reports Menu

6.1   Report Restricting Features

Most of the billing reports can be restricted to only those records that meet one or
more of the following exclusion parameters:

- Billing Entity

- Date Range

- Approving Official

- Closing Official

- Provider

- Eligibility Status

- Diagnosis Range

- CPT Range

- Report Type

Only those parameters applicable to the requested report will be available for selection.

To restrict the report to specific data elements, the user must loop through the desired exclusion parameters and specify the restrictive values. If a parameter is added in error, it can be removed by re-selecting the erroneous parameter and pressing the Enter key when prompted for the restrictive value.

Approving Official, Closing Official, Canceling Official, Provider

The Approving Official, Closing Official, Canceling Official and Provider exclusion parameters require selections from appropriate entry in the New Person file. The report will include only those records as a restrictive value where:

- The approving official is designated as the person who approved the claim into the bill for submission to the payer, or

- The closing official is designated as the person who closed the claim using the Open/Close claim option, or

- The canceling official is the user that has cancelled the claim for one reason or another, or

- The provider was specified as the primary provider on the bill. Any secondary providers, unless otherwise specified on the report parameters, will not be counted within this group.

Claim Status

If the report selected for printing is a claims report, the Approving Official parameter option is replaced with the Claim Status exclusion parameter, which allows the user to restrict the report to claims in a specific mode. For example,

```
Select one of the following:

          1           FLAGGED AS BILLABLE
          2           IN EDIT MODE
          3           BILLED AND UNEDITABLE
          4           COMPLETED ALL BILLING
          5           ROLLED FROM A/R AND IN EDIT MODE
          6           ALL

Select TYPE of CLAIM STATUS to Display:
```

Figure 6-2: Claim Status exclusion parameter values

When specifying the Claim Status exclusion parameter values,

- The Flagged as Billable status is assigned to claims that were created by the claim generator and have not been reviewed or edited by a billing technician.

- Once a claim has been reviewed or edited, it is assigned the In Edit Mode status. The claim will remain in this status until approved.

- Claims can be placed into Pending status. These claims are claims that are on hold from billing due to circumstances the billing technician determines. Pending claims will remain in this status until approved, and cannot be placed back into the In Edit Mode status.

- After a claim has been approved, it is assigned the Billed and Uneditable status. Claims in this status cannot be billed unless the bill has been cancelled.

- When a payment is posted on one of the bills created, and if the user elects not to open the claim for rebilling, the claim is assigned the Completed All Billing status.

- When a claim is closed using the Open/Close Claim option (located in the Claim/Bill Management Menu), the claim will be marked with a closed status.

- Finally, when the bill is posted down to a zero balance, the bill has been rolled back from the Accounts Receivable package and the claim is reopened, the system will assign a status of Rolled from A/R and In Edit Mode. This allows the billing technician to view the claim at a glance and identify if additional follow up is needed such as billing to a secondary or tertiary entity.

Diagnosis, CPT Range

The Diagnosis and CPT Range exclusion parameters require specifying the low and high restrictive values. Only those records with a diagnosis or procedure that falls between the high and low values will be included on the report.

Billing Entity

The Billing Entity exclusion parameter is used to designate a specific insurer or an insurer category. Only those records that are assigned to the selected insurer or insurer category will be included on the report. Insurers are assigned to each category by the insurer type recorded in each insurer record.

For example,

```
   Select one of the following:

          1            MEDICARE
          2            MEDICAID
          3            PRIVATE INSURANCE
          4            NON-BENEFICIARY PATIENTS
          5            BENEFICIARY PATIENTS
          6            SPECIFIC INSURER
          7            SPECIFIC PATIENT
          8            WORKMEN'S COMP
          9            PRIVATE + WORKMEN'S COMP
          10           CHIP

Select TYPE of BILLING ENTITY to Display: 3 <Enter>   PRIVATE INSURANCE
```

Figure 6-3: Billing Entity exclusion parameter values

In this example the user chose to generate a report restricted to private insurance entities.

To restrict the report to a specific insurer or a specific patient, the user is prompted to make a selection from the applicable file.

Date Range

The Date Range exclusion parameter is used to restrict the report to records that fall within a specified date range for a desired date category.

The selectable date categories vary, depending upon the report. If the report is related to claims, the visit date is the only applicable date parameter. If the report is related to bills, the rest of the applicable date parameters are selectable.

For example,

```
    Select one of the following:

          1          Approval Date
          2          Visit Date
          3          Export Date
          4          Payment Date

Select TYPE of DATE Desired: 3 <Enter>   Export Date

 ==========Entry of EXPORT DATE Range ==========

Enter STARTING EXPORT DATE for the Report:  3/1 <Enter>
Enter ENDING DATE for the Report:  3/31 <Enter>
```

Figure 6-4: Date Range exclusion parameters

Eligibility Status

The Eligibility Status parameter is used to restrict the report to those claims associated with the selected eligibility status. For example,

```
    Select one of the following:

          1          INDIAN BENEFICIARY PATIENTS
          2          NON-BENEFICIARY PATIENTS

Select the PATIENT ELIGIBILITY STATUS:
```

Figure 6-5: Eligibility Status exclusion parameters

Report Type

The Report Type parameter is used to control how the report is sorted or totaled. This parameter is only available on reports that print a listing.

```
    Select one of the following:

          1          BRIEF LISTING (80 Width)
          2          EXTENDED LISTING (132 Width)
          3          STATISTICAL SUMMARY ONLY
          4          ITEMIZED COST REPORT

Select TYPE of LISTING to Display:
```

Figure 6-6: Report Type exclusion parameters

Option 2, EXTENDED LISTING (132 Width), displays more data elements than option 1, BRIEF LISTING (80 Width), and none of the data will be truncated.

6.2   Device Selection

Every billing report in the system may be printed to any device (e.g., system printer, slave printer, host file, or the terminal).

Forced Queuing

If Forced Queuing has been specified in the Site Parameters file, the job will be queued automatically to run at the time specified by the user.

The following message displays:

```
As specified in the 3P Site Parameters file FORCED QUEUING is in effect!
```

Figure 6-7: Forced queuing message

When the report to be printed requires a 132-width output and a condensed print entry exists for the selected device, the following prompt displays:

```
(Report requires an output of 132 width)

Should Output be in CONDENSED PRINT (Y/N)?  Y//
```

Figure 6-8: Report "Should Output be in CONDENSED PRINT (Y/N)?" prompt

Typing **Y** (Yes) results in a condensed report.

> **Note:** Some reports require considerable computer resources and should be queued to run after hours or when access to the computer system is not required. Contact the Site Manager for assistance with queuing.

6.3   Brief (Single-line) Claim Listing (BRRP)

Main Menu > RPTP > BRRP

The Brief Claim Listing Reports option is particularly useful for determining which claims were created automatically, and which claims have yet to be billed. It functions as a tool for billing and finance. Finance utilizes this report to record potential revenue. Billing utilizes this report for tracking the number of claims ready to be billed.

> **Note:** Visit location is determined by the location where the user is currently logged in.

The following figure shows an example of the brief (single-line) claim listing sorted by visit type. This sample report was restricted to claims for visits between 05/01/2009 and 09/30/2009 in Edit Mode for all billing entities. Within each visit type, the patients are listed alphabetically.

```
================================================================================
BRIEF LISTING of CLAIMS Flagged as Billable              NOV 16,2009    Page 1
for ALL BILLING SOURCES with VISIT DATES from 05/01/2009 to 09/30/2009
Billing Location: INDIAN HOSP
================================================================================
                                                 Claim      Visit
Patient                 HRN   Active Insurer     Number     Date       Clinic
--------------------------------------------------------------------------------

   Visit Location: INDIAN HEALTH HOSPITAL
       Visit Type: INPATIENT
BIRD,AVERY              64307  NEW MEXICO MEDICAID    31612   06/01/2009 GENERAL
SAMPLE,HENRIETTA        1072   BC/BS OF OKLAHOMA      31550   05/19/2009 GENERAL
```

```
SAMPLE,VINCENT          1456   BCBS OF NEW MEXICO (FE  31620  06/17/2009 GENERAL
SAMPLE,VINCENT          1456   BCBS OF NEW MEXICO (FE  31626  09/01/2009 GENERAL
MEGABUCKS,SYLVIA        1122   BCBS OF NEW MEXICO      31560  06/03/2009 INTERNAL
PAN,PETER               7020   MEDICARE                31569  05/01/2009 GENERAL
SMITH,SAMMY D           209961 BC/BS OF OKLAHOMA       31613  06/01/2009 GENERAL
                                                       ------
                                        Subtotal:7

        Visit Type: OUTPATIENT
BILLER,ELIZABETH        7667   DONOTSMOKE INSURANCE    31658  09/21/2009 GENERAL
SAMPLE,VINCENT          1456   BCBS OF NEW MEXICO (FE  31546  06/17/2009 FAMILY PR
GEORGE,CURIOUS          845564 MEDICARE                31544  06/10/2009 GENERAL
GEORGE,CURIOUS          845564 MEDICARE                31548  06/01/2009 GENERAL
GREEN,FLOWER            3369   MEDICARE                31554  06/01/2009 GENERAL
KING,STEPHEN            12345  MEDICARE                31623  08/30/2009 GENERAL
MEGABUCKS,SYLVIA        1122   BCBS OF NEW MEXICO      31624  08/10/2009 IMMUNIZAT
MOUSE,MICKEY            101156 BC/BS OF ARIZONA INC    31568  06/20/2009 GENERAL
                                                       ------
                                        Subtotal:8

        Visit Type: EMERGENCY ROOM
SAMPLE,VINCENT          1456   BCBS OF NEW MEXICO (FE  31680  08/01/2009 EMERGENCY
                                                       ------
                                        Subtotal:1

        Visit Type: AMBULATORY SURGERY
LEE,BRUCE               7779   BCBS OF NEW MEXICO      31608  05/10/2009 DAY SURGE
                                                       ------
                                        Subtotal:1

        Visit Type: DENTAL
SAMPLE,VINCENT          1456   NEW MEXICO MEDICAID     31644  08/21/2009 DENTAL
SAMPLE,VINCENT          1456   NEW MEXICO MEDICAID     31645  08/06/2009 DENTAL
DEMO,JOHN               123567 EMPLOYERS DENTAL SERVI  31691  05/03/2009 DENTAL
DEMO,PATIENT,JR         2      BS OF MASSACHUSETTS IN  31603  06/24/2009 DENTAL
SELLECK,THOMAS          99865  NON-BENEFICIARY PATIEN  31675  09/30/2009 DENTAL
SELLECK,THOMAS          99865  NON-BENEFICIARY PATIEN  31676  08/20/2009 DENTAL
                                                       ------
                                        Subtotal:6

        Visit Type: PROFESSIONAL COMPONENT
ADAM,CHRIS              1239   MEDICARE                31597  06/10/2009 GENERAL
GEORGE,CURIOUS          845564 MEDICARE                31549  06/01/2009 GENERAL
GREEN,FLOWER            3369   MEDICARE                31555  06/01/2009 GENERAL
GREEN,FLOWER            3369   MEDICARE                31557  05/01/2009 GENERAL
LEE,BRUCE               7779   MEDICARE                31609  05/10/2009 DAY SURGE
TAXES,RINGO             44098  MEDICARE                31659  09/21/2009 GENERAL
                                                       ------
                                        Subtotal:6
                                                       ======
                                         Total:29
(REPORT COMPLETE):
```

Figure 6-9: Example of brief (single line) claim listing report (BRRP option)

6.4   Summarized (Multi-line) Claim Listing (SURP)

Main Menu > RPTP > SURP

The Summarized Claim Listing Reports option is particularly useful for viewing all elements of a visit to determine if the visit is billable. This report displays the visit demographics and all diagnosis, procedures, providers and insurers in a multi-line format for specified claims.

```
       11/30/2009            INDIAN HEALTH HOSPITAL            Page: 1
                SUMMARIZED LISTING of CLAIMS Flagged as Billable
                   for ALL BILLING SOURCES with VISIT DATES

Patient Name  (HRN)              CLM #       Date of Birth        SSN
=======================================================================
CHAVEZ,HENRIETTA  (1072)         31714       JAN 15,1911     505-84-1107

    Visit     Discharge
     Date       Date      Location          Clinic              Type
    -------------------------------------------------------------------
  10/16/2009 10/16/2009  INDIAN HOSP       DAY SURGERY         OUTPATIENT

   ICD Diagnosis                  Procedure Narrative        Provider Class
   --------------------------     --------------------------  ---------------
   CONGENITAL HIATUS HERNIA       ABD WALL HERN REPAIR NEC    PHYSICIAN
                                                              SURGEON


   Insurance Company                Coverage Types             Status
   -------------------------------------------------------------------
   MEDICARE                          PART A;PART B              ACTIVE
   BC/BS OF OKLAHOMA                                            PENDING
   D-AARP                                                       PENDING
   BC/BS OF ARIZONA INC             HMO                         PENDING
   NEW MEXICO MEDICAID                                          PENDING

(REPORT COMPLETE):
```

Figure 6-10: Example of summarized claim listing report (SURP option)

6.5   Detailed Display of Selective Claims (DERP)

Main Menu > RPTP > DERP

The Detail Display of Selective Claims Reports option prints all claim pages (with data), exactly as they appear in the claim editing process. This report is useful when a copy of a claim is needed to resolve a question or problem.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~ DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN                                        Claim Number: 31389
```

```
....................... (PAGE 1 - CLAIM IDENTIFIERS) .......................
                [1] Clinic.............: GENERAL
                [2] Visit Type.........: PROFESSIONAL COMPONENT
                [3] Bill Type..........: 111
                [4] Billing From Date..: 07/27/2008
                [5] Billing Thru Date..: 08/02/2008
                [6] Super Bill #.......:
                [7] Mode of Export.....: 837 PROF (HCFA)
                [8] Visit Location.....: INDIAN HEALTH HOSPITAL

............................ (PAGE 2 - INSURERS) ............................

To: TRAILBLAZER HEALTH ENT.LLC          Bill Type...: 111
    12800 INDIAN SCHOOL RD, NE          Proc. Code..: CPT4
    ALBUQUERQUE, NM  87222              Export Mode.: 837 PROF (HCFA)
    (888)763-9836                       Flat Rate...: N/A
..............................................................................
MSP STATUS AS OF MAY 16, 2006: NOT MSP ELIGIBLE
..............................................................................

          BILLING ENTITY                STATUS        POLICY HOLDER
    ============================== ========== ==============================
[1]  MEDICARE                       ACTIVE      DEMO,JOHN
[2]  MISSISSIPPI MEDICAID           PENDING     DEMO,JOHN
[3]  EMPLOYERS DENTAL SERVICES      PENDING     DEMO,ALICIA
-----------------------------------------------------------------------------

........................... (PAGE 3 - QUESTIONS) ............................

 [1] Release of Information..: YES
 [2] Assignment of Benefits..: YES
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.:
 [6] Special Program.........: NO
 [7] Outside Lab Charges.....:
 [8] Date of First Symptom...:
 [9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17)  :
[12] Case No. (External ID)..:
[13] Resubmission(Control) No:
[14] PRO Approval Number.....:
[15] HCFA-1500B Block 19.....:
[16] Supervising Prov.(FL19).:     NPI:
     Date Last Seen:
[17] Date of Last X-Ray......:
[18] Prior Authorization #...:
[19] Homebound Indicator.....:
[20] Hospice Employed Prov...:
[21] Reference Lab CLIA#.....: 12T1234567  THE REFERENCE LAB INC.
[22] In-House CLIA#..........: 12A3456789
-----------------------------------------------------------------------------
WARNING:199 - LAB CHARGES WITH NO REFERRING PROVIDER ON PAGE 3
-----------------------------------------------------------------------------

......................... (PAGE 4 - PROVIDER DATA) .........................

            PROVIDER                NPI              DISCIPLINE
     ========================== =========== ==============================
(attn)  DOCTOR,TRUDEL             1234567802   PHYSICIAN
```

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~ DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN                                    Claim Number: 31389
.......................... (PAGE 5A - DIAGNOSIS) ..............................

BIL    ICD9
SEQ    CODE   POA       Dx DESCRIPTION              PROVIDER'S NARRATIVE
===    ======= === ========================= ====================================
 1    458.8         OTHER SPECIFIED           HYPOTENSION
                       HYPOTENSION
 2    428.0         CONGESTIVE HRT FAILURE     CHF
                       UNSPEC
 3    305.1         TOBACCO USE DISORDER       TOBBACOUSE
 4    427.31        ATRIAL FIBRILLATION        AFIB
 5    784.7         EPISTAXIS                  EPISTAXIS
 6    V58.61        LONG-TERM USE              MED ABUSE
                       ANTICOAGULANTS
 7    562.10        DIVERTICULOSIS COLON W/O   DIVERTICULITIS OF COLON
                       HEM
 8    386.00        MENIERE'S DISEASE NOS      MENIER'S DISEASE
 9    401.9         HYPERTENSION NOS           HTN

........................ (PAGE 7 - INPATIENT DATA) ........................

[1] Admission Date...: 07-27-2008        [2] Admission Hour....: 08
[3] Admission Type...: 02 (URGENT)
[4] Admission Source.: 02 (CLINIC REFERRAL)
[5] Admitting Diag...:

[6] Discharge Date...: 08-02-2008        [7] Discharge Hour....: 14
[8] Discharge Status.:
[9] Service From Date: 07-27-2008        [10] Service Thru Date: 08-02-2008
[11] Covered Days...: 6                  [12] Non-Cvd Days...:
[13] Prior Auth Number.....:

........................ (PAGE 8A - MEDICAL SERVICES) ........................

    REVN                                        UNIT       TOTAL
    CODE        CPT - MEDICAL SERVICES          CHARGE QTY  CHARGE
    ==== ========================================== ====== === =========
[1]  CHARGE DATE: 07/27/2008 (DOCTOR,TRUDEL-R)
     0960 99221 INITIAL HOSPITAL CARE               137.00  1    137.00
[2]  CHARGE DATE: 07/28/2008 (DOCTOR,TRUDEL-R)
     0960 99231 SUBSEQUENT HOSPITAL CARE             72.00  1     72.00
[3]  CHARGE DATE: 07/27/2008 (DOCTOR,TRUDEL-R)
     0960 99232 SUBSEQUENT HOSPITAL CARE             99.00  1     99.00
                                                           ==========
                                                             $308.00


...................... (PAGE 8B - SURGICAL PROCEDURES) ......................

BIL  SERV  REVN   CORR   CPT
SEQ  DATE  CODE   DIAG   CODE            PROVIDER'S NARRATIVE   UNITS   CHARGE
===  ===== ====  ====== ======================================= ========
 1   CHARGE DATE: 07/29/2008 (RODRIGUEZ,MARIA L-R)
          ****  6      42650-22 DILATION OF SALIVARY DUCT     1      87.00
 2   CHARGE DATE: 07/29/2008 (DOCTOR,TRUDEL-R)
          ****  8,9    61490-51 INCISE SKULL FOR SURGERY      1   4,992.00
 3   CHARGE DATE: 07/27/2008 (RODRIGUEZ,MARIA L-R)
          ****  1,2,3  50125 EXPLORE AND DRAIN KIDNEY         1   2,593.00
                                                                =========
                                                                $7,672.00
-------------------------------------------------------------------------------
  ERROR:220 - NPI UNSPECIFIED IN NEW PERSON FILE FOR PROVIDER (2,4)
-------------------------------------------------------------------------------
Enter RETURN to continue or '^' to exit:
```

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~  DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN                                       Claim Number: 31389
.......................... (PAGE 8C - REVENUE CODE) ...........................

                                                            TOTAL
      REVENUE CODE                  CPT     CHARGE   DAYS   UNITS   CHARGE
      ============================  ===     ======   ====   =====   =========
[1]   CHARGE DATE: 07/27/2008
      0120 ROOM-BOARD/SEMI                  725.00     4      4     2,900.00
[2]   CHARGE DATE: 07/27/2008
      0981 PRO FEE/ER               99283   1220.00    0      1     1,220.00
[3]   CHARGE DATE: 07/29/2008
      0200 INTENSIVE CARE OR (ICU)          1196.00    1      1     1,196.00
[4]   CHARGE DATE: 07/29/2008
      0360 OR SERVICES                      573.00     0      1       573.00
                                                     ====          =========
                                                       5           $5,889.00


......................... (PAGE 8D - MEDICATIONS) ...........................

      REVN   CHARGE                                     DAYS          TOTAL
      CODE   DATE            MEDICATION                 SUPPLY  QTY    CHARGE
=============================================================================
[1]   ****   08/02/2008        Rx: 112233  (DOCTOR,TRUDEL-R)
      53746-0131-05    IBUPROFEN 400MG TAB              30      25      5.33
[2]   ****   07/27/2008        Rx: 113355  (DOCTOR,TRUDEL-R)
      59911-5874-01    METHOTREXATE 2.5MG TAB                    2      5.64
[3]   ****   07/28/2008        <No Rx> (DOCTOR,TRUDEL-R)
      00332-1171-09    PENICILLIN VK 250MG TAB                   2      5.03
[4]   0258   07/27/2008        <No Rx>
      <NO NDC>         SODIUM CHLORIDE 0.9%  1000                1      0.00
                                                                     ========
      TOTAL                                                        $16.00
-----------------------------------------------------------------------------
  ERROR:123 - PROCEDURE(S) MISSING THE NUMBER OF UNITS
WARNING:165 - DRUG(S) MISSING THE UNIT CHARGE AMOUNT
WARNING:188 - PHARMACY ENTRY MISSING CORRESPONDING DIAGNOSIS.
  ERROR:220 - NPI UNSPECIFIED IN NEW PERSON FILE FOR PROVIDER (2,4)
-----------------------------------------------------------------------------

...................... (PAGE 8E - LABORATORY SERVICES) ......................

      REVN                                           UNIT     TOTAL
      CODE        CPT - LABORATORY SERVICES          CHARGE QTY CHARGE
      ==== =========================================== ====== === =========
[1]   CHARGE DATE: 07/27/2008
      **** 80050 GENERAL HEALTH PANEL                 86.00  1     86.00
[2]   CHARGE DATE: 07/29/2008-07/28/2008
      **** 80050 GENERAL HEALTH PANEL                 86.00  1     86.00
[3]   CHARGE DATE: 07/27/2008
      **** 81005 URINALYSIS                           13.00  1     13.00
                                                            ==========
                                                            $185.00
```

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~  DETAILED CLAIM LISTING  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN                                       Claim Number: 31389
........................ (PAGE 8F - RADIOLOGY SERVICES) ........................

     REVN                                              UNIT      TOTAL
     CODE         CPT - RADIOLOGY SERVICES            CHARGE QTY CHARGE
     ==== =========================================== ====== === =========
[1]  CHARGE DATE: 07/27/2008
     **** 71010 CHEST X-RAY                            47.00  1     47.00
                                                             ==========
                                                                 $47.00


...................... (PAGE 8G - ANESTHESIA SERVICES) .......................

     REVN                                                        TOTAL
     CODE         CPT - ANESTHESIA SERVICES               MIN   CHARGE
     ==== =================================================== === ========
[1]  **** 50065-P1 INCISION OF KIDNEY                         105    555.00
          Start Date/Time: 28-AUG-2008 11:00 AM
           Stop Date/Time: 28-AUG-2008 12:45 PM
                                                             ==========
                                                                $555.00


......................... (PAGE 8H - MISC. SERVICES) .........................

     REVN                                              UNIT      TOTAL
     CODE         HCPCS - MISC. SERVICES              CHARGE QTY CHARGE
     ==== =========================================== ====== === =========
[1]  CHARGE DATE: 07/27/2008
     **** E0221 INFRARED HEATING PAD SYSTEM           132.00  1    132.00
                                                             ==========
                                                                $132.00


......................... (PAGE 9C - CONDITION CODES) .........................

     COND
     CODE                     CONDITION CODE DESCRIPTION
     ====    ============================================================
[1]   C1     APPROVED AS BILLED


............................. (PAGE 9F - REMARKS) .............................

             REMARKS
     =======================================
     (48 characters x 4 lines max)
     -------------------------------------------------
[1]  Send Payment to Provider
[2]  Patient has tribal self-insured plan
[3]
[4]
     -------------------------------------------------

Enter RETURN to continue or '^' to exit:
```

Figure 6-11: Example of a Detail Display of Selective Claims report (DERP option)

6.6   Employee Productivity Listing (PRRP)

Main Menu > RPTP > PRRP

The Employee Productivity Listing Reports option produces a productivity report for a particular approving official or for all employees. The exclusion parameter for the approving official is preset to be that of the current logged-in user.

For a productivity listing for all employees, select the approving official parameter and at the "Select Approving Official" prompt, press the Enter key.

If the report is for a specific employee, the header will include the name of the employee, and the listing will be totaled by the visit location. Otherwise, the header will indicate that it is for all employees and the report will be totaled by employee.

```
        WARNING: Confidential Patient Information, Privacy Act Applies
========================================================================
PRODUCTIVITY REPORT by BILLING,TECH                 NOV 30,2009   Page 1
for ALL BILLING SOURCES with APPROVAL DATES from 11/02/2009 to 11/03/2009
Billing Location: INDIAN HOSP
========================================================================
                                                  Number of      Amount
Location                        Visit Type           Claims      Billed
------------------------------------------------------------------------

INDIAN HEALTH HOSPITAL          INPATIENT                 2     8,800.00
                                OUTPATIENT                7     7,032.50
                                AMBULATORY SURGERY        2     2,672.00
                                LABORATORY                1       211.00
                                PROFESSIONAL COMPONENT    7     1,472.00
                                                      -----   ----------
                                          Subtotal:     19    20,187.50
                                                      -----   ----------
                                             Total:     19    20,187.50

(REPORT COMPLETE):
```

Figure 6-12: Example of Employee Productivity Listing report (PRRP option)

6.7   Bills Listing (BLRP)

Main Menu > RPTP > BLRP

The Bills Listing Reports option provides four types of reports:

1. Unpaid Bills

2. Paid Bills

3. All Bills (default)

4. Incomplete Bills

The Unpaid Bills report suppresses the payment fields and the lists the name of the patient, the export date and the billed amount. Remember, this report will reflect all unpaid bill where the bill in Third Party Billing contains a balance. This requires the rollover process from accounts receivable to be completed on a regular basis.

```
================================================================================
LISTING of UNPAID BILLS for ALL BILLING SOURCES          NOV 30,2009   Page 1
with VISIT DATES from 10/01/2009 to 11/30/2009
Billing Location: INDIAN HOSP
================================================================================
                        Claim                          Export     Billed
     Insurer            Number      Patient      HRN     Date      Amount
================================================================================
   Visit Location: INDIAN HEALTH HOSPITAL
      Visit Type: INPATIENT
NON-BENEFICIARY PATIENT  31660A  DEMO,DENISE      857485 10/21/2009   862.00
                         31507C  DEMO,THOMAS      99865  10/14/2009   862.00
                         31648A  DEMO,THOMAS      99865  10/21/2009   862.00
                         ------                                     ----------
     Sub-total:            3                                         2,586.00

      Visit Type: OUTPATIENT
BC/BS OF OKLAHOMA        31643A  SMITH,GRANNY     209961 10/06/2009    50.00
                        31650A  SMITH,GRANNY     209961 10/07/2009   150.00
                        31679B  SMITH,GRANNY     209961 11/05/2009   250.00
BCBS OF NEW MEXICO (FEP  31710A  BULLWINKLE,ROCKY 78532  11/24/2009   246.00
                        31704B  BULLWINKLE,ROCKY 78532  11/24/2009   222.00
                        31711A  BULLWINKLE,ROCKY 78532  11/24/2009   332.00
C-TRIBAL INSURANCE       31667B  STARR,TWINKLE    44098  10/29/2009   268.00
CATEGORY 3               31672A  DEMO,LUCY LUI    383283                20.00
MEDICARE                 31636   MEGABUCKS,SYLVIA 1122                 650.00
                        31649   DEMO,THOMAS      99865               9,000.00
                        31657B  STARR,TWINKLE    44098  10/20/2009   215.00
                        31664B  STARR,TWINKLE    44098  10/27/2009   215.00
                        31670B  STARR,TWINKLE    44098  11/02/2009   215.00
NEVERPAY INSURANCE       31688   DEMO,JOHN        123567              450.50
NON-BENEFICIARY PATIENT  31669A  DEMO,THOMAS      99865  11/02/2009    84.00
                         ------                                     ----------
     Sub-total:           15                                        12,367.50

      Visit Type: EMERGENCY ROOM
NON-BENEFICIARY PATIENT  31661A  DEMO,THOMAS      99865  11/02/2009   862.00
```

```
                    ------                                       ----------

     Sub-total:           1                                         862.00

        Visit Type: OPTOMETRY
MEDICARE                    31712    BULLWINKLE,ROCKY   78532           250.00
                            ------                                 ----------
     Sub-total:           1                                         250.00

        Visit Type: DENTAL
BC/BS OF OKLAHOMA           31689A   SMITH,GRANNY        209961 11/16/2009   102.00
DELTA DENTAL OF NEW MEX     31673    DEMO,THOMAS      99865                 175.00
NEW MEXICO MEDICAID         31655A   GLASSES,SUN         1180   10/19/2009   147.00
                            ------                                 ----------
     Sub-total:           3                                         424.00

        Visit Type: PROFESSIONAL COMPONENT
BC/BS OF OKLAHOMA           31678C   SMITH,GRANNY        209961 11/20/2009   200.00
LOVELACE SALUD              31677A   SALUD,LALACE        65040  11/05/2009   476.00
                            ------                                 ----------
     Sub-total:           2                                         676.00
                            ------                                 ----------
        Total:           25                                       17,165.50
                            ======                                 ==========
   GRAND TOTAL:           25                                       17,165.50

(REPORT COMPLETE):
```

Figure 6-13: Listing of unpaid bills for all billing sources

Figure 6-14 lists paid bills. The report populates with paid bills
if the rollover process has occurred from accounts receivable. The report displays a
list of bills sorted by insurer along with the paid amount. The date paid
is also displayed.

```
===============================================================================
LISTING of PAID BILLS for ALL BILLING SOURCES            NOV 30,2009   Page 1
with VISIT DATES from 10/01/2009 to 11/30/2009
Billing Location: INDIAN HOSP
===============================================================================
                Claim            Export        Billed    Date       Paid
     Insurer    Number   HRN     Date          Amount    Paid       Amount
-------------------------------------------------------------------------------
   Visit Location: INDIAN HEALTH HOSPITAL
      Visit Type: OUTPATIENT
C-TRIBAL INSURANCE  31657A  44098               268.00  10/20/2009      0.00
                    31664A  44098               268.00  10/27/2009      0.00
                    31668A  44098  10/29/2009   268.00  10/29/2009      0.00
                    31670A  44098  11/02/2009   268.00  11/02/2009      0.00
MEDICARE            31663   99865               263.00  10/27/2009    200.00
                    ------               ----------            ----------
      Total:    5                        1,335.00                  200.00
                    ======               ==========            ==========
   GRAND TOTAL:    5                        1,335.00                  200.00

(REPORT COMPLETE):
```

Figure 6-14: Listing of paid bills for all billing sources

Figure 6-15 displays the All Bills category. The report displays all bills for a user-defined period of time, regardless of the payment status.

```
================================================================================
LISTING of ALL BILLS for ALL BILLING SOURCES              NOV 30,2009   Page 1
with VISIT DATES from 10/01/2009 to 11/30/2009
Billing Location: INDIAN HOSP
================================================================================
                  Claim            Export        Billed   Date        Paid
     Insurer      Number   HRN     Date          Amount   Paid        Amount
--------------------------------------------------------------------------------
   Visit Location: INDIAN HEALTH HOSPITAL
        Visit Type: INPATIENT
NON-BENEFICIARY PA 31660A  857485 10/21/2009      862.00
                   31507C  99865  10/14/2009      862.00
                   31648A  99865  10/21/2009      862.00
                   ------                     ----------            ----------
      Sub-total:   3                           2,586.00                  0.00

        Visit Type: OUTPATIENT
BC/BS OF OKLAHOMA  31643A  209961 10/06/2009       50.00
                   31650A  209961 10/07/2009      150.00
                   31679B  209961 11/05/2009      250.00
BCBS OF NEW MEXICO 31710A  78532  11/24/2009      246.00
                   31704B  78532  11/24/2009      222.00
                   31711A  78532  11/24/2009      332.00
C-TRIBAL INSURANCE 31657A  44098               268.00  10/20/2009       0.00
                   31664A  44098               268.00  10/27/2009       0.00
                   31667B  44098  10/29/2009      268.00
                   31668A  44098  10/29/2009      268.00  10/29/2009       0.00
                   31670A  44098  11/02/2009      268.00  11/02/2009       0.00
CATEGORY 3         31672A  383283                 20.00
MEDICARE           31636   1122                  650.00
MEDICARE           31649   99865               9,000.00
                   31663   99865                 263.00  10/27/2009     200.00
                   31657B  44098  10/20/2009      215.00
                   31664B  44098  10/27/2009      215.00
                   31670B  44098  11/02/2009      215.00
NEVERPAY INSURANCE 31688   123567                450.50
NON-BENEFICIARY PA 31669A  99865  11/02/2009       84.00
                   ------                     ----------            ----------
      Sub-total:   20                         13,702.50                200.00

        Visit Type: EMERGENCY ROOM
NON-BENEFICIARY PA 31661A  99865  11/02/2009      862.00
                   ------                     ----------            ----------
      Sub-total:   1                             862.00                  0.00

        Visit Type: OPTOMETRY
MEDICARE           31712   78532                 250.00
                   ------                     ----------            ----------
      Sub-total:   1                             250.00                  0.00

        Visit Type: DENTAL
BC/BS OF OKLAHOMA  31689A  209961 11/16/2009      102.00
DELTA DENTAL OF NE 31673   99865                 175.00
NEW MEXICO MEDICAI 31655A  1180   10/19/2009      147.00
                   ------                     ----------            ----------
      Sub-total:   3                             424.00                  0.00
```

```
        Visit Type: PROFESSIONAL COMPONENT
BC/BS OF OKLAHOMA    31678C  209961 11/20/2009      200.00
LOVELACE SALUD       31677A  65040  11/05/2009      476.00
                     ------            ----------            ----------
    Sub-total:       2                     676.00                  0.00
                     ------            ----------            ----------
        Total:       30                18,500.50                200.00
                     ======            ==========            ==========
   GRAND TOTAL:      30                18,500.50                200.00

(REPORT COMPLETE):
```

Figure 6-15: Example of the Bill Listing Report (BLRP option) for All Bills

The extended (132-width) version of this report displays all visit identifiers.

6.8   Statistical Billed Payment Report (STRP)

Main Menu > RPTP > STRP

Use the Statistical Billed Payment reports option to print a summary report for all bills, sorted and tallied by facility and visit type.

```
================================================================================
STATISTICAL REPORT for ALL BILLING SOURCES              NOV 30,2009   Page 1
with VISIT DATES from 07/01/2009 to 11/30/2009
Billing Location: INDIAN HOSP
================================================================================

   VISIT            NUMBER    UNDUP      BILLED       PAID        UNPAID
   TYPE             VISITS    PATIENTS   AMOUNT       AMOUNT      AMOUNT
--------------------------------------------------------------------------------


INDIAN HEALTH HOSPITAL
   NON COVERED         1        1       2,900.00       0.00       2,900.00
   INPATIENT           5        3       4,554.00       0.00       4,554.00
   OUTPATIENT         22        8      14,193.50     627.02      13,566.48
   MENTAL HEALTH       1        1         200.00       0.00         200.00
   EMERGENCY ROOM      1        1         862.00       0.00         862.00
   FQHC                1        1         862.00       0.00         862.00
   AMBULATORY SURG     1        1         383.00       0.00         383.00
   OPTOMETRY           1        1         250.00       0.00         250.00
   DENTAL              4        3         677.00       0.00         677.00
   PROFESSIONAL CO    12        6       3,725.00     325.00       3,400.00
                    ------   ------   ----------   ----------   ----------
                      49       15      28,606.50     952.02      27,654.48

TOTAL COVERED INPATIENT DAYS  5


(REPORT COMPLETE):
```

Figure 6-16: Example of a Statistical Billed Payment report (STRP option)

> **Note:** The UNDUP PATIENTS column totals are a count
> of unique patients (i.e., if the same patient had an
> optometry visit and a dental visit, he/she would be counted
> only once in the totals).

6.9   Billing Activity for a Specific Patient (PTRP)

Main Menu > RPTP > PTRP

Use the Billing Activity for a Specific Patient Reports option to view/print the billing
activity for a specific patient. The user can include or exclude bills in a completed
status.

```
      WARNING: Confidential Patient Information, Privacy Act Applies
================================================================================
BILLING ACTIVITY of DEMO,JOHN                          NOV 30,2009   Page 1
for ALL BILLING SOURCES
Billing Location: INDIAN HOSP
================================================================================
                    Claim           Export       Billed    Date      Paid
      Insurer       Number   HRN    Date         Amount    Paid      Amount
--------------------------------------------------------------------------------
   Visit Location: INDIAN HEALTH HOSPITAL
       Visit Type: OUTPATIENT
MEDICARE            29724A  123567 08/13/2008      185.00
                    31381   123567                 100.00
NEVERPAY INSURANCE  31688   123567                 450.50
                    ------               ----------           ----------
     Sub-total:     3                               735.50                 0.00

      Visit Type: PHYSICAL THERAPY
MEDICARE            29083A  123567 04/20/2006      594.00
                    ------               ----------           ----------
     Sub-total:     1                               594.00                 0.00

      Visit Type: EMERGENCY ROOM
MEDICARE            29715A  123567 10/03/2006      700.00
                    ------               ----------           ----------
     Sub-total:     1                               700.00                 0.00
                    ------               ----------           ----------
         Total:     5                             2,029.50                 0.00
                    ======               ==========           ==========
   GRAND TOTAL:     5                             2,029.50                 0.00

(REPORT COMPLETE):
```

Figure 6-17: Billing Activity for a Specific Patient report

6.10   Listing of Billed Primary Diagnosis (DXRP)

Main Menu > RPTP > DXRP

Use the Listing of Billed Primary Diagnosis Reports option to print a list of primary diagnoses with the billed amount and percent of the total amount per diagnosis. The user can restrict the report to a designated ICD diagnosis range.

```
==========================================================================
BILLED PRIMARY DIAGNOSIS for ALL BILLING SOURCES        NOV 30,2009   Page 1
with VISIT DATES from 11/01/2009 to 11/30/2009
Billing Location: INDIAN HOSP
==========================================================================
  ICD9
  Code        Diagnosis Description        Bills      Amount     Percent
+-------+-----------------------------+-------+-------------+-------+
  250.00  DIABETES II/UNSPEC NOT UNCONTR     36     16,430.98     34%
  250.01  DIABETES I/JUV NOT UNCONTRL         1        332.00      0%
  250.02  DIABETES TYPE II/UNSPEC UNCON      10      6,122.00      9%
  250.40  DIAB W/RENAL TYII/UNSPEC CONT       2        286.00      1%
  311.    DEPRESSIVE DISORDER NEC             1        200.00      0%
  354.0   CARPAL TUNNEL SYNDROME              1      1,433.00      0%
  401.1   BENIGN HYPERTENSION                 1        200.00      0%
  401.9   HYPERTENSION NOS                   23     26,033.00     21%
  427.31  ATRIAL FIBRILLATION                 1      5,178.00      0%
  460.    ACUTE NASOPHARYNGITIS               1        281.00      0%
  521.81  CRACKED TOOTH                       1        987.00      0%
  525.9   DENTAL DISORDER NOS                 1         23.00      0%
  692.9   DERMATITIS NOS                      1        823.00      0%
  703.0   INGROWING NAIL                      2      1,450.00      1%
  724.5   BACKACHE NOS                        2        337.00      1%
  774.2   NEONAT JAUND PRETERM DEL            2      2,377.52      1%
  784.0   HEADACHE                            7      1,677.00      6%
  786.2   COUGH                               1        175.00      0%
  800.01  CL SKULL VLT FX W/O COMA            1      1,348.00      0%
  821.01  FX FEMUR SHAFT-CLOSED               1        476.00      0%
  924.3   CONTUSION OF TOE                    1        253.00      0%
                                        +=======+=============+
Primary Diagnosis Total                     105     67,738.50
                                        +=======+=============+

(REPORT COMPLETE):
```

Figure 6-18: Example of Listing of Billed Primary Diagnosis report (DXRP option)

6.11   Listing of Billed Procedures (PXRP)

Main Menu > RPTP > PXRP

Use the Listing of Billed Procedures Reports option to print a listing of procedures showing the billed amount and percent of the total amount per diagnosis. The user can list procedures for one or for all categories.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
        +              Listing of Billed Procedures              +
        |                 INDIAN HEALTH HOSPITAL                 |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                       30-NOV-2009 11:46 AM

----- PROCEDURE CATEGORIES -----


     Select one of the following:

          1          MEDICAL
          2          SURGICAL
          3          RADIOLOGY
          4          LABORATORY
          5          ANESTHESIA
          6          DENTAL
          7          ROOM & BOARD
          8          MISCELLANEOUS (HCPCS)
          9          PHARMACY
          10         ALL

Select Desired CATEGORY: 10  ALL
```

Figure 6-19: Listing of Billed Procedures report procedure categories

```
========================================================================
BILLED PROCEDURES for ALL BILLING SOURCES              NOV 30,2009   Page 1
with VISIT DATES from 11/01/2009 to 11/30/2009
Billing Location: INDIAN HOSP
========================================================================
                                                        Amount
 Code          Procedure Description        Count       Billed   Percent
-------+----------------------------------+-------+-------------+------
 2150     AMALGAM - TWO SURFACES               4         504.68   7.0%
 5850     TISSUE CONDITIONING, MAXILLARY       1         172.44   2.0%
 5851     TISSUE CONDITIONING, MANDIBULAR      1         176.64   2.0%
 44960    APPENDECTOMY                         1       1,820.00  25.0%
 64721    CARPAL TUNNEL SURGERY                1       1,433.00  20.0%
 81001    URINALYSIS, AUTO W/SCOPE             1          18.00   0.0%
 81005    URINALYSIS                           1          13.00   0.0%
 82947    ASSAY, GLUCOSE, BLOOD QUANT          1          19.00   0.0%
 85025    COMPLETE CBC W/AUTO DIFF WBC         1          30.00   0.0%
 92012    EYE EXAM ESTABLISHED PAT             2         126.00   1.0%
 92270    ELECTRO-OCULOGRAPHY                  1         101.00   1.0%
 99212    OFFICE/OUTPATIENT VISIT, EST        12         841.00  11.0%
 99213    OFFICE/OUTPATIENT VISIT, EST         4         248.00   3.0%
 99214    OFFICE/OUTPATIENT VISIT, EST         1          90.00   1.0%
 99221    INITIAL HOSPITAL CARE                1         137.00   1.0%
 99231    SUBSEQUENT HOSPITAL CARE             1          72.00   1.0%
 99238    HOSPITAL DISCHARGE DAY               1          86.00   1.0%
 0120     PERIODIC ORAL EVALUATION - ESTABLISHED P  2    82.14   1.0%
 0150     COMPREHENSIVE ORAL EVALUATION - NEW OR E  3   220.80   3.0%
          PRESCRIPTIONS                        5         954.28  13.0%
                                        +=======+=============+
                               Total:     45       7,144.98
                                        +=======+=============+


(REPORT COMPLETE):
```

Figure 6-20: Example of Billed Procedure Listing report (PXRP option) for all categories

6.12   Charge Master Listing (CHRP)

Main Menu > RPTP > CHRP

Use the Charge Master Listing Reports option to print a summary report for all items
in the Charge Master file. The listing can be sorted by one of eight categories. The
default sort category is Item Description.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |           THIRD PARTY BILLING SYSTEM - VER 2.5        |
          +                   Charge Master Listing               +
          |                   INDIAN HEALTH HOSPITAL              |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                      30-NOV-2009 11:51 AM


SORT BY: ITEM DESCRIPTION// ?

    Answer with FIELD NUMBER, or LABEL
   Choose from:
   .01         ITEM DESCRIPTION
   .02         REVENUE CODE
   .03         HCPCS CODE
   .04         UPC
   .05         OTHER IDENTIFIER
   .06         START DATE
   .07         STOP DATE
   .08         COST CENTER

        TYPE '-' IN FRONT OF NUMERIC-VALUED FIELD TO SORT FROM HI TO LO
        TYPE '+' IN FRONT OF FIELD NAME TO GET SUBTOTALS BY THAT FIELD,
          '#' TO PAGE-FEED ON EACH FIELD VALUE,  '!' TO GET RANKING NUMBER,
           '@' TO SUPPRESS SUB-HEADER,   ']' TO FORCE SAVING SORT TEMPLATE
        TYPE ';TXT' AFTER FREE-TEXT FIELDS TO SORT NUMBERS AS TEXT
        TYPE [TEMPLATE NAME] IN BRACKETS TO SORT BY PREVIOUS SEARCH RESULTS
        TYPE 'BY(0)' TO DEFINE RECORD SELECTION AND SORT ORDER

SORT BY: ITEM DESCRIPTION//
START WITH ITEM DESCRIPTION: FIRST//
DEVICE:   Virtual    Right Margin: 80//
```

Figure 6-21: Charge Master Listing Report sort by categories

The following example of a Charge Master Listing report is set to print in 80-column
width format. The extended version (132-column width) displays all identifiers.

```
================================================================================
OCT 19,2009               CHARGE MASTER LISTING                    PAGE   1
================================================================================
ITEM DESCRIPTION                  REVENUE CODE    HCPCS CODE    UPC CODE
OTHER IDENTIFIER                  START DATE      STOP DATE     COST CENTER
--------------------------------------------------------------------------------
99212
--------------------------------------------------------------------------------
99213
--------------------------------------------------------------------------------
00099                                             00099
    CPT CODE FOR AHCCCS
--------------------------------------------------------------------------------
4X4                               272
--------------------------------------------------------------------------------
BANDAIDS 3 INCH                   270             A4460
--------------------------------------------------------------------------------
CRUTCHES, ALUMINUM                450             J0110         0005940004
    123456787
--------------------------------------------------------------------------------
CRUTCHES, WOODEN                  273             E0112         43.00
--------------------------------------------------------------------------------
DISKETTES, 3.5 INCH               270                           0005940004
--------------------------------------------------------------------------------
GAUZE                             272             A4202
--------------------------------------------------------------------------------
J1101
--------------------------------------------------------------------------------
LITEPRO 720                       255             A0010         010013100
--------------------------------------------------------------------------------
Leg Splint
  12345 baxter
--------------------------------------------------------------------------------
SOME KINDA INJECTABLE             250             J1200
--------------------------------------------------------------------------------
SURGICAL SCISSORS
--------------------------------------------------------------------------------
SUTURE KIT                        272             A4208
--------------------------------------------------------------------------------
SYRINGE WITH NEEDLE, STERILE 1    272             A4206
--------------------------------------------------------------------------------
SYRINGE WITH NEEDLE, STERILE 2    272             A4207
--------------------------------------------------------------------------------
SYRINGE WITH NEEDLE, STERILE 3    272             A4208
--------------------------------------------------------------------------------
surgical tape
--------------------------------------------------------------------------------
training
```

Figure 6-22: Example of Charge Master Listing report (CHRP option)

6.13   PCC Visit Tracking/Audit (PARP)

Main Menu > RPTP > PARP

The PCC Visit Tracking/Audit Reports option displays the status of a PCC visit in the billing system. Use this report to determine why a visit exists in PCC, but a claim was **not** created in Third Party Billing.

All visits within a selected range are displayed with a claim status message attached.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |            THIRD PARTY BILLING SYSTEM - VER 2.6           |
          +                  PCC Visit Tracking/Audit                 +
          |                   INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                        30-NOV-2009 12:17 PM


 ============ Entry of VISIT Range =============

Enter STARTING Visit for the Report:  T-30  (OCT 31, 2009)

Enter ENDING DATE for the Report:  T  (NOV 30, 2009)


Output DEVICE: HOME//
```

Figure 6-23: Specifying date range for PCC Visit Tracking/Audit report

The Claim Status column specifies if a claim was created in ABM. If a claim was not created, the reason is displayed. For example,

```
================================================================================
PCC Status Report for ALL BILLING SOURCES                 NOV 30,2009   Page  1
Billing Location: INDIAN HOSP
================================================================================
  Patient          HRN    Clinic      Visit Date/Time      Third Party Billed
--------------------------------------------------------------------------------

   Visit Location: INDIAN HEALTH HOSPITAL
DEMO,JOHN          123567 DENTAL      MAY 03, 2009@08:00  CLAIM CANCELED (MANUAL
SALUD,LALACE       65040  GENERAL     OCT 06, 2009@14:00  EXISTING CLAIM MODIFIE
GREEN,APPLE        6670               FEB 26, 2009@07:00  INPATIENT CODING INCOM
DEMO,PATIENT,JR    2                  MAR 03, 2009@13:40  NO 'V' FILES POINTING
DEMO,JOHN          123567             MAY 28, 2009@16:05  NO 'V' FILES POINTING
DEMO,TONY          45236              JUL 29, 2009@09:00  NO DATA FOUND IN FILE
PEACH,GREEN        45631  GENERAL     JAN 09, 2009@09:00  NO ELIGIBILITY FOUND F
PEACH,GREEN        45631  GENERAL     FEB 22, 2009@11:00  NO ELIGIBILITY FOUND F
PEACH,GREEN        45631  GENERAL     FEB 10, 2009@12:00  NO ELIGIBILITY FOUND F
PEACH,GREEN        45631  GENERAL     JAN 07, 2009@09:00  NO ELIGIBILITY FOUND F
NIGHT,STAR         11149  GENERAL     FEB 01, 2009@06:00  OUTPATIENT VISIT WITH
PATIENT,CARL       55663              FEB 07, 2009@09:00  PCC SERVICE CATEGORY N
YELLOW,FLOWER      7749   GENERAL     JUL 06, 2009@10:00  PRIVATE INSURANCE; VIS
YELLOW,FLOWER      7749   GENERAL     MAY 20, 2008@10:00  PRIVATE INSURANCE; VIS
GRIFFIN,PETER      4302   EMERGENCY   FEB 04, 2009@15:20  VISIT IN REVIEW STATUS
DOE,LINDA L        61699  GENERAL     JAN 07, 2009@15:00  VISIT IN REVIEW STATUS
DEMO,JOHN          123567 GENERAL     FEB 18, 2009@13:00  VISIT IN REVIEW STATUS
PEBBLES,FRUITY            GENERAL     JUL 04, 2009@12:30  NO ELIGIBILITY FOUND F
NIGHT,STAR         11149  GENERAL     MAY 01, 2009@08:00  OUTPATIENT VISIT WITH
DALION,LIONEL             GENERAL     FEB 11, 2009@09:00  VISIT IN REVIEW STATUS
DOLL,BARBIE              GENERAL     FEB 12, 2009@19:30  VISIT IN REVIEW STATUS
DOLL,BARBIE              GENERAL     FEB 01, 2009@12:30  VISIT IN REVIEW STATUS
DOLL,BARBIE              GENERAL     FEB 04, 2009@13:30  VISIT IN REVIEW STATUS
DEMO,TRACY               GENERAL     FEB 22, 2009@09:00  VISIT OCCURRED BEFORE
DEMO,TRACY               GENERAL     FEB 14, 2009@11:00  VISIT OCCURRED BEFORE
                            ------
                 Count:  25
```

Figure 6-24: Example of PCC Visit Tracking/Audit report (PARP option)

6.14   View PCC Visit (VPRP)

Main Menu > RPTP > VPRP

Use the View PCC Visit Reports option to view PCC data in the ABM system. This report displays a list of visits for a specified patient, where selecting a visit displays the details for that visit.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
          +                     View PCC Visit                      +
          |                   INDIAN HEALTH HOSPITAL                |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                       30-NOV-2009 12:19 PM

Select PATIENT NAME: DEMO,JOHN              M 01-01-1950 XXX-XX-2222  IHH 123567


PATIENT: DEMO,JOHN                          SSN: 222-22-2222
         VISIT DATE/TIME      VISIT LOCATION      SERVICE CATEGORY
==============================================================================

   (1)   OCT 14, 2009@15:00   INDIAN HEALTH HOS   AMBULATORY
          Claim Status: CLAIM CREATED
   (2)   MAY 28, 2009@12:40   INDIAN HEALTH HOS   AMBULATORY
          Claim Status: VISIT IN REVIEW STATUS
   (3)   MAY 28, 2009@16:05   INDIAN HEALTH HOS   HOSPITALIZATION
          Claim Status: NO 'V' FILES POINTING TO THIS VISIT
   (4)   MAY 03, 2009@08:00   INDIAN HEALTH HOS   AMBULATORY
          Claim Status: CLAIM CANCELED (MANUALLY)
   (5)   JUL 27, 2008@03:30   INDIAN HEALTH HOS   AMBULATORY
          Claim Status: EXISTING CLAIM MODIFIED
   (6)   JUL 27, 2008@08:00   INDIAN HEALTH HOS   HOSPITALIZATION
          Claim Status: EXISTING CLAIM MODIFIED
   (7)   JUL 27, 2008@14:00   INDIAN HEALTH HOS   IN HOSPITAL
          Claim Status: EXISTING CLAIM MODIFIED
   (8)   FEB 02, 2008@10:00   INDIAN HEALTH HOS   AMBULATORY
          Claim Status: EXISTING CLAIM MODIFIED

Enter a number (1-8): 1
Enter Device: HOME//   Virtual


~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
VISIT IEN:  249119

HRN: IHH 123567
```

Figure 6-25: View PCC Visit screen (Continued on next page)

```
------------------------------     VISIT FILE     -----------------------------
VISIT/ADMIT DATE&TIME: OCT 14, 2009@15:00
  DATE VISIT CREATED: NOV 13, 2009      TYPE: IHS
  THIRD PARTY BILLED: CLAIM CREATED     PATIENT NAME: DEMO,JOHN
  LOC. OF ENCOUNTER: INDIAN HEALTH HOSPITAL
  SERVICE CATEGORY: AMBULATORY          CLINIC: GENERAL
  DEPENDENT ENTRY COUNT: 6              DATE LAST MODIFIED: NOV 13, 2009
  WALK IN/APPT: UNSPECIFIED             CREATED BY USER: TESTER,TEST
  USER LAST UPDATE: TESTER,TEST
  OLD/UNUSED UNIQUE VISIT ID: 2028100000249119
  ORIGINAL DATA ENTRY DATE: NOV 13, 2009
  DATE/TIME LAST MODIFIED: NOV 13, 2009@09:59:36
  CHART AUDIT STATUS: REVIEWED/COMPLETE
  NDW UNIQUE VISIT ID (DBID): 183460000249119
-----------------------------     V PROVIDER     ----------------------------
PROVIDER: DOCTOR,TRUDEL                 PATIENT NAME: DEMO,JOHN
  VISIT: OCT 14, 2009@15:00             PRIMARY/SECONDARY: PRIMARY
  AFF.DISC.CODE (c): 10000
-------------------------     V POV     ------------------------------
POV: 784.0                              PATIENT NAME: DEMO,JOHN
  VISIT: OCT 14, 2009@15:00             PROVIDER NARRATIVE: HEADACHE
  FIRST/REVISIT: REVISIT
  ICD NARRATIVE (c): HEADACHE
-----------------------------     V CPT     ------------------------------
CPT: 99212                              PATIENT NAME: DEMO,JOHN
  VISIT: OCT 14, 2009@15:00
  CPT SHORT NAME (c): OFFICE/OUTPATIENT VISIT, EST
CPT: 81001                              PATIENT NAME: DEMO,JOHN
  VISIT: OCT 14, 2009@15:00
  CPT SHORT NAME (c): URINALYSIS, AUTO W/SCOPE
-----------------------------     V CHART AUDIT     ----------------------------
DATE OF AUDIT: NOV 13, 2009@09:46:03    PATIENT: DEMO,JOHN
  VISIT: OCT 14, 2009@15:00             CHART AUDIT STATUS: INCOMPLETE
  AUDITOR/USER: TESTER,TEST         CHART DEFICIENCY REASON: CPT CODES
DATE OF AUDIT: NOV 13, 2009@09:59:29    PATIENT: DEMO,JOHN
  VISIT: OCT 14, 2009@15:00             CHART AUDIT STATUS: REVIEWED/COMPLETE
  AUDITOR/USER: TESTER,TEST
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

End of visit display, <ENTER> to Continue
```

Figure 6-26: Example of PCC Visit report (PVRP option)

6.15   Cancelled Claims Report (CCRP)

Main Menu > RPTP > CCRP

The Cancelled Claims Report tracks the number of claims cancelled by one or more users, and by cancelled date range, etc.

The following lists a detailed report for the month of November for a specific user.

```
================================================================================
CANCELLED CLAIMS LISTING for ALL BILLING SOURCES        DEC 1,2009   Page 1
with CANCELLATION DATES from 11/01/2009 to 12/01/2009
Billing Location: INDIAN HOSP
```

```
===============================================================================
                    Active         Claim     Visit
  Patient           HRN    Insurer         Number    Date        Reason
-------------------------------------------------------------------------------

Cancelling Official: WORKER,CORA
   Visit Location: INDIAN HEALTH HOSPITAL
      Visit Type: INPATIENT
TURKEY,FAT          99096  DENTAL BENEF  31515   03/16/2009  OTHER
                                         ------
              Subcount:  1

      Visit Type: OUTPATIENT
MEGABUCKS,SYLVIA 1122   NON-BENEFICI  24595   04/02/2004  ORPHAN CLAIM
                                         ------
              Subcount:  1

      Visit Type: DENTAL
DEMO,JOHN           123567 EMPLOYERS DE  31690   05/03/2009  OTHER
                                         ------
              Subcount:  1

      Visit Type: PROFESSIONAL COMPONENT
DEMO,JOHN           123567 MEDICARE      31692   04/03/2006  OTHER
                                         ------
              Subcount:  1
                                         ------
                 Count:  4

(REPORT COMPLETE):
```

Figure 6-22: Detailed report for November

6.16   Closed Claims Report (CLRP)

Main Menu > RPTP > VPRP

The Closed Claims Report prints a listing of claims that have been placed into the closed status. Claims that have been closed multiple times are indicated with an asterisk (*).

The following example shows a detailed Closed Claims Report.

```
=============================================================================
BRIEF LISTING of CLAIMS Closed Claims Report          DEC 1,2009   Page 1
for ALL BILLING SOURCES
Billing Location: INDIAN HOSP
=============================================================================
A "*" beside the claim number means the claim has been closed multiple times
                        Active        Claim      Visit
  Patient          HRN   Insurer      Number     Date        Reason
-----------------------------------------------------------------------------

Closing Official: TESTER,TEST
   Visit Location: INDIAN HEALTH HOSPITAL
       Visit Type: OUTPATIENT
JONES,CHIPPER     12770  NON-BENEFICI  31600*  06/20/2009 PATERNITY ELIGIBLE
                         ------
                Subcount: 1

       Visit Type: CROSSOVER (OUTPT)
CAT,COPY          6      NON-BENEFICI  31599*  06/20/2009 PAST BACKBILLING L
                         ------
                Subcount: 1

       Visit Type: DENTAL
DEMO,JOHN         123567 EMPLOYERS DE  31598*  05/03/2009 PAST BACKBILLING L
                         ------
                Subcount: 1
                         ------
                   Count: 3

(REPORT COMPLETE):
```

Figure 6-27: Example of Closed Claims Report

6.17   Pending Claims Status Report (PCRP)

Main Menu > RPTP > PCRP

The Pending Claims Status Report allows the user to print a listing of claims that currently have a status of Pending. This report can be used as a follow up for the billing technician or to report a summary of pended claims for management reporting.

The following exclusion parameters will be displayed:

```
   EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
   ====================================================================
   - Claim Status.......: PENDING STATUS
   - Report Type........: BRIEF LISTING (80 Width)

     Select one of the following:

          1              LOCATION
          2              BILLING ENTITY
          3              DATE RANGE
          4              STATUS UPDATER
          5              PROVIDER
          6              ELIGIBILITY STATUS
          7              REPORT TYPE

Select ONE or MORE of the above EXCLUSION PARAMETERS:
```

Figure 6-28: Display of exclusion parameters

The user can choose 4 STATUS UPDATER to obtain a list of pending claims. Once
the selection criteria have been defined, the user also has the option to see one or
more pending categories to report. The user may select the default of ALL or may
indicate the pending status number to display on the report:

```
Select Reason: ALL// 3  Claim not coded with HCPCS codes
Select Another Reason: 5  Missing POV
Select Another Reason: 7  Verify Eligibility
Select Another Reason: 8  PIN# License Missing
Select Another Reason:
```

Figure 6-29: Default of ALL selected for report

The following displays the detailed report for all users sorted by visit type.

```
================================================================================
PENDING CLAIMS STATUS LISTING                          DEC 1,2009   Page 1
for ALL BILLING SOURCES
Billing Location: INDIAN HOSP
================================================================================
                         Claim   Visit
   Patient          HRN   Number  Date        Clinic        Reason
--------------------------------------------------------------------------------
    Visit Location: INDIAN HEALTH HOSPITAL
        Status Updater: WORKER,CORA
      Visit Type: OUTPATIENT
            Active Insurer: MEDICARE

BING,CHERRY        978321  29324   04/12/2006  PODIATRY      Record not legible

        Status Updater: BILLER,FAST
            Active Insurer: WIND INSURANCE GROUP

GARDEN,FLOWER      5000    29645   07/10/2006  URGENT CARE   Claim not coded
                                                             with CPT codes

        Status Updater: WORKER,CORA
            Active Insurer: MARITIME HEALTH PLANS

TWIST,OLIVER       5138    28598   01/04/2005  PODIATRY      Claim not coded
                                                             with ICD codes

        Status Updater: BILLER,FAST
                        ------
                Subtotal: 3

     Visit Type: PROFESSIONAL COMPONENT
            Active Insurer: MEDICARE

DEMO,JOHN          123567  29072   12/10/2005  GENERAL
                                                             Missing POV
                        ------
                Subtotal: 1
                        ------
                   Total: 4

E N D   O F   R E P O R T
```

Figure 6-30: Detailed report for all users sorted by visit type

7.0   Print Bills Menu (PRTP)

Main Menu > PRTP

The process of exporting bills includes sending claims to Medicaid, Medicare, and other third party insurers in a format that meets their requirements. The Print Bills menu options address the needs of printing and managing claim submission to the various insurers.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |              THIRD PARTY BILLING SYSTEM - VER 2.6           |
         +                      Print Bills Menu                       +
         |                    INDIAN HEALTH HOSPITAL                   |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: TESTER,TEST                       1-DEC-2009 11:11 AM


   AWPR    Bills Awaiting Export Report
   EXPR    Print Approved Bills
   WSPR    Print Worksheet (Itemized CPT Data)
   MLPR    Print Mailing Address Labels
   REPR    Reprint Bill
   RESB    Enter Resubmission Number
   REPT    Print Patient Statement
   TRPR    Transmittal Listing
   TSPR    Test Forms Alignment
   EMPR    Recreate batch of ICD-9 bills

Select Print Bills Menu Option:
```

Figure 7-1: Print Bills Menu (PRTP) options

7.1   Selection of Bills for Printing

7.1.1   Mode Definition

The term **mode** or **export mode** specifies the form on which the bill will be printed. Several insurers may use the same form, and the bills for several insurers may be organized into the same batch. Most insurers use the UB-04 and the CMS-1500 forms.

7.1.2   Exclusion Parameters

Bills can be grouped in a batch for printing, using one or more of the following exclusion parameters:

- Location

- Billing entity

- Date range

- Approving official

- Provider

- Eligibility status

These restrictions are available when selecting bills for processing; for example,

```
EXCLUSION PARAMETERS CURRENTLY IN EFFECT FOR RESTRICTING THE EXPORT TO:
   ============================================================
    - APPROVING OFFICIAL.: WORKER,CORA

      SELECT ONE OF THE FOLLOWING:

            1            LOCATION
            2            BILLING ENTITY
            3            DATE RANGE
            4            APPROVING OFFICIAL
            5            PROVIDER
            6            ELIGIBILITY STATUS

SELECT ONE OR MORE OF THE ABOVE EXCLUSION PARAMETERS:
```

Figure 7-2: Exclusion Parameters available when selecting bills for printing

7.2   Bills Awaiting Export Report (AWPR)

Main Menu > PRTP > AWPR

Use the Bills Awaiting Export Report print option to view and/or print a listing of bills with an Approved claim status. These bills are ready to be sent to the insurer, but have not been printed yet. It may be necessary to print this report on a regular basis to ensure bills are exported in a timely manner.

There are three options available for listing bills that are ready for printing.

- Summarized Report by Export Mode

The mode specifies the form to be used for printing the bill. Several insurers may use the same form, and because of this, the bills for several insurers may be printed in the same batch. This report allows the user to see how many bills are ready to be sent to insurers by mode.

```
================================================================================
BILLS AWAITING EXPORT for ALL BILLING SOURCES              DEC 1,2009    Page 1
Billing Location: INDIAN HOSP
================================================================================
                                           Avg Days
                                Number      Awaiting         Total
    Export Mode                 Bills        Export         Charges
--------------------------------------------------------------------------------
    UB-82                          1          522           8,505.00
    HCFA-1500A                     1          875             200.00
    HCFA-1500B                    14          705          76,772.50
    UB-92                          4          742          18,314.00
    ADA-94                         1           76              19.00
    HCFA-1500 Y2K                 45          815          77,206.15
    ADA-99 v2000                   1           98             234.00
    CMS-1500 (08/05)               4           74             810.00
    UB-04                          2           12              63.00
                                =====                     ===========
                                  73                       182,123.65

(REPORT COMPLETE):
```

Figure 7-3: Example of BILLS AWAITING EXPORT Report summarized by export mode

- Summarized Report by Insurer

This report shows how many bills are ready to be sent to each insurer.

```
================================================================================
BILLS AWAITING EXPORT for ALL BILLING SOURCES              DEC 1,2009    Page 1
Billing Location: INDIAN HOSP
================================================================================
                                           Avg Days
                                Number      Awaiting         Total
    Insurer                     Bills        Export         Charges
--------------------------------------------------------------------------------
    BC/BS OF ARIZONA INC           1          106             223.00
    BC/BS OF OKLAHOMA              4           91           1,066.00
    CATEGORY 3                     2           42             220.00
                                =====                     ===========
                                   7                        1,509.00

(REPORT COMPLETE)
```

Figure 7-4: Example of BILLS AWAITING EXPORT Report summarized by insurer

- Listing of Unprinted Bills

This report displays information on all bills that are ready to be printed. This report is sorted alphabetically by patient name.

```
==============================================================================
BILLS AWAITING EXPORT for ALL BILLING SOURCES              DEC 1,2009   Page 1
Billing Location: INDIAN HOSP
==============================================================================
  Bill                                   Export
 Number         Patient                  Mode            Billing Source
------------------------------------------------------------------------------
 31540A    DEMO,BABY                      HCFA-1500 Y2KBC/BS OF ARIZONA INC
 31613A    SMITH,GRANNY                   CMS-1500 (08/05)BC/BS OF OKLAHOMA
 31614A    SMITH,GRANNY                   CMS-1500 (08/05)BC/BS OF OKLAHOMA
 31618A    SMITH,GRANNY                   HCFA-1500 Y2KBC/BS OF OKLAHOMA
 31637A    SMITH,GRANNY                   CMS-1500 (08/05)CATEGORY 3
 31642A    SMITH,GRANNY                   HCFA-1500 Y2KBC/BS OF OKLAHOMA
 31672A    DEMO,LUCY LUI                  CMS-1500 (08/05)CATEGORY 3

(REPORT COMPLETE):):
```

Figure 7-5: Example of BILLS AWAITING EXPORT Report by patient

7.3   Print Approved Bills (EXPR)

Main Menu > PRTP > EXPR

Use the Print Approved Bills option to print bills that have been approved and are ready to be sent to an insurer. This option:

a. Prompts the user to select the mode (form) to be printed (exported).

b. Reminds the user to load the specified form in the printer.

c. Counts the number of approved bills that exist in the system for the specified mode of export and displays the total.

d. Evaluates the specified exclusion parameters and displays a new count of bills ready for printing.

e. Sends the bills to the specified printer (device).

f. Displays a summary when printing is complete, which lists the batch number created, the number of bills, the number of insurers, and the dollar amount contained in the batch.

For example,

```
             +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
             |          THIRD PARTY BILLING SYSTEM - VER 2.6        |
             +              Print Approved Bills                    +
             |               INDIAN HEALTH HOSPITAL                 |
             +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
             User: TESTER,TEST                    1-DEC-2009 11:22 AM


Select the FORM to be EXPORTED: 14  HCFA-1500 Y2K     HCFA 1500 Y2K version

        (NOTE: HCFA-1500 Y2K forms should be loaded in the printer.)

Counting...  Number of HCFA-1500 Y2K forms awaiting export: 45

   EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
   =====================================================================
   - Approving Official.: TESTER,TEST

      Select one of the following:

            1           LOCATION
            2           BILLING ENTITY
            3           DATE RANGE
            4           APPROVING OFFICIAL
            5           PROVIDER
            6           ELIGIBILITY STATUS

Select ONE or MORE of the above EXCLUSION PARAMETERS:

Establishing Bills to be Exported for the Parameters Specified...

     Number of HCFA-1500 Y2K forms to be Printed: 1


Output DEVICE: HOME// <Enter>


                (All Print-outs are Complete)

     For Printing Mailing Labels, Worksheets or a Transmittal Listing...
     ...refer to EXPORT BATCH: 1867
                =========================
                Number of Records Exported: 1
                Number of Insurers........: 1
                Total Amount Billed.......: 242.14

Enter RETURN to continue or '^' to exit:
```

Figure 7-6: Example of Print Approved Bills (EXPR option)

7.4   Print Worksheet (Itemized CPT Data) (WSPR)

Main Menu > PRTP > WSPR

The Print Worksheet (Itemized CPT Data) option closely resembles the Detailed Display of Selective Claims Report. However, Print Worksheet enables the user to print itemized CPT data for selected claims or all claims for an export (print) batch.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
        +            Print Worksheet (Itemized CPT Data)          +
        |                  INDIAN HEALTH HOSPITAL                 |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                        1-DEC-2009 11:27 AM

PRINT WORKSHEET FOR:

     Select one of the following:

         1            SELECTIVE CLAIMS
         2            ALL CLAIMS FOR AN EXPORT DATE

Select Desired Option: 1  SELECTIVE CLAIMS


Select 1st CLAIM: 31691  DEMO,JOHN     M 01-01-1950 XXX-XX-2222    IHH 123567
```

Figure 7-7: Specifying the data to report on the Print Worksheet (WSPR option)

7.5   Print Mailing Address Labels (MLPR)

Main Menu > PRTP > MLPR

The Print Mailing Address Labels option prints labels that can be affixed to an envelope or cover letter used to submit claims or correspondence to the insurer.

Be aware that the labels will print single file, on the left side of the form.

Labels can be printed by

- Selected insurers. The user may enter multiple insurer entries so labels can be printed. If no additional insurers are needed, press the enter key to continue, or

- All insurers in a batch. If this option is selected, the "Print Labels for all EXPORT BATCHES that haven't been Previously Printed?" will display. If the user types **N** (No), the system will ask for the batch information used to print the batch. If the user types **Y** (Yes), the system will print labels for all bills that have been approved but not printed.

After the selection has been entered, the system prompts for the number of labels to be printed for each insurer. Type the number of labels needed, and press the Enter key. The system also prompts for the number of lines per label. The default is "6" assuming that the label requested will contain 6 lines of data. If this needs to be adjusted, type the correct number of lines. Otherwise, press the Enter key to continue.

7.5.1   Printing Labels for Selected Insurers

To print labels for selected insurers, the user is prompted to

- Select insurers by name.

- Specify the number of labels to print per insurer (default = 1)

- Specify the number of line to print on each label (default = 6)

- Specify the printer (output device).

The system reminds the user to load the mailing labels in the specified printer and allows the user to test the label alignment before printing.

For example,

```
Select 1st INSURER: NEW MEXICO MED <Enter>
(MED/MEDCARE/MEDCENTER/MEDICAID/MEDICAL/MEDICARE/MEDIGROUP/MEDMARK MEXICO NEW )

NEW MEXICO MEDICAID                   - 999 MENAUL
                                        ALBUQUERQUE, NM 87108
 OK? Y// <Enter>
Select 2nd INSURER: <Enter>

Enter Desired Number of Labels Printed Per Insurer:  (1-50): 1// <Enter>

Enter the Number of Lines per Label:  (4-8): 6// <Enter>

            (NOTE: Mailing Labels need to be loaded in the printer.)

Output DEVICE: specify printer <Enter>

PRINT TEST ALIGNMENT PATTERN? N//
```

Figure 7-8: selecting insurers for printing mailing address labels (MLPR option)

7.5.2   Printing Labels for Batches

To print labels for all insurers in a batch, the user is prompted to

- Print all export batches not previously printed, *o*r
  Select one or more specific batches.

- Specify the number of labels to print per insurer (default = 1)

- Specify the number of line to print on each label (default = 6)

- Specify the printer (output device).

The system reminds the user to load the mailing labels in the specified printer and allows the user to test the label alignment before printing.

For example,

```
Print Labels for all EXPORT BATCHES that haven't been Previously Printed?
N// <ENTER>
Select 1st EXPORT BATCH (NUMBER or DATE): T <ENTER>  JUL 02, 1997  HCFA-
1500B ALL SOURCES   WORKER,CORA

Select 2nd EXPORT BATCH (NUMBER or DATE): <ENTER>

Enter Desired Number of Labels Printed Per Insurer:  (1-50): 1// <ENTER>

Enter the Number of Lines per Label:  (4-8): 6// <ENTER>

              (NOTE: Mailing Labels need to be loaded in the printer.)

Output DEVICE: specify printer <ENTER>

PRINT TEST ALIGNMENT PATTERN? N//
```

Figure 7-9: Selecting batches for printing mailing address labels (MLPR option)

7.6   Reprint Bill (REPR)

Main Menu > PRTP > REPR

Once a bill has been printed, it may be reprinted at any time, using the Reprint Bill option. The user may reprint

- A single bill or selected bills

- All bills for an export batch

- Unpaid bills

After reprinting the bills, the system displays summary data concerning those bills, including the number of bills, number of insurers, and total amount billed.

7.6.1   Reprinting One or More Selected Bills

When option 1 Selective Bill(s) is selected, the system prompts for bills, one at a time. For example,

```
Re-Print Bills for:

     Select one of the following:

          1          SELECTIVE BILL(S)
          2          ALL BILLS FOR AN EXPORT BATCH
          3          UNPAID BILLS

Select Desired Option: 1  SELECTIVE BILL(S)


Select 1st BILL to Re-Print: 31691A
                Visit: 05-03-2009 DENTAL          DENTAL              INDIAN
HOSP
                   Bill: EMPLOYERS DENTAL SERVICES      ADA-2006
63.00


Select 2nd BILL to Re-Print:

               (NOTE: ADA-2006 forms need to be loaded in the printer.)


Output DEVICE: HOME//

                 (All Print-outs are Complete)
                 ===========================
                 Number of Records Exported: 1
                 Number of Insurers........: 1
                 Total Amount Billed.......: 63.00

Enter RETURN to continue or '^' to exit:
```

Figure 7-10: Example of reprinting one or more selected bills

7.6.2   Reprinting All Bills for an Export Batch

When the user selects option 2 ALL BILLS FOR AN EXPORT BATCH, the system prompts for an Export Batch date. This is the date that the bills were originally printed or exported. For example,

```
Re-Print Bills for:

     Select one of the following:

          1          SELECTIVE BILL(S)
          2          ALL BILLS FOR AN EXPORT BATCH
          3          UNPAID BILLS

Select Desired Option: 2  ALL BILLS FOR AN EXPORT BATCH

Select EXPORT BATCH (Date): T   DEC 01, 2009
     1   12-1-2009     CMS-1500 (08/05)                          DAY,VALENTINA
     2   12-1-2009     HCFA-1500 Y2K    ALL SOURCES              WORKER,CORA
     3   12-1-2009     ADA-2006         ALL SOURCES              WORKER,CORA
CHOOSE 1-3: 2  12-1-2009   HCFA-1500 Y2K   ALL SOURCES          WORKER,CORA

            (NOTE: HCFA-1500 Y2K forms need to be loaded in the printer.)


Output DEVICE: HOME//

                (All Print-outs are Complete)

     For Printing Mailing Labels, Worksheets or a Transmittal Listing...
     ...refer to EXPORT BATCH: 1867
                 ===========================
                 Number of Records Exported: 1
                 Number of Insurers........: 1
                 Total Amount Billed.......: 242.14

Enter RETURN to continue or '^' to exit:
```

Figure 7-11: Example of reprinting all bills for an export batch

7.6.3   Reprinting Unpaid Bills

When the user selects option 3 UNPAID BILLS, the system prompts for the form (Export Mode) on which to print and the number of bills to reprint.

```
      Select one of the following:

          1              SELECTIVE BILL(S)
          2              ALL BILLS FOR AN EXPORT BATCH
          3              UNPAID BILLS

     Select Desired Option:  3 <ENTER>   UNPAID BILLS

 Select FORM to Re-Print: ?
 Answer with 3P EXPORT MODE NUMBER, or FORMAT
Choose from:
   1              UB-82       OMB NO. 0938-0279
   2              HCFA-1500A      Old Version Dated 1-84
   3              HCFA-1500B      New Version Dated 12-90
   4              ADA-90      Dental Claim Form Dated 1990
   10             UB-92-E V4      UB-92 Electronic (NSF Version 4)
   11             UB-92       OMB NO. 0938-0279
   12             ADA-94       DENTAL ADA-94 FORM
   13             UB-92-E V5      Electronic UB-92 (NSF Version 5)
   14             HCFA-1500 Y2K      HCFA 1500 Y2K version
   15             HCFA-1500-E      Electronic HCFA-1500 (NSF Version 2.0)

Select FORM to Re-Print: 3 <ENTER>  HCFA-1500B     New Version Dated 12-90

For the parameters specified, the
          Number of Bills to Reprint: 1 <ENTER>

          (NOTE: HCFA-1500B forms need to be loaded in the printer.)

Output DEVICE: specify printer <ENTER>
Printing...

                (All Print-outs are Complete)
                ==========================
                Number of Records Exported: 1
                Number of Insurers........: 1
                Total Amount Billed.......: 95.64

Enter RETURN to continue or '^' to exit:
```

Figure 7-12: Example of reprinting unpaid bills

7.7   Manual Entry of Resubmission Number

Main Menu > PRTP > RESB

This option allows for manual entry of the resubmission number. This is used when the payer has returned a claim, and the billing technician needs to resubmit after corrections have been made. The user also has the option to reprint the bill as soon as the resubmission number has been entered.

To use this option, consider the following:

- The system displays the Bill Type field. This allows the Bill Type to be updated to correctly reflect a resubmitted bill. Normally, the third digit of the bill type indicates the submission status of the claim.

- Resubmission (Control) Number is the number that has been assigned to the claim for processing by the payer. This is also known as the Internal Control Number (ICN). The user can enter a number up to 29 characters.

- Resubmission (Control) Note is a field that allows the user to enter a message as to why they are resubmitting a claim. The entry of a message is mandatory and is stored into the bill file for historical reference. The user can enter up to 80 characters into this free-text field.

- The user has the option to review the information they entered. The system displays the user's information and the data entered. He/she can choose to make corrections if needed.

- If the information entered is correct, the user can reprint the bill at that time.

```
Select BILL or PATIENT: 31691A      DEMO,JOHN       NEVERPAY INSURANCE CO
Bill 31691A? Y// ES
Bill type: 131// 135
Resubmission (Control) Number: // 123465789000
Resubmission (Control) note: // Resubmit with correct provider ID

      Bill# 31691A   05/03/2009  OUTPATIENT      GENERAL          INDIAN HOSP
       CMS-1500    BILLED            NEVERPAY INSURANCE CO            63.00

      Bill Type: 135                  User: WORKER,CORA
      Resubmission Number: 123465789000  Date: 12/01/2009
      Notes: Resubmit with correct provider ID


Correct? Y// ES

Reprint bill? Y// ES

              (NOTE: CMS-1500 forms need to be loaded in the printer.)


Output DEVICE: HOME//
```

Figure: Example of Enter Resubmission Number (RESB) option screen

The date entered is used to populate the CMS-1500 Version 2006 and the UB-04 version. The Bill Type and Resubmission number prompts are audited and track the user who edited this information. This can be seen in the Inquire on a Bill option.

```
                     *** BILL FILE INQUIRY ***

==========================================================================
BILL NUMBER: 29733A                    BILL TYPE: 135
  VISIT LOCATION: INDIAN HEALTH HOSPITAL
  BILL STATUS: COMPLETED                PATIENT: DEMO,JOHN
  EXPORT MODE: 837 PROF (HCFA)          VISIT TYPE: PROFESSIONAL COMPONENT
  ACTIVE INSURER: MEDICARE              PROCEDURE CODING METHOD: CPT
  CLINIC: EMERGENCY MEDICINE            APPROVING OFFICIAL: TESTER,TEST
  DATE/TIME APPROVED: APR 02, 2009@09:28:48
.
.
.
DATE STMT WAS PRINTED: APR 04, 2009@08:04:58
  USER WHO PRINTED STMT: RENDER,SHONDA
  STMT NOTE: Your insurance has been billed
==========================================================================

Select BILL or PATIENT:
```

Figure: Example of BILL FILE INQUIRY with resubmission control number and note

7.8   Patient Statement

Main Menu > PRTP > REPT

This Patient Statement (REPT) option allows the user to print an itemized statement for a patient or for an insurance company requesting an itemized bill. This statement can be used to notify the patient of the services that were provided for each bill approved.

The prompts that allow the statements to print are driven by the patient's eligibility status. The menu automatically screens out beneficiary patients, but the user can select to print a beneficiary statement. The user will be able to print a statement one at a time, by approving official, or by approval date.

Note that the statement is only to be used to inform the patient or insurer of services performed for a specific service date. Payments or adjustments posted to the Accounts Receivable application do not reflect on this statement. Please refer to the Statement section of the Accounts Receivable manual for additional information on printing the A/R statement.

```
                    DEPARTMENT OF HEALTH & HUMAN SERVICES
                           INDIAN HEALTH SERVICE

                              INDIAN HOSP


                           STATEMENT OF SERVICES



     DATE   : 12/02/2009                    DEMO,THERESA
     CHART #: 3644                          2435 E INDIAN SCHOOL ROAD
     REF #  : 25665C                        PHOENIX, AZ  23456



-------------------------------------------------------------------------------
===============================================================================
|PATIENT NAME: DEMO,THERESA          |SERVICE DATE: 06/17/2004   |PAGE: 001|
-------------------------------------------------------------------------------
|VISIT TYPE: OUTPATIENT              |ATTENDING PHYSICIAN: PILLS,TED       |
===============================================================================
|SERVICE |SERVICE  |                                          |   |          |
|DATE    |CODE     |DESCRIPTION                               |QTY|AMOUNT    |
|--------|---------|------------------------------------------|---|----------|
|06/17/04|         |0009-7387-02 IBUPROFEN 800MG TAB          | 30|      5.78|
|06/17/04|         |45-0187-03 ACETAMINOPHEN 80MG/0.8ML 15ML| 30|     29.17|
|06/17/04|  120202 |0168-0035-04 VITAMIN A & D OINT           | 30|     31.19|
|06/17/04|   99212 |OFFICE/OUTPATIENT VISIT, EST              |  1|     86.00|
|06/17/04|   80051 |ELECTROLYTE PANEL                         |  1|     18.00|
|06/17/04|   A6218 |NON-STERILE GAUZE > 48 SQ IN              | 30|     30.00|
|06/17/04|   H5230 |REHABILITATIVE EVALUATION, 2             |  1|     30.00|
|06/17/04|   T1017 |TARGETED CASE MANAGEMENT                  | 12|     12.00|
|        |         |                                          |   |==========|
|        |         |                          TOTAL CHARGES|   |    242.14|
|        |         |                                          |   |          |
```

```
    |       |       |                                    |   |       |
    |       |       |                                    |   |       |
    |       |       |                                    |   |       |
    |       |       |                                    |   |       |
    |       |       |                                    |   |       |
    |       |       |                                    |   |       |
    |       |       |                                    |   |       |
    |       |       |                                    |   |       |
    |       |       |                                    |   |       |
    |       |       |                                    |   |       |
    ------------------------------------------------------------------------
    Your coverage on file is:
    3. MUTUAL OF OMAHA              TRIPLE OPTION PLAN      Eff: 01/01/1993

    ------------------------------------------------------------------------
    |Your insurance has been billed (12/01/2009)                           |
    ------------------------------------------------------------------------
    Payments or inquiries may be sent to:        INDIAN HEALTH HOSP
                                                 PO BOX 34982
                                                 PASADENA, CA  91110-0655

                                                 505 248 4349
```

Figure 7-13: Patient STATEMENT OF SERVICES screen

7.8.1   Setting-up the Header

The statement was designed with the following header:

```
                DEPARTMENT OF HEALTH & HUMAN SERVICES
                        INDIAN HEALTH SERVICE
```

Figure 7-14: Patient statement of services header

The user may edit the header to more accurately reflect the name of the billing facility or the location where services were rendered. To do so, the user will need to access the Site Parameters menu.

```
USE A/R PARENT SATELLITE SET-UP?:
MEDICARE PART B?...........: NO//
DEFAULT DENTAL CODE PREFIX.:
STATEMENT HEADER PRINT     :
```

Figure 7-15: Patient statement of services header setup

The user can enter up to 80-characters of free-text data. Once the header has been edited, it is ready for use.

7.8.2   Printing a Statement

The inclusion parameters for printing a statement are similar to how the Reprint Print Bills option works. The user may elect to print bills one by one or by statements within an approval date. The user can also sort the statements by approving official.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |              THIRD PARTY BILLING SYSTEM - VER 2.6       |
        +                    Print Patient Statement             +
        |                    INDIAN HEALTH HOSPITAL              |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                       2-DEC-2009 7:55 AM

Re-Print Statements for:

     Select one of the following:

          1             SELECTIVE STATEMENT(S)
          2             ALL STATEMENTS WITHIN APPROVED DATE RANGE
          3             APPROVING OFFICIAL

Select Desired Option:
```

Figure 7-16: Example of Re-Print Statements options

The default print option is to print non-beneficiary (non-Indian patients). A patient is considered non-beneficiary, if any insurer on the claim is a Non-Beneficiary (Indian patient) entry. A patient is considered beneficiary, if the CHS Eligibility status that has been approved on the bill is Ineligible or if any insurer on the claim is a Beneficiary (Indian patient) entry.

7.8.3   Printing Selective Statements

Statements may be printed individually. The difference between printing individually and printing in a batch is that by printing individually, the user has the option of adding a message that the patient can view. For example, the message could advise the patient of a payment amount due or to contact the Business Office.

After the bills and bill number have been entered, the system displays a prompt which gives the user the option to enter a free-text message up to 80 characters.

```
Re-Print Statements for:

      Select one of the following:

            1          SELECTIVE STATEMENT(S)
            2          ALL STATEMENTS WITHIN APPROVED DATE RANGE
            3          APPROVING OFFICIAL

Select Desired Option: 1  SELECTIVE STATEMENT(S)


Select 1st BILL to Re-Print: 25665C
              Visit: 06-17-2004 OUTPATIENT    GENERAL            INDIAN HOSP
                  Bill: NON-BENEFICIARY PATIENT       HCFA-1500 Y2K     220.14


This message will print on bottom of statement:

Your insurance has been billed

Would you like to edit it?? N// YES
Your insurance has been billed: This is your first notice. Please remit
payment promptly. Thank you.


Select 2nd BILL to Re-Print:

                (NOTE: Plain Paper needs to be loaded in the printer.)


Output DEVICE: HOME//
```

Figure 7-17: Example of adding a free text message to the statement

When printed, the bottom of the form appears similar to the following screen:

```
Your coverage on file is:
 3. MUTUAL OF OMAHA                  TRIPLE OPTION PLAN      Eff: 01/01/1993

-----------------------------------------------------------------------------
|This is your first notice. Please remit payment promptly. Thank you.      |
|(12/01/2009)                                                              |
-----------------------------------------------------------------------------
Payments or inquiries may be sent to:          INDIAN HEALTH HOSP
```

Figure 7-18: Example of printed bottom of statement

If the user selects a bill for a beneficiary (Indian) patient, the system displays the message in Figure 7-19. The user still has the option of printing the statement.

```
YOU HAVE SELECTED A STATEMENT FOR AN INDIAN BENEFICIARY.
DO YOU WISH TO CONTINUE PRINTING? N//
```

Figure 7-19: Message displayed when user selects a statement for a beneficiary patient

7.8.4   Printing All Statements within an Approved Date Range

The user may elect to print a batch of statements within an approval date range. To do this, the user selects option 2 ALL STATEMENTS WITHIN APPROVED DATE RANGE from the menu. The user can enter the range of approval dates to print the statements.

```
Select Desired Option: 2 <Enter>  ALL STATEMENTS WITHIN APPROVED DATE RANGE

Enter STARTING APPROVAL DATE for the Report:  04/02/2009// <Enter>  (APR 02, 2009)

Enter ENDING APPROVAL DATE for the Report:  04/02/2009// <Enter>  (APR 02, 2009)

       (NOTE: Plain Paper needs to be loaded in the printer.)

Output DEVICE: HOME//
```

Figure 7-20: Example of prompts for printing All Statements within Approved
Date Range option

The user does not have the choice of adding a patient message, if they print statements using option 2. Option 2 only prints statements where any insurer on the bill is a non-beneficiary (non-Indian) patient.

7.8.5   Approving Official

Use this option to apply Approving Official as an inclusion parameter. This prints the statements by the approving official.

7.9   Transmittal Listing (TRPR)

Main Menu > PRTP > TRPR

A transmittal list is a listing of all entries (bills) contained in an export batch. After selecting one or more batches by batch number or batch date, select the type of transmittal listing to print. There are two types of transmittal lists:

- The first is a continuous listing sorted by location and visit type, used for internal management and record keeping.

- The second is a listing with each insurer on a separate page, used as an attachment to a cover letter for submission with the bills.

For example,

```
              +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
              |           THIRD PARTY BILLING SYSTEM - VER 2.6           |
              +                 Transmittal Listing                     +
              |                 INDIAN HEALTH HOSPITAL                   |
              +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
              User: TESTER,TEST                       2-DEC-2009 8:01 AM

List BILLS for all EXPORT BATCHES that havn't been Previously Printed? Y//
NO


Select 1st EXPORT BATCH (NUMBER or DATE): 12/1/2009   DEC 01, 2009
    1   12-1-2009      CMS-1500 (08/05)                         DAY,VALENTINA
    2   12-1-2009      HCFA-1500 Y2K    ALL SOURCES             WORKER,CORA
    3   12-1-2009      ADA-2006         ALL SOURCES             WORKER,CORA
CHOOSE 1-3: 1  12-1-2009   CMS-1500 (08/05)                     DAY,VALENTINA
Select 2nd EXPORT BATCH (NUMBER or DATE): 1867  12-1-2009   HCFA-1500 Y2K
ALL SOURCES   WORKER,CORA
Select 3rd EXPORT BATCH (NUMBER or DATE):

AVAILABLE REPORTS:
==================

     Select one of the following:


          1           Sorted by LOCATION/VISIT TYPE
          2           Separated by INSURER for attachment to COVER LETTERS

Select desired REPORT TYPE:
```

Figure 7-21: Transmittal Listing by location and visit type

7.9.1   Transmittal Listing for Internal Use

```
AVAILABLE REPORTS:
==================

     Select one of the following:

          1          Sorted by LOCATION/VISIT TYPE
          2          Separated by INSURER for attachment to COVER LETTERS

Select desired REPORT TYPE: 1  Sorted by LOCATION/VISIT TYPE


Output DEVICE:

       WARNING: Confidential Patient Information, Privacy Act Applies
==============================================================================
TRANSMITTAL LIST (Export No: 1866,1867)                  DEC 2,2009   Page 1
Billing Location: INDIAN HOSP
==============================================================================
     "*" following the bill number denotes a bill that has been cancelled
                              BILL                                     BILL
          PATIENT            NUMBER     ACTIVE INSURER              AMOUNT
------------------------------------------------------------------------------


            Visit Location: INDIAN HEALTH HOSPITAL
OUTPATIENT
     PATIENT,VINCENT         31717A   BCBS OF NEW MEXICO (FEP)      175.00
     DEMO,THERESA            25665C   NON-BENEFICIARY PATIENT       220.14
                             ------                             ----------
             Subtotal:          2                                  395.14
                             ======                             ==========
         Total:                 2                                  395.14
```

Figure 7-22: Example of Transmittal Listing (TRPR option) for internal use

7.9.2   Transmittal List for Cover Letter

The following example of the transmittal list is intended for submission with a cover letter to each billed insurer. This report form feeds on each insurer change.

```
Select desired REPORT TYPE: 2  Separated by INSURER for attachment to COVER
LETTERS

Output DEVICE:

       WARNING: Confidential Patient Information, Privacy Act Applies
=============================================================================
TRANSMITTAL LIST for BCBS OF NEW MEXICO (FEP)           DEC 2,2009   Page 1
Billing Location: INDIAN HOSP
=============================================================================
     "*" following the bill number denotes a bill that has been cancelled
                         Bill     Visit        Visit                 Bill
     Patient            Number    Date         Location              Amount
-----------------------------------------------------------------------------
PATIENT,VINCENT          31717A  11/21/2009 INDIAN HEALTH HOSPIT      175.00
                         ------                                    ----------
   Subtotal:             1                                            175.00

Enter RETURN to continue or '^' to exit:
       WARNING: Confidential Patient Information, Privacy Act Applies
=============================================================================
TRANSMITTAL LIST for EMPLOYERS DENTAL SERVICES          DEC 2,2009   Page 1
Billing Location: INDIAN HOSP
=============================================================================
     "*" following the bill number denotes a bill that has been cancelled
                         Bill     Visit        Visit                 Bill
     Patient            Number    Date         Location              Amount
-----------------------------------------------------------------------------
DEMO,JOHN                31691A  05/03/2009 INDIAN HEALTH HOSPIT       63.00
                         ------                                    ----------
   Subtotal:             1                                             63.00

Enter RETURN to continue or '^' to exit:


       WARNING: Confidential Patient Information, Privacy Act Applies
=============================================================================
TRANSMITTAL LIST for NON-BENEFICIARY PATIENT            DEC 2,2009   Page 1
Billing Location: INDIAN HOSP
=============================================================================
     "*" following the bill number denotes a bill that has been cancelled
                         Bill     Visit        Visit                 Bill
     Patient            Number    Date         Location              Amount
-----------------------------------------------------------------------------
DEMO,THERESA             25665C  06/17/2004 INDIAN HEALTH HOSPIT      220.14
                         ------                                    ----------
   Subtotal:             1                                            220.14

Enter RETURN to continue or '^' to exit:

       WARNING: Confidential Patient Information, Privacy Act Applies
```

```
================================================================================
TRANSMITTAL LIST for NON-BENEFICIARY PATIENT                 DEC 2,2009   Page 2
Billing Location: INDIAN HOSP
================================================================================
      "*" following the bill number denotes a bill that has been cancelled
                           Bill    Visit       Visit                   Bill
     Patient               Number  Date        Location              Amount
--------------------------------------------------------------------------------
                           ------                                  ----------
       Total:              3                                          458.14
```

Figure 7-23: Example of Transmittal List (TRPR option) for cover letter

7.10   Test Forms Alignment (TSPR)

Main Menu > PRTP > TSPR

Use the Test Forms Alignment option to test the alignment of specified forms before printing bills. The system will continue to print test forms until the user responds that the alignment is correct.

> **Note:** The printer named should be the printer used
> to print the specified forms.

To test the form alignment for printing, follow these steps:

1. At the "Select Print Bills Menu Option" prompt, type **TSPR** and press the Enter key.

2. At the "Select 3P EXPORT MODE FORMAT" prompt, type the form (mode) type and press the Enter key.

3. At the "DEVICE" prompt, type the name of the printer to print the test form and press the Enter key.

4. At the "Right Margin" prompt,

   - If the right margin is at 80 (or if the user is unsure what the margin is), press the Enter key to accept the default, 80.

   - If the right margin is different than 80, type the right margin number and press the Enter key.

The system prints the test form.

5. At the "IS THE ALIGNMENT CORRECT?" prompt, do one of the following:

- If the alignment is correct, type **Y** and press the Enter key to return to the Print Bills menu.

- If the alignment is incorrect, make the necessary adjustments to the printer's alignment, type **N** and press the Enter key. Another test form is printed.

If necessary, repeat Step 5 to adjust the printer alignment and print a test form until the alignment is correct.

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       |          THIRD PARTY BILLING SYSTEM - VER 2.6          |
       +                 Test Forms Alignment                  +
       |                 INDIAN HEALTH HOSPITAL                |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: TESTER,TEST                        2-DEC-2009 8:34 AM

Select 3P EXPORT MODE FORMAT: UB-04  <Enter>     OMB No. 0938-0997
DEVICE: HOME//   (Specify printer) <Enter>    Right Margin: 80// <Enter>


IS THE ALIGNMENT CORRECT? Y// Y <ENTER>  Yes
```

Figure 7-24: Example of Test Forms Alignment (TSPR option)

7.11   Recreate Batch of ICD-9 Bills (EMPR)

Main Menu > PRTP > EMPR

The Recreate Batch of ICD-9 Bills option is used to resubmit a large number of bills to a payer that contains all ICD Procedure Codes.

Prior to Version 2.5 Patch 15, the system would place the ICD-9 Procedure code on the claim form if the All-Inclusive Mode was set for the insurer, the Bill Type of the claim was not "131," and the name of the Active Insurer billed was "Medicaid Exempt." The Version 2.5 Patch 5 removed all ICD-9 Procedure codes from the UB-04 and the 837 Institutional format. Trailblazer Health Enterprises published guidelines on correcting and resubmitting claims (See the April 5, 2007 guidelines published on the http://www.trailblazerhealth.com website for details).

This section describes the set up and resubmission of inpatient bills to Medicare that contain ICD-9 procedure codes upon the installation of Patch 15

NOTE: Please continue with the following if the user has not resubmitted Inpatient Claims upon the installation of Version 2.5 Patch 12.

1. Contact the RPMS Systems Administrator to request a patch list for the Third Party Billing (ABM) system. The user's list may look similar to the one in Figure 7-25. Write down the date Patch 5 was installed. This date will be needed when creating the electronic batch file.

```
PACKAGE: IHS 3P BILLING SYSTEM    Aug 29, 2008 8:55 am              PAGE 1
PATCH #               INSTALLED                    INSTALLED BY
------------------------------------------------------------------------
VERSION: 2.5          JUN 03, 2002                 TESTER,TEST

   1                  DEC 16, 2002                 TESTER,TEST
   2                  JAN 19, 2003                 TESTER,TEST
   3                  MAY 19, 2003                 TESTER,TEST
   837                OCT 08, 2003                 TESTER,TEST
   4                  FEB 06, 2004                 TESTER,TEST
   5                  JUN 24, 2004                 TESTER,TEST
   6                  AUG 11, 2004                 TESTER,TEST
   8                  FEB 15, 2006                 TESTER,TEST
   9                  MAR 20, 2006                 TESTER,TEST
   10                 MAR 20, 2007                 TESTER,TEST
   11                 MAY 09, 2007                 TESTER,TEST
   12                 SEP 21, 2007                 RENDER,SHONDA
   13                 JAN 29, 2008                 STARR,MARSHA
   14                 APR 28, 2008                 RENDER,SHONDA
   15                 AUG 26, 2008                 RENDER,SHONDA
```

Figure 7-25: Patch list

2. Select the Recreate batch of ICD-9 bills option from the Print Bills Menu (TP->PRTP->EMPR).

3. The system will display the criteria for creating an electronic file. The system creates a file as long as the first two numbers of the bill type equals eleven, which indicates an inpatient bill. The bill has to contain ICD-9 Procedure codes, has to be an active (Billed or Completed) bill, and has to be approved on an 837 Institutional format:

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       |          THIRD PARTY BILLING SYSTEM - VER 2.6           |
       +              Recreate batch of ICD-9 bills              +
       |                 INDIAN HEALTH HOSPITAL                  |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: TESTER,TEST                      28-AUG-2009 8:48 AM

This option will create a batch of claims that meet the following criteria:
     * Bill type is 11* where * is any number
     * The bill contains ICD Procedure codes
     * Bill status is NOT cancelled
     * 837I export mode only
```

Figure 7-26: Display of criteria for creating an electronic file

The system will also display what the user needs to enter.

```
You will be asked the following to complete the selection criteria:
     * Insurer (multiple entries not allowed)
     * Date range (either by approval, batch, or visit date)
     * Resubmission note that will be put on ALL claims

Enter RETURN to Continue:
```

Figure 7-27: Display of information the user needs to enter for creation of an electronic file

4. The system requires the user to enter the name of the insurer. Type in the name of the patient's Medicare insurer and press the Enter key.

```
Select INSURER NAME:     MEDICARE     NEW MEXICO     87125
         ...OK? Yes//    (Yes)
```

Figure 7-28: Example of selection for insurer name

5. The system will now display a list of dates to select from. Choose option A APPROVAL DATE, and use the date from the Patch History for the installation of Patch 5 of Version 2.5. For example, in this system, Patch 5 was installed on June 24, 2004. This date will be used as the begin date. Use the most recent date up to when Patch 15 of Version 2.5 was installed as your end date. For example, if Patch 15 was installed on August 10, 2008, this is the date to be used as the end date.

```
     Select one of the following:

          A          APPROVAL DATE
          B          BATCH DATE
          V          VISIT DATE

Apply range to: APPROVAL DATE
Enter FROM date:  6/24/2004
Enter TO date:  8/10/2008
```

Figure 7-29: Example of option A APPROVAL DATE

6. The system will now prompt for a Resubmission Note. This note is submitted to Medicare to notify them to reprocess claims. At the "Resubmission note" prompt, type **Justify: Other Involvement – procedure codes omitted** and press the Enter key.

```
Resubmission note: Justify: Other Involvement - procedure codes omitted
```

Figure 7-30: Resubmission note

7. The system displays the list of criteria, and what was entered by the user. Review the entries on the screen. If the user agrees with the data entered, type **YES** to continue.

```
Bills meeting the following criteria will be recreated in a new batch:
      * Bill type is 11* where * is any number
      * The bill contains ICD Procedure codes
      * Bill status is NOT cancelled
      * 837I export mode only

      * Active insurer is MEDICARE
      * Bills approved between 06/24/2004 and 08/10/2008
      * With the resubmission note: Justify: Other Involvement - procedure
        Codes omitted

Do you wish to continue? YES
```

Figure 7-31: Display of criteria list

8. The system prompts for the EMC directory. Accept the default by pressing the Enter key or type the name of the directory.

9. Type the filename used to create the Medicare files. The user must follow guidelines for naming claim files.

10. The system creates an EMC file which can be used to submit to Medicare. Please follow the instructions provided by Trailblazer when submitting claim files since Customer Service will need to be contacted prior to resubmission.

11. The system creates an entry in the 3P TX Status file. To obtain a list of bills included in the file, run the Batch Summary (TPB->EMTP->BSEM). The system displays all bills resubmitted within the time period selected.

8.0   Table Maintenance Menu (TMTP)

Main Menu > TMTP

The Table Maintenance Menu options enable users to manage specific files that are instrumental to the billing process. The available management tools vary by file type, but may include editing, listing, merging, inquiring, or establishing keyword entries.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
        +                   Table Maintenance Menu                +
        |                      DEMO HOSPITAL                      |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                        23-JUL-2009 9:08 AM


   FETM    Fee Schedule Menu ...
   CPTM    CPT File Menu ...
   PRTM    Provider Menu ...
   LOTM    Location File Menu ...
   INTM    Insurer File Menu ...
   COTM    Coverage Type File Menu ...
   SITM    Site Parameter Maintenance
   ERTM    Error Codes Menu ...
   GRTM    Group Insurance Plans Menu ...
   RVTM    Revenue Codes Menu ...
   UCTM    UB-92 Codes Menu ...
   EMTM    Employer File Menu ...
   DRTM    Drug File Menu ...
   VITM    Visit Type Maintenance
   CMTM    Charge Master Add/Edit
   DMTM    Dental Remap Table Maintenance
   FLTM    Form Locator Override
   RLTM    Add/Edit Reference Lab Locations
   SSTM    Initialize New Facility
   TMRP    Manager Reports ...

Select Table Maintenance Menu Option:
```

Figure 8-1: Example of the Table Maintenance Menu (TMTP) options

8.1   Fee Schedule Menu (FETM)

Main Menu > TMTP > FETM

The Fee Schedule Menu options enable the user to update fee schedules. These fee tables contain the charges for those goods and services provided by the user's site.

> **Note:** Since the fee schedules are no longer distributed or maintained by IHS National Programs, each site is responsible for ordering and updating their tables.

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+H
       |           THIRD PARTY BILLING SYSTEM - VER 2.6         |
       +                    Fee Schedule Menu                   +
       |                      DEMO HOSPITAL                     |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: TESTER,TEST                       23-JUL-2009 9:13 AM


   EDFE    Fee Schedule Maintenance
   LSFE    Print Fee Schedule Listing
   RPFE    CPT-Corresponding ICD-Fee Listing
   ASFE    Update ASC Fee Schedule
   DTFE    Transfer Drug Prices from Drug File
   FIFE    Import Foreign Fee Schedule
   IDFE    Increase/Decrease Fee Schedule

Select Fee Schedule Menu Option:
```

Figure 8-2: Example of Fee Schedule Menu (FETM) options

The following sections describe each of the Fee Schedule Menu options and how to use them.

8.1.1   Fee Schedule Maintenance (EDFE)

Main Menu > TMTP > FETM > EDFE

Use the Fee Schedule Maintenance option to add or modify charges associated with goods and services provided. Keeping these fees up to date is an important part of generating revenue.

Each site may have its own fee schedule. Only the fee schedule owner is allowed to modify it, providing one level of security.

Multiple fee tables per site may be necessary, if different insurers pay at different rates. For now, sites are encouraged to add a new fee table for each complete fee schedule update.

Considerations

- Items in the Medical, Surgical, Radiology, Laboratory, and Anesthesia Fee categories are restricted to certain CPT code ranges. For example, the Medical Fee category accepts only medical CPT codes at the prompt.

- Items in the Dental Fees category are identified by ADA codes, Revenue Code Fees by revenue codes, HCPCS Fees by HCPCS code.

- If choosing an item for Drug Fees or the Charge Master category, the item must first exist in the Drug or Charge Master files (respectively). However, entry of a new Charge Master item into the Charge Master file is allowed.

- When entering fees for IVs, the charge must be per unit of measure. For the calculation to be performed correctly, the unit of measure entered here must be the same as the unit of measure entered in the Drug file by the pharmacist.

To update fee schedules, follow these steps:

1. At the Fee Schedule Menu option prompt, type EDFE and press the Enter key.

2. At the "Select FEE SCHEDULE" prompt, do one of the following

   - Type the fee schedule table number and press the Enter key.

     To see a list of tables, type a question mark (**?**).

   - To create a new fee schedule, type the new fee schedule number at the prompt and press the Enter key.

3. At the "Select Desired CATEGORY" prompt, type the number (from the list displayed) of the fee schedule category to edit and press the Enter key.

4. At the "Select MEDICAL (CPT Code)" prompt, type the code to edit and press the Enter key.

The system displays the information for the selected code

5. At the "OK?" prompt, do one of the following:

   - If the code information displayed is what the user wants to edit, type **Y** and press the Enter key.

     The system displays the date of the last update to the selected code.

- If the code information displayed is not what the user wants, type **N** and press the Enter key to return to the "Select Desired CATEGORY" prompt.

6. At the "CHARGE" prompt, the current charge is displayed as the default. Type the new charge and press the Enter key.

> **Note**: For an item to be selectable in the claim editor,
> a corresponding charge in the fee table must be
> greater than zero.

The system returns to the "Select Desired CATEGORY" prompt.

```
Select FEE SCHEDULE: 1// ?
Answer with 3P FEE TABLE SCHEDULE NUMBER
Choose from:
    1       IHS STANDARD FEE SCHEDULE
    2       MEDICARE O/P SURGERY

     You may enter a new 3P FEE TABLE, if you wish
     Type a Number between 1 and 999, 0 Decimal Digits

Select FEE SCHEDULE: 1// 1 <ENTER>  IHS 1995 STANDARD FEE SCHEDULE
----- FEE SCHEDULE CATEGORIES -----

Select one of the following:

          1            MEDICAL FEES
          2            SURGICAL FEES
          3            RADIOLOGY FEES
          4            LABORATORY FEES
          5            ANESTHESIA FEES
          6            DENTAL FEES
          7            REVENUE CODE
          8            HCPCS FEES
          9            DRUG FEES
          10           CHARGE MASTER

Select Desired CATEGORY: 1 <ENTER>  MEDICAL FEES
Select MEDICAL (CPT CODE): 90720 <ENTER>    DTP/HIB VACCINE
       IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND PERTUSSIS
       (DTP) AND HEMOPHILUS INFLUENZA B (HIB) VACCINE
         ...OK? Yes// Y <ENTER>  (Yes)     - DTP/HIB VACCINE        35.00
Last Updated: 06/30/2008

CHARGE: 35// 45 <ENTER>
Select MEDICAL (CPT CODE):
```

Figure 8-3: Example of updating a FEE SCHEDULE (EDFE option)

8.1.2   Print Fee Schedule Listing (LSFE)

Main Menu > TMTP > FETM > LSFE

Use the Print Fee Schedule option to display a listing of the entries in a selected fee schedule. It is recommended to print a list after uploading a new fee schedule.

To print a fee schedule list, follow these steps:

1. At the Fee Schedule Menu option prompt, type **LSFE** and press the Enter key.

2. At the "Select FEE SCHEDULE" prompt, type the fee schedule table number and press the Enter key.

To see a list of tables, type a question mark (**?**).

3. At the "Select Desired CATEGORY" prompt, type the number (from the list displayed) of the fee schedule category to edit and press the Enter key.

4. At the "DEVICE" prompt, type the name of the printer and press the Enter key.

The system prints the fee schedule selected.

```
Select FEE SCHEDULE: 1// 1 <ENTER>   IHS 1995 STANDARD FEE SCHEDULE

======== FEE SCHEDULE CATEGORIES ========

     Select one of the following:

          1            MEDICAL
          2            SURGICAL
          3            RADIOLOGY
          4            LABORATORY
          5            ANESTHESIA
          6            DENTAL
          7            REVENUE CODE
          8            HCPCS
          9            DRUG
          10           CHARGE MASTER

Select Desired CATEGORY: 1 <ENTER>   MEDICAL

DEVICE: HOME//  (specify printer) <ENTER>
```

Figure 8-4: Example of print Fee Schedule Listing (LSFE option)

8.1.3   CPT - Corresponding ICD-Fee Listing (RPFE)

Main Menu > TMTP > FETM > RPFE

The CPT-Corresponding ICD-Fee Listing option displays every active CPT code in the CPT file, regardless of whether that code has an entry in the selected fee schedule. If a corresponding ICD description exists, it will be displayed.

To print CPT - Corresponding ICD-Fee Listing, follow these steps:

1. At the "Fee Schedule Menu option" prompt, type RPFE and press the Enter key.

2. At the "Select FEE SCHEDULE" prompt, type the fee table schedule number and press the Enter key.

To see a list of tables, type a question mark (**?**).

3. At the "Select Desired CATEGORY" prompt, type the category number and press the Enter key.

4. At the "Output DEVICE" prompt, specify the printer and press the Enter key.

5. At the "Should Output be in CONDENSED PRINT (Y/N)?" prompt, type **Y** for condensed print, if the specified printer supports it; otherwise, type **N** and press the Enter key.

Note: If you are printing the report to the screen display, type **N**.

```
Select FEE SCHEDULE: 1// 1 <ENTER>  IHS 1995 STANDARD FEE SCHEDULE

======== FEE SCHEDULE CATEGORIES ========

     Select one of the following:

          1          MEDICAL
          2          SURGICAL-ANESTHESIA
          3          RADIOLOGY
          4          LABORATORY

Select Desired CATEGORY: 1 <ENTER>  MEDICAL

NOTE: Report requires 132 Width Export Format!

Output DEVICE: HOME//  (specify printer) <ENTER>

     (This report requires 132 Width export format)

Should Output be in CONDENSED PRINT (Y/N)? Y// N <ENTER>
```

Figure 8-5: Example of printing a CPT–Corresponding ICD-Fee Listing (RPFE option)

The following figure shows an example of a CPT - Corresponding ICD-Fee report:

```
Page: 1
CPT                                                         ICD      CORRESPONDING                FEE
CODE  -      CPT DESCRIPTION                                CODE  -   ICD DESCRIPTION          AMOUNT
========================================================================================================
90700 - IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND                                   30.00
  ACELLULAR PERTUSSIS VACCINE (DTAP)
90701 - IMMUNIZATION, ACTIVE; DIPHTHERIA AND TETANUS TOXOIDS AND    99.39 - DPT ADMINISTRATION    30.00
  PERTUSSIS VACCINE (DTP)
90702 - IMMUNIZATION, ACTIVE; DIPHTHERIA AND TETANUS TOXOIDS        99.36 - DIPHTHERIA TOXOID ADMIN  16.00
  (DT)
90703 - IMMUNIZATION, ACTIVE; TETANUS TOXOID                        99.38 - TETANUS TOXOID ADMINIST  16.00

90704 - IMMUNIZATION, ACTIVE; MUMPS VIRUS VACCINE, LIVE            99.46 - MUMPS VACCINATION       19.00

90705 - IMMUNIZATION, ACTIVE; MEASLES VIRUS VACCINE, LIVE,         99.46 - MUMPS VACCINATION       19.00
  ATTENUATED

Enter RETURN to continue or '^' to exit: ^
```

Figure 8-6: Example of a CPT–Corresponding ICD-Fee Report

8.1.4   Update ASC Fee Schedule (ASFE)

Main Menu > TMTP > FETM > ASFE

Use the Update ASC Fee Schedule option to update automatically the fees in the ASC fee schedule for each CPT code related to an ASC group. There are nine ASC groups, and Medicare assigns a fee to each group.

> **Note:** Effective January 1, 2008 IHS/Tribal hospitals that have been certified to perform as ASC surgery centers will no longer submit those services to Part A. Those facilities that bill to Part B will not update their ASC fee schedule with this option.

The benefit of using this option to update the ASC Fee Schedule is that the rate for each group is entered only once, and the system updates the corresponding CPT codes automatically. The more tedious alternative to this option is to update the rate of each CPT code individually through the Fee Schedule Maintenance option.

> **Note:** It is strongly recommended that a global save of global ^ABMDFEE is done before proceeding with this option.

To update an ASC Fee Schedule, follow these steps:

1. At the "Fee Schedule Menu option" prompt, type **LSFE** and press the Enter key.

2. At the "Enter the Number of your ASC Fee Schedule" prompt, type the fee schedule table number and press the Enter key.h

To see a list of tables, type a question mark (**?**).

3. At each "Enter Rate for ASC Payment Group # (1 - 8)" prompt, type the rate for the specified group number and press the Enter key.

When rates have been entered for all groups, the system displays the rates entered for each group for review.

4. At the "Continue?" prompt, do one of the following:

    - If the rate for each group displayed is correct, type **Y** and press the Enter key.

      The system updates the group payment rates entered and displays the fees entered for review.

    - If a rate needs to change, press the Enter key to accept the default response (No). The system returns to the Fee Schedule menu.

```
Enter the Number of your ASC Fee Schedule: 2//        MEDICARE O/P SURGERY

CURRENT RATES
   Rate for ASC Payment Group 1:$0
   Rate for ASC Payment Group 2:$0
   Rate for ASC Payment Group 3:$0
   Rate for ASC Payment Group 4:$0
   Rate for ASC Payment Group 5:$0
   Rate for ASC Payment Group 6:$0
   Rate for ASC Payment Group 7:$0
   Rate for ASC Payment Group 8:$0
   Rate for ASC Payment Group 9:$0

NEW RATES
Enter Rate for ASC Payment Group #1:  56
Enter Rate for ASC Payment Group #2:  72
Enter Rate for ASC Payment Group #3:  94
Enter Rate for ASC Payment Group #4:  109
Enter Rate for ASC Payment Group #5:  122
Enter Rate for ASC Payment Group #6:  139
Enter Rate for ASC Payment Group #7:  151
Enter Rate for ASC Payment Group #8:  167
Enter Rate for ASC Payment Group #9:  190


==========================================================================

Rate for ASC Payment Group 1: $56
Rate for ASC Payment Group 2: $72
Rate for ASC Payment Group 3: $94
Rate for ASC Payment Group 4: $109
Rate for ASC Payment Group 5: $122
Rate for ASC Payment Group 6: $139
Rate for ASC Payment Group 7: $151
Rate for ASC Payment Group 8: $167
Rate for ASC Payment Group 9: $190
Continue? NO// y  YES <ENTER>

Finished.
Enter RETURN to continue or '^' to exit:
```

Figure 8-7: Example of updating the fees in the ASC fee schedule for each CPT code related to an ASC group automatically (ASFE option)

8.1.5   Transfer Drug Prices from Drug File (DTFE)

Main Menu > TMTP > FETM > DTFE

Use the Transfer Drug Prices from Drug File option to transfer the Average Wholesale Price (AWP) price per dispense unit or the cost per dispense unit from the Drug file to the Third Party Billing Fee table. The values from the Drug file will be used to populate the specified fee table in Third Party Billing.

> **Note:** For sites using the Pharmacy Point of Sale applications (POS) it is recommended to upload the average wholesale prices from the Drug File as soon as the prices are updated from the update to the Drug File.
>
> Since drug pricing can be set up in the Point of Sale application, it may be best to confirm with the software application coordinator to validate the fee schedule being used.

Before transferring the fees, the user can apply a specified percentage increase or decrease.

> **Note:** Save the global ^ABMDFEE before executing this option.

To transfer drug prices from the Drug file, follow these steps:

1. At the "Update which Fee Table Entry" prompt, type the fee table entry number and press the Enter key.

2. At the "Select Field from Drug file to Transfer" prompt, type the number that corresponds to the Drug file field to transfer data from and press the Enter key.

3. At the "Apply Percentage Increase or Decrease" prompt, type

   - **Y** (Yes) to apply a percentage increase or decrease to the price *before* storing it in the Third Party Billing Fee table.

   - **N** (No) if the user does not want to apply an increase or decrease to the price, and skip to Step 7.

4. At the "Enter Response" prompt, type

   - **1** to apply an increase to the price

   - **2** to apply a decrease to the price

5. At the "Enter Percent (0-99999)" prompt, type the percentage increase or decrease in the drug price and press the Enter key.

Type a whole number, for example, 10 (for 10%).

6. When the system displays a review of the user's selections, verify that the selections were entered correctly.

7. At the "Continue" prompt, type

- **Y** (Yes) to process the drug data entered.

  When processing completes, the system displays the word "Finished."

- **N** (No) to not process the drug data and return to the Fee Schedule menu.

```
Update which Fee Table Entry? 1// 1 <Enter>  IHS 1995 STANDARD FEE SCHEDULE

     Select one of the following:
          1          Average Wholesale Price (AWP) per Dispense Unit
                     (field# 9999999.32)
          2          Price (cost) per Dispense Unit (field# 16)

Select Field from Drug file to Transfer: 1// 1 <Enter>  Average Wholesale Price
(AWP) per Dispense Unit                        (field# 9999999.32)

Apply percentage increase or decrease? NO// Y <Enter>  YES

     Select one of the following:

          1          INCREASE
          2          DECREASE

Enter response: 1 <Enter>  INCREASE
Enter percent:  (0-99999): 10// 10 <Enter>

I will move the Average Wholesale Price per Dispense Unit field from the
Drug file to the 3P Fee Table.
I will apply a 10 percent increase.

Continue? NO// YES <Enter>.
Finished.
Enter RETURN to continue or '^' to exit
```

Figure 8-8: Example of transferring drug prices from the Drug file (DTFE option)

8.1.6   Import Foreign Fee Schedule (FIFE)

Main Menu > TMTP > FETM > FIFE

Use the Import Foreign Fee Schedule option to update a fee schedule, using fees
supplied by a third party vendor.

> **Note:** Save the global ^ABMDFEE prior to running this
> procedure.

To import a foreign fee schedule, follow these steps:

1. At the "Update which Fee Table Entry" prompt, type the Fee table number and
   press the Enter key.

   To see a list of fee table entries, type a question mark (**?**) at the prompt.

2. At the "What is the host file record delimeter?" prompt, type the delimiter used and press the Enter key.

    The default delimiter is the comma (,).

3. At the "Which piece of the host file record contains the CPT code?" prompt, type the number and press the Enter key.

    To see the number of pieces of the host file record, type a question mark (**?**) at the prompt.

4. At the "Which piece of the host file record contains the price?" prompt, type the number and press the Enter key.

5. At the "DEVICE: HOST FILE SERVER" prompt, type **HFS** and press the Enter key.

> **Note:** The foreign fee schedule file should reside on the directory used to upload into the RPMS system. Contact an RPMS Administrator for assistance if this has not already been done.

6. At the "HOST FILE NAME" prompt, type pathname location of the foreign fee schedule file and press the Enter key.

> **Note:** The Input/Output Operation field is always set to R (read).

```
Enter Fee Schedule to Update: 1// 4 <Enter>  NAVAJO AREA FEE TABLE

FOREIGN HOST FILE DESCRIPTION

What is the host file record delimiter? ,// , <Enter>
Which piece of the host file record contains the CPT code? 1// 1 <Enter>
Which piece of the host file record contains the price? 2// 2 <Enter>
OPEN AND READ FOREIGN FILE

DEVICE: HOST FILE SERVER// HFS <Enter>  HOST FILE SERVER #1
HOST FILE NAME: /file_pathname <Enter>        INPUT/OUTPUT OPERATION: R
10040,115
10060,146
10061,225
10081,278
10120,182
10121,286
10140,153
0160,120
```
Figure 8-9: Example of Importing a Foreign Fee Schedule (FIFE option)

When the system finds the appropriate data in the foreign fee schedule file, it displays the data and transfers the data to the selected fee schedule.

8.1.7   Increase/Decrease Fee Schedule (IDFE)

Main Menu > TMTP > FETM > IDFE

Use the Increase/Decrease Fee Schedule option to apply a percentage increase or decrease to a selected segment of the entire fee schedule.

To increase of decrease a segment of or the entire fee schedule, follow these steps:

1. At the "Select 3P FEE TABLE SCHEDULE NUMBER" prompt, type the number corresponding to the fee table schedule to adjust and press the Enter key.

    To see a list of available fee schedule tables, type a question mark (**?**) at the prompt.

2. At the "Enter response" prompt, type

    *   **1** to increase the fee schedule
    *   **2** to decrease the fee schedule

3. At the "Enter PERCENTAGE (0.01-100)" prompt, type the percentage increase or decrease in the fee schedule and press the Enter key.

    Type a whole number, for example, 10 (for 10%).

4. At the "Select FEE SCHEDULE CATEGORY" prompt, type the number corresponding to the fee schedule category the user wants to edit and press the Enter key.

    The system displays a summary of the user's selections.

5. At the "Are you sure" prompt, type **YES** and press the Enter key to update the fee schedule.

    If the fee schedule does not need to be updated, press the Enter key to return to the Fee Schedule menu.

In the following example, all fees in the Navajo Area Dental fee table are decreased by 10 percent.

```
Select 3P FEE TABLE SCHEDULE NUMBER: 4 <Enter>          NAVAJO AREA FEE TABLE
Select one of the following:


        1            INCREASE
        2            DECREASE

Enter response: 1// 2 <Enter>  DECREASE
Enter PERCENTAGE:  (0.01-100): 10 <Enter>

     Select one of the following:
        1            ALL
        11           SURGERY
        13           HCPCS
        15           RADIOLOGY
        17           LABORATORY
        19           MEDICINE
        21           DENTAL
        23           ANESTHESIA
        25           DRUG
        31           ROOM & BOARD

Select FEE SCHEDULE CATEGORY: 21 <Enter>  DENTAL

I am going to apply a 10 percent DECREASE to category DENTAL
 for fee schedule #4.
ARE YOU SURE? NO// YES <Enter>

Finished.
Enter RETURN to continue or '^' to exit:
```

Figure 8-10: Example of increasing or decreasing a segment of or the entire fee schedule (IDFE option)

8.2   CPT File Menu (CPTM)

Main Menu > TMTP > CPTM

The CPT file contains the procedure codes as established by the American Medical Association (AMA). This file is proprietary and requires a license from the AMA.

Version 2.6 allows for changes for use of the CPT codes from the VA. As a result, there will no longer be options in Third Party Billing that allow for the editing or adding of CPT codes.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |           THIRD PARTY BILLING SYSTEM - VER 2.6          |
          +                       CPT File Menu                     +
          |                       DEMO HOSPITAL                     |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                        23-JUL-2009 1:50 PM


   RPCP    Replacement Text for CPT File Lookups
   LSCP    Print CPT Procedure File
   IQCP    Inquire to CPT File
   LACP    LAB CPT codes to pass to TPB
   MDCP    Modifiers Add/Edit

Select CPT File Menu Option:
```

Figure 8-11: CPT File Menu options

Selecting CPT Entries

The Keyword Lookup System currently used for the ICD Diagnosis and Procedure files has been adapted for selecting CPT entries. This system enables the selection of a CPT record by entering either its code or a narrative description. When a narrative description is entered, prior to using it for lookup, replacement text is substituted for keywords and conjunctive words (less than 3 characters) are removed. Those CPT procedures that contain the altered text are displayed for selection.

Keywords for the Lookup System have not been provided for the CPT file. It is recommended that the local site establish its own keywords (see Section 8.2.1 "Replacement Text for CPT File Lookups (RPCP)").

8.2.1   Replacement Text for CPT File Lookups (RPCP)

Main Menu > TMTP > CPTM > RPCP

Use the Replacement Text for CPT File Lookups option to specify the replacement text used by the CPT keyword lookup system.

When using this option, the system displays a prompt to enter the keyword (replacement text).

To specify replacement text for a CPT keyword, follow these steps:

1. At the "Fee Schedule Menu option" prompt, type **RPCP** and press the Enter key.

2. At the "Select REPLACED TEXT" prompt, type the keyword text and press the Enter key; for example, UA.

3. At the "REPLACED TEXT [*text*]" prompt,

   - If the keyword [*text*] is correct, press the Enter key.

   - If the keyword [*text*] is incorrect, type the correct keyword text and press the Enter key.

4. At the "REPLACEMENT" prompt, type the text that will replace the keyword and press the Enter key; for example, URINALYSIS.

```
Select REPLACED TEXT: UA <Enter>
  REPLACED TEXT: UA// <Enter>
  REPLACEMENT: URINALYSIS <Enter>
```

Figure 8-12: Example of entering replacement text for CPT keyword file lookup
(RPCP option)

8.2.2   Print CPT Procedure File (LSCP)

Main Menu > TMTP > CPTM > LSCP

Use the Print CPT Procedure File option to list the following CPT code-related information, as stored in the CPT Procedure file:

- Short name
- Description
- CPT category

- ASC Payment Group

- Corresponding ICD code

- Inactivation status

- Starred procedure status

The listing can be restricted to a designated CPT Code range. The listing is in CPT Code order unless specified differently.

To print or display CPT information in the CPT Procedure file, follow these steps:

1. At the "Fee Schedule Menu option" prompt, type **LSCP** and press the Enter key.

2. At the "SORT BY" prompt, type the field number or label to be used to sort the list.

   The default is by CPT code. To see the list of sort options, type two question marks (**??**) at the prompt.

3. At the "START WITH [*field type*]" prompt, type the starting point of the selected sort field or label.

   Depending on the field or label selected, first, last, a particular date, or another item can be specified.

4. At the "DEVICE" prompt,

   - Press the Enter key to display the list on the screen, or

   - Type the name of the printer; and at the "Right Margin" prompt, press the Enter key to accept the default value of 80, or type the size of the right margin.

```
SORT BY: CPT CODE// <Enter>
START WITH CPT CODE: FIRST// <Enter>
DEVICE: HOME <Enter>  Right Margin: 80// <Enter>
```

Figure 8-13: Example of printing CPT information in the CPT Procedure file (LSCP option)

8.2.3   Inquire to CPT File (IQCP)

Main Menu > TMTP > CPTM > IQCP

Use the Inquire to CPT File option to display all the available information for a selected CPT code.

To display the information for a specified CPT code, follow these steps:

1. At the "Fee Schedule Menu option" prompt, type **IQCP** and press the Enter key.

2. At the "CPT CODE" prompt, type the number of the CPT code the user wants to view and press the Enter key.

   The system displays the CPT short name and description for review.

3. At the "OK?" prompt, press the Enter key to verify that the correct CPT code was selected, and to display all related information.

   To return to the CPT File Menu, type **N** (No) and press the Enter key.

```
Select CPT PROCEDURE: 20206 <Enter>    NEEDLE BIOPSY, MUSCLE
       BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE

                       *** CPT PROCEDURE FILE INQUIRY ***
===============================================================================
CPT CODE: 20206                         SHORT NAME: NEEDLE BIOPSY, MUSCLE
  CPT CATEGORY: MUSCULOSKELETAL SYSTEM  SOURCE: CPT
  ACTIVE DATE: OCT 01, 1990
EFFECTIVE DATE: OCT 01, 1990            STATUS: ACTIVE
VERSION DATE: OCT 01, 1990
  SHORT NAME (VERSIONED): NEEDLE BIOPSY, MUSCLE
VERSION DATE: OCT 01, 1990
DESCRIPTION (VERSIONED): BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE
  ASC PAYMENT GROUP: 01                 DATE ADDED: 2005
DESCRIPTION: BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE
CORRESPONDING ICD CODES: 83.21
===============================================================================

Select CPT PROCEDURE:
```

Figure 8-14: Example of CPT Procedure File inquiry (IQCP option)

8.2.4   LAB CPT Codes to Pass to TPB (LACP)

Main Menu > TMTP > CPTM > LACP

Use the LAB CPT Codes for the Pass to TPB option to enter the Pathology, Cytology, and Blood Bank CPT Code in the 3P CPT Code file. Once the codes reside in 3P CPT Code file and have been entered into PCC through the CPT Mnemonic option, the claim generator code is updated to pass the information to Third Party Billing.

Historically, Pathology, Cytology, and Blood Bank codes were never sent to PCC. As a result, the Third Party Billing system did not pick up those lab codes. Also, several IHS sites that do not use the Laboratory package were using the CPT mnemonic option in PCC. Those lab codes were not designed to cross over to the Third Party Billing package. Third Party Billing was modified to allow Laboratory CPT codes to pass to Third Party Billing.

To specify the LAB CPT Codes to pass to 3rd Part Billing, follow these steps:

1. At the "Fee Schedule Menu option" prompt, type **LACP** and press the Enter key.

2. At the "Lab CPT Table Entry" prompt, type the table entry number and press the Enter key.

3. At the "Are you adding a new 3P CPT TABLE?" prompt, type **Y** (Yes) and press the Enter key to continue.

If the Enter key is pressed (No), the system returns to the CPT File menu.

4. At the "LEVEL" prompt, type the table entry number and press the Enter key.

5. At the "Low CPT" prompt, type the beginning number of CPT codes to cross and press the Enter key.

For example, if all lab codes need to cross, type **80000**. If a range of CPT Pathology codes need to cross, type **88300**.

6. At the "High CPT" prompt, type the ending number of CPT codes to cross and press the Enter key.

For example, if all lab codes need to cross, type **89999**. If only Pathology codes should cross, type **88399**.

```
Select Lab CPT table entry: 18 <Enter>
  Are you adding a new 3P CPT TABLE? No// Y <Enter>  (Yes)
    LEVEL: 18 <Enter>
Low CPT:  (80000-89999): // 80000 <Enter>
High CPT:  (80000-89999): // 89999 <Enter>
Select Lab CPT table entry:
```

Figure 8-15: Example of specifying Lab CPT codes to pass to 3rd Party Billing (LACP option)

8.2.5   Modifiers Add/Edit (MDCP)

Main Menu > TMTP > CPTM > MDCP

Use the Modifiers Add/Edit option to change a CPT modifier code. At this time, the user is only allowed to edit the description of the modifier.

To add or edit a CPT Modifier code, follow these steps:

1. At the "Fee Schedule Menu option" prompt, type **MDCP** and press the Enter key.

2. At the "Select CPT Modifier Code" prompt, type the modifier code to edit and press the Enter key.

3. At the "OK?" prompt, the system displays additional information for user verification.

    – Press the Enter key for the default (Yes) to verify, or
    – Type **N** (No) and press the Enter key to return to the "Select CPT Modifier Code" prompt.

4. At the "DESCRIPTION" prompt, type the new or revised description for the modifier.

    Note: The description has a 150-character maximum

If a description exists for this modifier, the system displays it between the prompt and two slashes (//). Do one of the following:

- Press the Enter key to accept the displayed description, or

- Type a new description and press the Enter key.

```
Select CPT MODIFIER CODE: 76 <Enter>    REPEAT PROCEDURE BY SAME PHYSICIAN
        ...OK? Yes// : <Enter> (Yes)
DESCRIPTION: REPEAT PROCEDURE BY SAME PHYSICIAN   Replace <Enter>
```

Figure 8-16: Example of adding/editing a CPT Modifier code (MACP option)

8.3   Provider Menu

The provider menu allows the user to view provider data, add/edit Legacy provider numbers, and add/edit provider National Provider Index number (NPI).

```
             +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
             |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
             +                        Provider Menu                   +
             |                   INDIAN HEALTH HOSPITAL               |
             +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
             User: TESTER,TEST                    30-MAR-2009 3:42 PM

   PRTM   Inquire to Provider File
   PETM   Provider Number Edit
   NPI    Add/Edit NPI values for Providers

Select Provider Menu Option:
```

Figure 8-17 : Provider Menu option

8.3.1   Inquire to Provider File (PRTM)

Main Menu > TMTP > PRTM > PRTM

Use the Inquire to Provider File option to view all of the information in the Provider file for a selected provider. Only those fields that contain data are displayed.

To view the information in the Provider file for a specified provider, follow these steps:

1. At the "Table Maintenance Menu Option" prompt, type **PRTM** and press the Enter key.

2. At the "Select Provider Menu Option" prompt, type **PRTM** and press the Enter key.

3. At the "Select Provider" prompt, type the name of the provider and press the Enter key.

If the system finds a match in the Provider file, it displays the available information for the specified provider.

```
                       *** PROVIDER FILE INQUIRY ***

===============================================================================
NAME: PHYSICIAN,MARY                      INITIAL: MP
  DISUSER: YES                            TITLE: PHYSICIAN
  PERSON FILE POINTER: PHYSICIAN,MARY   NICK NAME: MARY
  STREET ADDRESS 1: 1000 MEDICAL DRIVE  CITY: JOHNSTON
  STATE: RHODE ISLAND                    ZIP CODE: 02919
  OFFICE PHONE: 555 555-5555             SEX: FEMALE
  DOB: JUN 30, 1944                      DATE ENTERED: NOV 09, 1999
  CREATOR: SITEMANAGER,ROGER             SSN: 555555555
  XUS Active User: No                    Entry Last Edit Date: OCT 14, 2004
  NAME COMPONENTS: 200                   SERVICE/SECTION: MEDICAL STAFF
  SIGNATURE BLOCK PRINTED NAME: RODERICK T BEAMAN
KEY: PROVIDER                            GIVEN BY: SITEMANAGER,ROGER
```

```
  DATE GIVEN: NOV 09, 1999
  MULTIPLE SIGN-ON: ALLOWED               AFFILIATION: IHS
  CODE: MPA                               MEDICARE PROVIDER NUMBER: 320099
  MEDICAID PROVIDER NUMBER: Z99999        UPIN NUMBER: Z9999
  IHS ADC INDEX: 100MPA
INSURER: PAYLESS INSURANCE COMPANY
  PAYER ASSIGNED PROVIDER NUMBER: 998989998
INSURER: ANYSTATE MEDICAID
  PAYER ASSIGNED PROVIDER NUMBER: XX293983
  AUTHORIZED TO WRITE MED ORDERS: YES   DEA#: AJ2008832
  VA#: 1000883                          PROVIDER CLASS: PHYSICIAN
  PROVIDER TYPE: PART TIME
LICENSING STATE: RHODE ISLAND           LICENSE NUMBER: D0990909
===========================================================================
```

Figure 8-18: Example of report on specified provider from Provider File (PRTM option)

8.3.2   Provider Number Edit

This option allows the user to enter Legacy provider numbers for those payers accepting the Legacy number. The option allows entry of the following:

- Medicare Provider Number – Part A only

- Medicaid Provider Number

- UPIN

- State License Number

- Payer Assigned Provider Number

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            |           THIRD PARTY BILLING SYSTEM - VER 2.6           |
            +                    Provider Number Edit                  +
            |                       DEMO HOSPITAL                      |
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            User: TESTER,TEST                        27-JUL-2009 9:51 AM

Enter Provider Name:    PHYSICIAN,MARY

     CURRENT MEDICAID NUMBER:

MEDICARE PROVIDER NUMBER: 320099
MEDICAID PROVIDER NUMBER: Z99999
UPIN NUMBER: Z9999
Select LICENSING STATE: NEW MEXICO
  Are you adding 'NEW MEXICO' as a new LICENSING STATE (the 1ST for this NEW
PERSON)? No// YES  (Yes)
  LICENSE NUMBER: 12345667
Select INSURER: MEDICAID( MEDICAID )
.....................................................
Are you adding 'MEDICAID' as
a new PAYER ASSIGNED PROVIDER NUMBER (the 3RD for this NEW PERSON)? No// YES
  PAYER ASSIGNED PROVIDER NUMBER: 12345

Enter Provider Name:
```

Figure 8-19: Provider Number Edit screen

8.3.3   Adding the NPI Number in RPMS

When selected, the NPI option displays the "Select Provider" prompt. At this prompt, type the name of the provider for which the NPI is being entered. To be selected, the provider must be stored in the New Person File (File #200).

After selecting the name of the provider, the system prompts the user to enter the NPI. Once the user enters a valid number, the system will display a re-verification prompt. Enter the number again. Entering the number correctly alerts the user that the number was saved successfully.

For example,

```
             +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
             |                THIRD PARTY BILLING SYSTEM - VER 2.5           |
             +                Add/Edit NPI values for Providers             +
             |                   INDIAN HEALTH HOSPITAL                      |
             +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
             User: TESTER,TEST                         30-MAR-2009 3:44 PM

Select Provider: UNDER,ANESTASIA        ADU
This user doesn't have a Taxonomy Code indicating a need for an NPI.
Provider: UNDER,ANESTASIA   XXX-XX-   DOB:

Enter NPI (10 digits): 1234567810
Please re-enter NPI  : 1234567810

For provider UNDER,ANESTASIA the NPI 1234567810
was saved to VistA successfully.
```

Figure 8-20: Example of entering the NPI for a provider

Tips for Entering the NPI Number

The Indian Health Service has adopted the standard of entering the NPI from the Veterans Administration. As a result, logic has been associated to the entry of the NPI. It is helpful to keep the following points in mind when entering an NPI:

- An NPI can never be entered more than once. This prevents the duplication of NPI entries by provider. For example,

```
Select Provider: RADISSON,RONALD        RR
This user doesn't have a Taxonomy Code indicating a need for an NPI.
Provider: RADISSON,RONALD   XXX-XX-   DOB:
Enter NPI (10 digits): 1234567802
That NPI value is already associated with DOCTOR,TRUDEL
```

Figure 8-21: Screen for entering the NPI number

- The Provider Taxonomy code is required when submitting claims that contain a provider or institution NPI.

Because of this, users must ensure that the correct Provider Taxonomy code has been submitted with the provider's NPI application. Also, the user may have to verify the Provider Taxonomy code used, from the View Provider option on Page 4 of the Claim Editor.

- The National Provider Identifier check digit is calculated using the Luhn formula for computing the modulus 10 "double-add-double" check digit. This logic applies during the entry of the NPI.

If the user enters an invalid NPI, the system will display the following response:

```
Enter NPI (10 digits): 1234567813
NPI values have a specific structure to validate them...
The Checksum for this entry is not valid
```

Figure 8-22: Error message when NPI number is invalid

- A message will be displayed, if the NPI already exists. At this point, the user has the option of deleting or replacing the current value. For example,

```
Select Provider: UNDER,ANESTASIA        ADU
This user doesn't have a Taxonomy Code indicating a need for an NPI.
This provider already has an NPI value (1234567810) entered.

     Select one of the following:


        D          Delete
        R          Replace

Do you want to (D)elete or (R)eplace this NPI value?:
```

Figure 8-23: Message if NPI number already exists

Once the National Provider Identifier has been added, it is ready for use in the Claim Editor and on claim forms.

8.4   Location File Menu (LOTM)

Main Menu > TMTP > LOTM

The Location file contains the demographic data for each IHS facility. The menu options for managing the Location file are

- Location File Maintenance (EDLO)

- Display Location File Entry (IQLO)

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |           THIRD PARTY BILLING SYSTEM – VER 2.6           |
        +                     Location File Menu                   +
        |                       DEMO HOSPITAL                      |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                          27-JUL-2009 9:55 AM


  EDLO    Location File Maintenance
  IQLO    Display Location File Entry

Select Location File Menu Option:
```

Figure 8-24: Location File Menu options (LOTM option)

8.4.1   Location File Maintenance (EDLO)

Main Menu > TMTP > LOTM > EDLO

Use the Location File Maintenance option to edit the data in the Location file.

All billing locations must be entered with complete data. The user must have the mailing address **and** the physical address where services are rendered. Sites that are billing home or school services may use the physical address of the parent billing location.

If data exists for any of the following fields, the system displays the information between the prompt and two slashes (//).

- Mailing Address–Street, City, State, Zip. These fields are used to identify the mailing or correspondence address for the facility where services were rendered. This is also the address where the payment will be sent to. Please use **caution** when updating these fields as they do affect other software applications in RPMS.

- Phone. Used to note the phone number for the facility.

- Federal Tax Number

- Medicare Number

- Street Address–Street, City, State, Zip. These fields are used to populate the physical address needed to designate the physical location where services were rendered.

- Place of Service Code

- Bill Number Suffix

- Medicare B Only (Yes/No)

For any prompt that displays data from the file, do one of the following:

- To accept the current information, press the Enter key.

- To change the current information, type the new data after the two slashes and press the Enter key.

To edit the Location File, follow these steps:

1. At the "Location File Menu Option" prompt, type **EDLO** and press the Enter key.

2. At the "Select Location to Edit" prompt, type the facility name or ASUFAC (Area Service Unit-Facility Code) and press the Enter key.

3. Use the following table to guide you through the prompts to add or edit information.

Prompt:	Action:
Mailing Address-Street	Add or edit the street mailing address of the selected location and press the Enter key. This address will appear in Box 33 of the CMS-1500 or Box 1 of the UB-04.
Mailing Address-City	Add or edit the city mailing address of the selected site and press the Enter key.
Mailing Address-State	Add or edit the state mailing address of the selected site and press the Enter key.
Mailing Address Zip	Add or edit the zip code mailing address of the selected site and press the Enter key.
Phone	Add or edit the phone number of the selected site and press the Enter key.
Federal Tax No.	Add or edit the federal tax number assigned to the selected site and press the Enter key.
Medicare No.	Add or edit the Medicare number assigned to the selected site and press the Enter key.
Street Address 1	Add or edit the physical location of the selected site and press the Enter key. This is the location where services were rendered and displays in Box 32 of the CMS-1500 or Box 2 of the UB-04.
Street Address 2	Add or edit the physical location second address of the selected site and press the Enter key.
City	Add or edit the physical location city of the selected site and press the Enter key.
State	Add or edit the physical location state of the selected site and press the Enter key.
ZIP	Add or edit the physical location ZIP code of the selected site and press the Enter key.
Place of Service Code	Add or edit the place of service code of the selected site and press the Enter key.
Bill Number Suffix	Add or edit the Bill number suffix of the selected site and press the Enter key. **Note:** This field enables the site to identify quickly where the bill resides and is very useful for those sites that utilize the Use A/R Parent/Satellite option to bill for non-IHS locations.

Prompt:	Action:
Medicare B Only	If the selected site is a freestanding clinic **and** the clinic can bill Medicare Part B only, type **Y** (yes) and press the Enter key. Otherwise, type **N** (no) and press the Enter key. **Note:** Before a freestanding clinic site can bill Medicare Part B, Medicare must be made billable and address information must be entered, which can be done using the Table Maintenance menu option, Insurer File (INTM).

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       |           THIRD PARTY BILLING SYSTEM - VER 2.6        |
       +              Location File Maintenance                +
       |                    DEMO HOSPITAL                      |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: TESTER,TEST                         27-JUL-2009 9:57 AM



Select LOCATION to Edit: DEMO HOSPITAL     HEADQUARTERS WEST     NON SERVICE
 UNIT        01                   XX  IHS        497

MAILING ADDRESS-STREET: PO BOX 12345
MAILING ADDRESS-CITY: SILVER CITY
MAILING ADDRESS-STATE: NEW MEXICO
MAILING ADDRESS-ZIP: 99999
PHONE: (555)555-5555
FEDERAL TAX NO.: 85-9999999
MEDICARE NO.: 320099

STREET ADDR. 1: 505 NORTH 1ST STREET
STREET ADDR. 2:
CITY: SILVER CITY
STATE: NM  NEW MEXICO
ZIP: 99999

PLACE OF SERVICE CODE: 22
BILL NUMBER SUFFIX: DH
MEDICARE B:
```

Figure 8-25: Example of Location File Maintenance (EDLO option)

8.4.2   Display Location File Entry (IQLO)

Use the Display Location File Entry option to display all the available information in the Location file for a selected facility. This option displays only those fields containing data.

To display the information for a specified facility in the Location file, follow these steps:

1. At the "Location File Menu Option" prompt, type **IQLO** and press the Enter key.

2. At the "Select Location to Edit" prompt, type the facility name or ASUFAC (Area Service Unit-Facility Code) and press the Enter key.

The system displays the information from the Location file for the selected site. For example,

```
                        *** LOCATION FILE INQUIRY ***

========================================================================
NAME: DEMO HOSPITAL                        SHORT NAME: DEMO HOSP
  AREA: HEADQUARTERS WEST                  SERVICE UNIT: NON SERVICE UNIT
  CODE: 01                                 ABBRV: DEMO
  ASUFAC INDEX: 230001                     PHONE: (555)555-5555
  MAILING ADDRESS-STREET: PO BOX 12345  MAILING ADDRESS-CITY: SILVER CITY
  MAILING ADDRESS-STATE: NEW MEXICO     MAILING ADDRESS-ZIP: 99999
  FACILITY LOCATION CODE: 999              FINANCIAL LOCATION CODE: 032
  FEDERAL TAX NO.: 85-9999999              MEDICARE NO.: 320099
  MODIFIED DATE: DEC 11, 2001              STATE: NEW MEXICO
  PSEUDO PREFIX: ZZZ                       UNIQUE RPMS DB ID: 99999
BEGIN DATE: JAN 01, 1960                   AFFILIATION: IHS
  IHS/NON-IHS: IHS FAC                     FACILITY TYPE: HOSPITAL
  ASUFAC CODE: 999901                      CLASS: GENERAL ACUTE CARE HOSPITAL
========================================================================
```

Figure 8-26: Example of a Location File Display for a selected site (IQLO option)

8.5   Insurer File Menu (INTM)

Main Menu > TMTP > INTM

When the Billing system is installed, approximately 800 insurers, complete with demographic information, are added to the Insurer file. These insurers comprise the majority of the largest insurance carriers in the nation. However, they do not comprise all of the nation's insurance carriers, so adding insurers locally is still necessary.

Use the Insurer File Menu to view and edit the contents of the Insurer File, and add new insurers. The Insurer File Menu options are:

- Add/Edit Insurer (EDIN)

- Replacement Text for Insurer Lookups (RPIN)

- Display Insurer Info (IQIN)

- Merge Duplicate Insurers (MRIN)

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.6         |
          +               Insurer File Menu                      +
          |             INDIAN HEALTH HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                        2-DEC-2009 11:52 AM


   EDIN   Add/Edit Insurer
   RPIN   Replacement Text for Insurer Lookups
   LSIN   Insurer Listing
   IQIN   Display Insurer Info (Inquire)

Select Insurer File Menu Option:
```

Figure 8-27: Insurer File Menu Options (INTM option)

Insurer Selection

The Keyword Lookup System currently used for the ICD Diagnosis and Procedure files has been adapted for selecting insurers. This system alters the text entered by substituting replacement text for keywords and removing conjunctive words. The text is then broken into individual words and matched against the Insurer file. Those insurers that contain all of the individual words in the Long Lookup Name field are considered hits and are displayed for selection.

In the following example, the keywords BC and CA are entered. The system matches BC to display BLUE CROSS and CA to display CALIFORNIA. The system finds and displays one insurer match, Blue Cross of California.

```
Select INSURER: BC CA <Enter>
( BLUE CROSS CALIFORNIA)

BLUE CROSS OF CALIFORNIA
- PO BOX 70000                        Domain: CA
VAN NUYS, CA 91470
```

Figure 8-28: Example of using keywords to display insurers

8.5.1   Add/Edit Insurer (EDIN)

Main Menu > TMTP > INTM > EDIN

Use the Add/Edit Insurer option to add or edit insurers in the Insurer file. Whether the user is adding a new insurer or editing an existing one, the prompts are the same.

Before adding a new insurer, search through the existing insurers first to prevent the creation of duplicate records.

Remember: When editing a field, the existing text displays between the prompt and two slashes (//).

- To keep the existing text, press the Enter key at the prompt.

- To change the existing text, type the new text after the two slashes (//) and press the Enter key, which replaces the existing data.

To add/edit an Insurer, follow these steps:

Note: The FileMan caret (^) Jump feature is not allowed when using the Add/Edit Insurer File option.

1. At the "Insurer File Menu Option" prompt, type **EDIN** and press the Enter key.

2. At the "Select Desired Action" prompt, type one of the following:

   - **1** to edit an existing insurer

   - **2** to add a new insurer

3. If the user selects 1 to edit an existing insurer, the system prompts him/her to screen out insurers flagged as unselectable. For example,

```
     Select one of the following:

          1          EDIT EXISTING INSURER
          2          ADD NEW INSURER

Select DESIRED ACTION: 1 <Enter>  EDIT EXISTING INSURER

Screen-out Insurers with status of Unselectable? Y// <Enter>  YES

Select INSURER:
```

Figure 8-29: Selecting to edit existing insurer

A deactivated insurer cannot be edited if the default (Yes) is accepted.

4. Prompts are displayed by category. Add text or changed text for any/all of the following insurer data categories:

    a. Demographics

    b. Billing Status

    c. Electronic Media Claims (EMC) and Plan Name

    d. Group Number and Provider Data

    e. Visit Type(s)

5. Continue adding/editing visit types until all additions/changes are made.

6. When finished, at the "Select Visit Type" prompt, press Enter to return to the Insurer File menu.

8.5.1.1 Add/Edit Insurer Demographics

The following prompts are related to the insurer's demographic information.

Mailing Address

Use the following table to guide you through the prompts to add or edit information.

Mailing Address Prompt:	Action:
Street	Add or edit the street mailing address and press the Enter key. If a Billing Address is entered, that address will be used to print on claim forms. This address is used if the Billing Address prompts are blank. This address is also used when looking up insurance companies.
City	Add or edit the city mailing address and press the Enter key.
State	Add or edit the state mailing address and press the Enter key.
Zip Code	Add or edit the zip code mailing address and press the Enter key.

Billing Address

The Billing Address fields should be entered only when an insurer has a mailing address for correspondence and a billing address for bill submission.

Use the following table as a guide for the prompts to add or edit information.

Billing Address Prompt:	Action:
Billing Office	Add or edit the Billing address (if different than Mailing Address) and press the Enter key. This address is printed on the claim forms. If the billing and mailing addresses are the same, press the Enter key at this prompt to continue.
Phone Number	Add or edit the billing office phone number and press the Enter key.
Contact Person	Add or edit the billing office contact person for your site and press the Enter key.
Federal Tax ID#	Type the Tax Identification Number used by this payer. This is used for IHS Federal Locations only and is used by the federal financial system to identify the payer billed.
AO Control Number	Add or edit the insurer's AO Control Number and press the Enter key. The **AO control number** is used to eliminate duplicate insurers. This value should match the number assigned to the insurer by the National Association of Insurance Commissioners (NAIC). When sending bills electronically, the AO control number identifies the insurer. This number can also be used to select the insurer. For electronic billing purposes, this field populates the ISA08 element of the HIPAA 837 Version 4010.

```
<--------------- MAILING ADDRESS --------------->
Street...: 123 MAIN// <Enter>
City.....: ANYWHERE// <Enter>
State....: NEW MEXICO// <Enter>
Zip Code.: 12345// <Enter>

<--------------- BILLING ADDRESS --------------->
      (if Different than Mailing Address)
Billing Office.: <Enter>

Phone Number.......: (###)###-####// <Enter>
Contact Person.....: FIRSTNAME LASTNAME <Enter>
Federal Tax ID#....: 859999999 <Enter>
AO Control Number..: 55387 <Enter>
```

Figure 8-30: Adding/editing Insurer demographic information

8.5.1.2   Add/Edit Insurer Billing Status

The following prompts are related to the insurer's status.

Use the following table to guide you through the prompts to add or edit information.

Insurer Status Prompt:	Action:
Insurer Status	Type **BILLABLE**, **UNBILLABLE**, or **UNSELECTABLE** and press Enter. If the insurer status is: • Unbillable, no claims for the insurer can be created or approved. • Unselectable, the Patient Registration system can not use this insurer when adding new eligibility but claims will continue to generate.
Type of Insurer	Type the category, for example, MEDICARE, PRIVATE INSURANCE, MEDICARE, or other and press the Enter key. This category can be used as a restrictive parameter when printing bills or reports. Care should be taken when changing the value of this field as it may impact reports, or processes in the claim generator.
All Inclusive Mode	Type **Y** (Yes) or **N** (No) and press the Enter key. If Y (Yes), this field designates that the insurer is to be billed at an All-Inclusive (flat) rate, and the Flat Rate fields can be edited for a Visit Type and select a Prior Approval Required ICD9 code.
Backbill Limit (months)	Type the number of previous months that billing is allowed to occur for this insurer. Claims prior to this value will not generate.
Dental Bill Status	Type **U** (Dental visits are unbillable) if the Dental visit is not billable or type Type **O** (Only Dental visits are billable) and press the Enter key.
RX Billing Status	Type **U** to make Prescription claims unbillable. Type **O** to allow outpatient medications to display in the claim editor. Type **P** to indicate that claims submitted to this payer are submitted via the Pharmacy Point of Sale system. If set to P, medication data will not display on the claim.

Insurer Status Prompt:	Action:
Select Clinic Unbillable	Enter any additional clinic types that the insurer considers unbillable and press the Enter key. **Note:** If the user removes entries from this field, a Backbilling Check must be tasked.

```
Insurer Status.....: BILLABLE// <Enter>
Type of Insurer....: PRIVATE INSURANCE// <Enter>
All Inclusive Mode.: <Enter>
Backbill Limit (months): 2 <Enter>
Dental Bill Status.: DENTAL VISITS ARE UNBILLABLE
        //<Enter>
Rx Billing Status..: <Enter>

Select CLINIC UNBILLABLE:
```

Figure 8-31: Adding/editing insurer status information

8.5.1.3   Add/Edit Electronic Media Claims (EMC) and Plan Name

The following prompts must have values if the Mode of Export is 837-I, 837-P, 837-D or any of the UB-92-E (electronic UB-92) or HCFA-1500-E formats. If no values are entered, the entire batch of bills sent electronically will be rejected by the payer.

Use the following table to guide you through the prompts to add or edit information.

EMC related Prompt:	Action:
EMC Submitter ID	Add or edit the login ID assigned to your facility by the insurer and press the Enter key. Data in this field populates the ISA06 and GS02 elements of the 837 formats.
EMC Password	Add or edit the system password assigned to your facility by the insurer and press the Enter key. Data in this field populates the ISA04 element of the 837 format.
EMC Test Indicator	Type **T** to mark the transmission as a test transmission. If the transmission is NOT a test, leave blank and press the Enter key. Data in this field populates the ISA15 element of the 837 formats.
Use Plan Name?	This field is used by locations that bill to Medicare managed care plans. Type **Y** to use the Medicaid managed care plan instead of billing to the state Medicaid plan. Type **N** or leave blank and press the Enter key to use the insurer name. All claims for the Medicaid Managed Care plan will generate under the state Medicaid insurer.

```
        EMC SUBMITTER ID: IHSIHS <Enter>
        EMC PASSWORD: XXXXXX <Enter>
        EMC TEST INDICATOR: <Enter>
        USE PLAN NAME?: Y <Enter>  YES
```

Figure 8-32: Adding/editing Electronic Media Claims (EMC option) information

8.5.1.4 72-Hour Rule

The following lists the rules for establishing the 72-hour rule in the insurer file.

If the service category for the visit is ambulatory or day surgery, and the primary payer has an insurer type of Medicare (including railroad retirement) or Medicaid, and the 72 Hour Rule is set to **yes**, the system will check all visits that occur within the last 72 hours.

```
72 HOUR RULE: YES
```

Figure 8-33: The 72-hour rule set to Yes in the insurer file

8.5.1.5   Select NPI Usage Indicator

Every payer that is affected by National Provider Identifier (NPI) will need to be updated by entering a value into the NPI USAGE field.

The NPI USAGE field can contain one of the following values:

NPI Indicator:	Action:
NPI Only	Print and display the NPI on the claim forms. Payers that require the NPI to only be submitted will need to use this status. For the electronic forms, the Tax Identification Number of the facility will also be used.
NPI & Legacy	Display both the NPI and Legacy number on the claim forms. Payers that allow the NPI and the Legacy number to be submitted will use this status.
Legacy Only	Prints and displays the legacy number only. The Legacy number is the number that currently prints on the claim forms.

If the field is left blank, the system will continue to use the existing format of displaying/printing the provider numbers on the claim forms (also known as the LEGACY ONLY status).

```
NPI USAGE: ??

     Choose from:
       N          NPI ONLY
       B          NPI & LEGACY
       L          LEGACY ONLY
NPI USAGE:
```

Figure 8-34: Selecting the NPI usage indicator

8.5.1.6   Tribal Self-Insured

Use this field to indicate if the payer is a Tribal self-insured entity or not. By indicating that the insurer is a Tribal self insured payer, certain edits will be activated in the claim editor, and will export to the claim form. This field will do the following if YES, TRIBAL SELF-INSURED is selected:

- Claim Editor: If the primary insurer bill status is marked COMPLETED, the active insurer contains a Medicare insurer type, and the export mode is an electronic format, then the Coordination of Benefits (COB) page will be skipped. This prevents the addition of any payment/adjustment codes to the claim when submitted to Medicare.

- Claim Forms (paper and electronic): The following remark will be printed in the comments section of the paper forms or will be submitted on the electronic format: PT HAS TRIBAL SELF-FUNDED INSURANCE.

```
TRIBAL SELF-INSURED?: ?
     Choose from:
       Y         YES, TRIBAL SELF-INSURED
       N         NO, NOT TRIBAL SELF-INSURED
TRIBAL SELF-INSURED?:
```

Figure 8-35: "TRIBAL SELF-INSURED?" prompt

8.5.1.7   Add/Edit Group Number and Provider Data

The user can cycle through the following prompts until he/she has added and/or edited the desired provider names and PIN numbers to the insurer's file. Data in these fields are used primarily for Medicare and/or Oklahoma Medicaid when billing the Professional Component. The user may populate the Legacy number (if needed). The Group and Provider number entered are used when billing the 999 – Professional Component visit type.

Use the following table as a guide for the prompts to add or edit information.

Group Number, Provider Data Prompt:	Action:
Group Number	Add or edit the group number assigned to this insurer and press the Enter key.
Select Provider: Provider:	Add or edit the name of the provider and press the Enter key. Type the name of the provider whose data needs to be added or edited for billing this insurer. Press the Enter key and continue to the "Visit Type" prompts, if provider names do not need to be added to the insurer's file.
PIN #	Type the PIN number assigned to the provider by the insurer.

```
GROUP NUMBER: 8796

PROVIDER PIN#
Select PROVIDER: ADAM,ADAM//
  PROVIDER: ADAM,ADAM//
  PIN #: 123456//

Select PROVIDER:
```

Figure 8-36: Adding/Editing group number and provider data

8.5.1.8   Add/Edit Visit Types

The Visit Type fields control the mode in which an insurer is billed. The visit types correspond to those contained in the Visit Type file. Visit types are used primarily for reporting purposes (if clinic type isn't being used).

The visit type of claims created automatically can be Inpatient, Outpatient, Ambulatory Surgery or Dental; whichever is most applicable. All claims that coincide with an established visit type entry for an insurer will be billed in the manner specified by that entry. The Visit Type of a claim can be changed on Page 1 (Claim Identifiers) of the Claim Editor.

Visit Types can be added locally, using the Visit Type Maintenance option. Locally added visit types must be clearly labeled.

To add/edit a Visit Type, follow these steps:

1. At the "Select Visit Type" prompt, enter the number that corresponds to the visit type.

2. At the "Are you Adding '*VisitTypeName*' as a new Visit Type?" prompt,

   - Press the Enter key to accept the default (No).

   - Type **Y** and press the Enter key if this is a new visit type.

3. Use the following as a guide for the prompts to add or edit information.

Visit Type Prompt:	Action:
Billable	If the visit type is • Billable, type **Y** (Yes). • Unbillable for this insurer, type **N** (No). • Billable through software other than the RPMS Third Party Billing system, type **E** (Billable/Billed Elsewhere).

4. The "Do you want to replace with another insurer/visit type*?*" prompt was designed to allow the user to set up an insurer to substitute by visit type for certain services without having to add that eligibility to the patients file. For example, if Payer A requires claims for mental health services to be submitted to Payer B with the same Insurer Identification number, the user can set up the replacement insurer with Payer B's insurance information. When billing, the user will need to edit the visit type linked to Payer B's replacement insurer.

5. At the prompt,

- Type **No** or leave blank to prevent the claim editor from displaying the replacement insurer.

- Type **Yes** to replace the active insurer being billed for this visit type.

  – At the "Effective Date" prompt, type in the date this payer will override the current payer. This date corresponds to the date of service on the visit. This prompt was also designed to store multiple entries in case the replacement payer changes.

  – The "Replace Insurer Effective Date End Date" prompt will display. If the replaced payer is overridden for a period of time, the user may elect to enter an end date. Once the end date is entered, the system will use the current payer in the claim editor.

  – At the "Replace Insurer Effective Date Replacement Insurer" prompt, enter the name of the replaced insurer. This is the insurer that will appear when the visit type is changed in the claim editor.

  – At the "Replace Insurer Effective Date Replacement Visit Type" prompt, enter the visit type of the replaced insurer that will be used for billing. If the visit type does not exist at the replaced insurer, the system will display the following message:

```
Replacement Insurer/Visit Type not set up!  Must be set up before it can replace
```

Figure 8-37: Prompt that is displayed if the visit type does not exist

Once the insurer has been replaced, the Visit Type will be displayed with the following:

```
Visit                       Mode of    Mult  Fee    ------- Flat Rate --------
Type – Description          Export     Form Sched  Start      Stop        Rate
==============================================================================
993   MEDICAL SUPPLY     ** Replace with: AETNA **
```

Figure 8-38: Additional information displayed when insurer has been replaced

> **Note:** If the replacement insurer has been set up, the remaining prompts will not display for the user to edit.

Visit Type Prompt:	Action:
Start Billing Date	Type the date of service that the system should use as the start date for generating claims for this visit type for this insurer. Any visit occurring before the date entered here will **not** have a corresponding claim. Entering a start date helps prevent unwanted claims from generating.
Procedure Coding	Type one of the following: • **ICD**. Used for all-inclusive (flat rate) billing • **CPT**. Used to itemize charges on the claim • **ADA**. Used for dental billing This allows the system to pick a coding method to use when creating a claim.
Fee Schedule	Type the number of the applicable fee schedule, so the system can pick which fee schedule to use when creating a claim. If left blank, the fee schedule entered in "Site Parameters, Default Fee Schedule" prompt will be used. Unless the payer requires a different fee schedule for this visit type, it is strongly encouraged to leave this field blank. **Note:** This prompt does not appear if the Procedure Coding method is ICD.
Add Zero Fees	Type **Y** (Yes) if all fees should be carried forward to the claim editor. This includes all codes that do not contain a fee associated to it. Type **N** (No) or leave blank if not allowing all fees to come across to the claim editor. This means that charges with no associated fee in the fee schedule will no be included on the claim.

Visit Type Prompt:	Action:
Multiple Forms	Type **Y** (Yes) if the insurer requires that the professional component is billed on a different form than the medical procedures. **Note:** If Y (Yes) is entered, the Mode of Export field on PAGE 8A and PAGE 8B of the Claim Editor defaults to the value defined in the Professional Component Visit Type (Visit Type 999). This means that Visit Type 999 will need to be set up in the Insurer file
Payer Assigned Provider Number	Enter the provider number **only** if the insurer has assigned a provider number for this visit type. The provider number, if entered, must be 3-13 characters. This number is displayed on the UB-04 in block 51 or the CMS-1500 in block 33 as long as the NPI status indicates Legacy or NPI & Legacy. If the NPI status is set to NPI Only, this number will not reflect on any of the export forms.
EMC Submitter ID#	Enter the payer-specific EMC Submitter Identifier, if required, in fields ISA06, GS03, and enter NM109 of the Submitter (Loop 1000A) of the 837 electronic formats.

Visit Type Prompt:	Action:
EMC Reference ID	Enter one of the following, if required, for the payer for electronic claims: **1A** Blue Cross Provider **1B** Blue Shield Provider **1G** Provider UPIN Number **1H** CHAMPUS Identification Number **1J** Facility ID Number **B3** Preferred Provider Organization **BQ** HMO Code Number **EI** Employers Identification Number **FH** Clinic Number **G2** Provider Commercial Number **G5** Provider Site Number **LU** Location Number **SY** Social Security Number **U3** Unique Supplier ID Number **X5** State Industrial Accident Provider Number This entry populates the REF01 of the Billing Provider (Loop 2010AA) and REF01 of the Pay-To-Provider (Loop 2010AB) of the 837 formats.
Subpart NPI	Populate this field with the location from the Institution file that contains the NPI to bill. Entries from this field will override the NPI stored in Site Parameters or the NPI of the location you are billing for. Sites may elect to populate this if they obtained an NPI for a specialty.

6. At the "Auto Approve?" prompt,

   - Type **N** (No) or leave blank to **not** auto approve the claim for this insurer/visit type.

   - Type **Y** (Yes) to auto approve the claim for this insurer/visit type.

   | **Important:** Exercise extreme **CAUTION** with this option. |

If auto approve is selected (Yes), when the claim generator creates a new claim for this insurer and visit type, it examines the new claim for errors. If no errors are found that would normally prevent approval, it approves the claim automatically and creates a bill ready for printing or export. The approving official is identified as the individual who initiates the claim generator for all auto approved claims.

The auto approve process may be desirable when trying to process a high volume of non-itemized claims for an insurer. For example, auto approve would allow sites to send outpatient claims to Medicare, via the RPMS Third Party Billing EMC menu, without incurring a large increase in the workload of claims editing and approval in the Billing office.

7. At the "Mode of Export" prompt, enter the name of the billing form/mode for this insurer.

> **Note:** The Mode of Export specified here sets the default selection for this insurer.

If the entry matches more than one mode of export, the system displays a list and prompts the user to choose one. At the prompt, type the number that corresponds to the correct mode of export.

```
Visit                    Mode of     Mult  Fee    ------- Flat Rate --------
Type - Description       Export      Form Sched   Start      Stop        Rate
==============================================================================

Select VISIT TYPE..: 550  TEST <Enter>
  Are you adding 'TEST' as a new VISIT TYPE (the 1ST for this 3P INSURER)?
No//
Y <Enter>  (Yes)
Billable (Y/N/E)....: Y <Enter>  YES
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before): T <Enter>
(MAR 13, 2009)
Procedure Coding....: CPT// <Enter>
Fee Schedule........: <Enter>
Add Zero Fees?...: N <Enter> NO
Multiple Forms?.....: N <Enter> NO
Payer Assigned Provider Number.....: <Enter>
EMC Submitter ID #..: 9999999 <Enter>
EMC Reference ID....: 1A <Enter> Blue Cross Provider Number
Auto Approve?.......:N <Enter>  NO
Mode of Export......: 837 PROF (HCFA)// CMS-1500 (08/05)   OMB No. 0938-0999
SUBPART NPI:
```

Figure 8-39: Adding/Editing standard visit types

8.5.1.9   Additional Mode of Export Fields

Additional fields for all inclusive (flat rate) insurer status

When the insurer status is all inclusive, additional prompts appear after the "Mode of Export" prompt. Use the following table as a guide for the prompts to add or edit information.

Prompt:	Action:
Revenue Code	Type the Revenue Code number for this visit type. Only revenue codes designated as all-inclusive may be selected. **Note:** This field is mandatory if the Export Mode is UB-92, UB-04 or 837 Institutional. The revenue code will be displayed as a single line item on the bill. Revenue Codes in the Revenue Code file may be edited, using the Revenue Code Maintenance option.
Revenue Description	Enter a brief description of the revenue code or leave blank. The description entered here is displayed on the UB-92, UB-04 in block 43 or the 837 Institutional format. If this field is left blank, the description in the Revenue Code file is used.
Bill Type	Use this field to enter a default bill type for use on the UB-92, UB-04 or the 837 Institutional format. Before entering the bill type into this field, the user must add the entry into the UB-92 Codes Menu, UB-92 Code Maintenance option.
CPT Code	Enter the default CPT or HCPCS code used to bill for these services. If left blank, the flat rate dollar amount will print in Box 44 of the UB-04.
Select Start Date	Start dates are used to identify flat rate dollar amounts that are effective for the period of time specified and are only used when billing for the all-inclusive rate. The user may elect to add multiple entries. Enter the date range start date. The system prompts the user to verify that the date entered is the 1st for this Visit Type. Type **Y** (Yes) or press Enter to accept the default, No.

Prompt:	Action:
Start Date	If the date displayed is correct, press enter to accept.
Rate	Enter the applicable flat rate dollar amount.
Stop Date	Enter the stop date for billing at the rate specified. This field is usually populated prior to entering a new flat rate dollar amount.
Prior Approval Required	Enter the ICD Procedure Code that is required prior to approval. If entered into this field, the system will display a warning in the claim editor if the ICD Procedure Code is used, and a prior approval from the payer has not been obtained.

```
Revenue Code........: 100//
Revenue Description.:
Bill Type...........: 111//
CPT Code............:
Select START DATE: T   MAR 13, 2002
  Are you adding 'MAR 13, 2002' as a new START DATE (the 1ST for this VISIT
TYPE)? No// Y  (Yes)
START DATE: MAR 13,2002//
RATE ($): 450.00
STOP DATE: T+90  (JUN 11, 2002)
```

Figure 8-40: Additional Visit Type Export Mode fields for all inclusive (flat rate) billing status

Additional fields for UB-92, UB-04 or 837 Institutional Export Mode

If the Mode of Export is set to the UB-92, UB-04 or 837 Institutional formats, the following prompts appear:

Prompt:	Action:
Relationship Code?	Type **UB-92** if the payer requires the UB-92 relationship codes to be used. If left blank, the new relationship codes will be used. The old codes list Self as '01', Spouse as '02', etc.
Itemized UB?	Type **Y** (Yes) if all services are to be itemized on the UB-04 at the time of billing. Itemizing the UB-04 means that all CPT, NCPDP as well as the date of service for the charge will print on the paper form. Type **N** (No) or leave blank and press the Enter key to have the system prepare a non-itemized bill.
ICD PX on Claim?	This field displays if the Export Mode is 837 Institutional, UB-04 or UB-92. Type **N** (No) to remove the ICD-9 Procedure codes from the claim. Type **Y** (Yes) or leave the field blank for the Procedure codes to display on the claim. It is recommended to set up all insurers and all visit types used to bill ICD-9 Procedures. Modifications made to this field will affect only the UB-92, UB-04 or the 837-I and have no affect on the claim editor. Use extreme **caution** when editing this field as claim data is affected.

```
Mode of Export......: UB-92          OMB NO. 0938-0279
Relationship Code?: UB92 CODES
Itemized UB?.....: Y  YES
ICD PX on Claim?:
```

Figure 8-41: Additional Visit Type fields for UB-92 (paper only) export mode

Additional Fields for HCFA-1500 (paper only) export mode

If the Mode of Export field is set to HCFA-1500 paper only format (non-electronic), the following prompts appear:

Prompt:	Action:
Block 24K	Type **RX** (RX Number) or **MD** (MD Provider Number) and press the Enter key.
Block 29	Type **DO** to print or **DON'T** to not print, and press the Enter key. Typing DO allows the provider name and credentials to print in Box 29.
Block 33 PIN#	Type the one of the following or leave blank: • **LOC** (Location code) is obtained from the Insurer file, which contains a field titled, Locations Assigned W/ PROV #. This field is populated with the facility identification number. • **PRO** (Provider code) is obtained from the New Person file, which contains a field titled, Payer Assigned Provider Number. This field is populated with the individual provider numbers.

> **Note:** The information for both Location and Provider codes is generally populated with VA FileMan. Site manager assistance may be needed to add the location codes to the Insurer file via VA FileMan.

```
Mode of Export......: HCFA-1500-E// HCFA-1500 Y2K        HCFA 1500 Y2K
version
Block 24K...........: MD  MD PROVIDER NUMBER
Block 29...........: ?
     Choose from:
       DO       PRINT
       DONT     DO NOT PRINT
Block 29...........:
Block 33 PIN#.......: ??
     Choose from:
       LOC      LOCATION CODE
       PRO      PROVIDER CODE
Block 33 PIN#.......: pro  PROVIDER CODE
```

Figure 8-42: Information populated by the VA FileMan for Location and Provider codes

Additional Fields for DME Contractor

The DME Contractor fields are used to identify payers that allow billing for Durable Medical Equipment (DME) electronically. The DME Contractor section displays the following questions:

- Use the DME Group Number/Name field for DME payers that require a group name or number to be submitted on their claim forms. The user can enter a default group number or name in this field, which will print on the paper or electronic export.

- The CLIA# Req'd for all Visits field is for payers that require the CLIA number to be submitted on all DME Claims. Users now have the ability to print the CLIA number on the paper or electronic export. Typing **Yes** enables the printing of the CLIA number.

- The Which CLIA Should Print field will display if the user indicated that the CLIA Number is required when submitting to the payer. Type the Reference Lab CLIA Number or the In-House Lab CLIA Number. Depending on the selection, the system will pull the value indicated in the Site Parameters CLIA Number section.

```
DME Contractor?.....: YES//
DME GROUP NUMBER/NAME: DME GROUP NAME//
CLIA# req'd for all visits? : YES//
Which CLIA should print? : IN-HOUSE LAB CLIA// ??

     Choose from:
       R         REFERENCE LAB CLIA
       I         IN-HOUSE LAB CLIA
```

Figure 8-43: Additional fields for DME Contractor

8.5.2   Replacement Text for Insurer Lookups (RPIN)

Main Menu > TMTP > INTM > RPIN

Use the Replacement Text for Insurer Lookups option to add/change replacement text used by the insurer keyword lookup system. Keywords, abbreviations, acronyms, and the corresponding replacement text have been added for many common insurers. Adding to this table will assist the user in selecting an entry in the insurer file without typing the complete insurer name. For example, the replacement text of PHP can be used to lookup the insurer entry labeled PRESBYTERIAN HEALTH PLAN. This can save keystrokes, and allows the user to quickly identify this payer.

To add/change replacement text for insurer lookups, follow these steps:

1. At the "Select Replaced Text" prompt, type the text to be automatically replaced. The text should be an abbreviation or word that will be associated with an insurer name.

2. At the "Replacement" prompt, type the text that will replace the selected text. The name entered should be the complete name of the insurer.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |            THIRD PARTY BILLING SYSTEM - VER 2.6           |
          +            Replacement Text for Insurer Lookups          +
          |                   INDIAN HEALTH HOSPITAL                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                       3-DEC-2009 7:52 AM


Select REPLACED TEXT: PHP
  Are you adding 'PHP' as a new REPLACED TEXT (the 77TH for this KEYWORD
LOOKUP CONTROL)? No// YES  (Yes)
  REPLACEMENT: PRESBYTERIAN HEALTH PLAN
Select REPLACED TEXT:
```

Figure 8-44: Adding replacement text for insurer lookups

In this example, a new keyword and its text replacement is added to the Insurer
Lookup. The new keyword to be replaced (PHP) is entered followed by the text that
will serve as its replacement (Presbyterian Health Plan). Now, whenever PHP is
entered during an insurer selection, Presbyterian Health Plan will be substituted for it.

8.5.3   Insurer Listing (LSIN)

Main Menu > TMTP > INTM > LSIN

Use the Insurer Listing option to view and/or print a list of the entries in the Insurer
file. The listing prints with the Mailing and Billing address, and notifies the user of
merged entries.

To view/print the contents of the Insurer file, follow these steps:

At the "DEVICE" prompt,

- Press the Enter key to display the list on the screen, or

- Type the name of the printer; and at the "Right Margin" prompt, either press
  the Enter key to accept the default value of 80, or type the size of the right
  margin.

The system displays or prints the contents of the Insurer file; for example,

```
===== INSURER LISTING =====                     DEC  3,2009  07:57    PAGE 1
MAILING ADDRESS                           BILLING ADDRESS
-----------------------------------------------------------------------

CELINA MUTUAL GRP
ONE INSURANCE SQUARE
CELINA, OH  45822
(419)-586-518

CELTIC INSURANCE CO                       CELTIC INSURANCE COMPANY
233 S WACKER DR STE 700                   PO BOX 06410
CHICAGO, IL  60606-0410                   CHICAGO, IL  60606-0410
(800)477-7870

CHAMPUS                                   BLUE CROSS/BLUE SHIELD OF SC
P.O. BOX 100502                           P.O. BOX 100502
FLORENCE, SC  29501-0502                  FLORENCE, SC  29501-0502

CIGNA DENTAL HEALTH OF KY INC
PO BOX 4650
MIAMI, FL  33269-1650
(305)-620-992

CIGNA DENTAL HEALTH OF MD INC
PO BOX 4650
MIAMI, FL  33269-1650
(305)-620-992
   *** MERGED TO: CIGNA DENTAL HEALTH OF OH INC ***

CIGNA DENTAL HEALTH OF OH INC
PO BOX 4650
MIAMI, FL  33269-1650
(305)-620-992
```

Figure 8-45: Example of insurer listing (LSIN option)

8.5.4   Display Insurer Info (IQIN)

Main Menu > TMTP > INTM > IQIN

Use the Display Insurer Info (Inquire) option to view all of the available information for a selected insurer.

To view the available information for a specific insurer,

1. At the "Select Insurer" prompt, type the name of the insurer and press the Enter key.

2. At the "OK?" prompt, type **Y** (Yes) and press the Enter key.

The system displays the information in the Insurer file for the specified insurer.

```
                      *** INSURER FILE INQUIRY ***

========================================================================
NAME: INSURANCE CO NAME                   STREET: 123 MAIN
  CITY: ANYWHERE                          STATE: NEW MEXICO
  ZIP: 12345                              PHONE: (505)505-5050
  CONTROL NUMBER: 99999                   CONTACT PERSON: Firstname Lastname
  STATUS: BILLABLE                        TYPE OF INSURER: PRIVATE INSURANCE
  ALL INCLUSIVE BILLING (Y/N): NO         BACKBILLING LIMIT (MONTHS): 3
  DENTAL BILLING STATUS: DENTAL VISITS ARE UNBILLABLE
  LONG NAME: INSURANCE CO NAME
CLINIC UNBILLABLE: EMERGENCY MEDICINE
CLINIC UNBILLABLE: LABORATORY SERVICES
CLINIC UNBILLABLE: PHARMACY

VISIT TYPE: TEST                          PROCEDURE CODING METHOD: CPT
  REVENUE CODE: 100                       MODE OF EXPORT: HCFA-1500 Y2K
  FEE SCHEDULE: 1                         MULTIPLE FORMS?: NO
  BILLABLE STATUS: YES                    UB92 BILL TYPE: 111
  ITEMIZED UB-92?: YES                    AUTO APPROVE?: NO
```

Figure 8-46: INSURER FILE INQUIRY (IQIN option) screen

8.5.5   Merge Duplicate Insurers (MRIN)

Main Menu > TMTP > INTM > MRIN

The Merge Duplicate Insurers option has been temporarily removed.

8.6   Coverage Type File Menu (COTM)

Coverage Types can be established for insurers to enable specifying those providers, clinics, and diagnoses that are not billable, based on the patient's insurance type. If a patient is linked to a particular coverage type, the ABM system will not bill the insurer for those visits that the patient's insurance type does not consider reimbursable.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |            THIRD PARTY BILLING SYSTEM - VER 2.6          |
          +                  Coverage Type File Menu                 +
          |                    INDIAN HEALTH HOSPITAL                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                        3-DEC-2009 8:05 AM


    EDCO    Add/Edit a Coverage Type
    LSCO    Print Coverage Type Listing

Select Coverage Type File Menu Option:
```

Figure 8-47: Coverage Type File Menu (COTM option)

8.6.1   Add/Edit a Coverage Type (EDCO)

Main Menu > TMTP > COTM > EDCO

The ABM system is distributed with the coverage plans available for Federal employees, and Medicare Part A and Part B plans. The coverage types initially distributed include the identifiers of the plans, but do not include the unbillable diagnoses, clinics, dental categories, or provider disciplines for plans other than Medicare Part B.

As with all fields that contain entries to make the claim unbillable, this field should be reviewed on a regular basis and compared with the requirements set forth by the payer.

Use the Add/Edit a Coverage Type option to add new or edit existing coverage types. The prompts are the same for the addition of new coverage types, and for editing an existing entry.

Considerations:

- The system prompts the user to verify entries.

- When editing a field, the existing text displays between the prompt and two slashes (//).

- When prompted to "Select a Coverage Type" and the corresponding unbillable clinics, ICD9 codes and Provider Class, type a question mark (**?**) to display a list of existing names.

- Unbillable clinics and ICD9 codes, remain unbillable until they are deleted from the their respective lists, using the "at" symbol (@)

To add or edit a coverage type, follow these steps:

1. At the "Select Insurer" prompt, enter the insurer name and press the Enter key.

The system displays the insurance company name and address, and prompts the user to verify that this is the correct insurer.

- If the insurance company name and address are correct press the Enter key at the "OK?" prompt.

- If the insurance company displayed is not correct, type **N** (No) and press E the Enter key to repeat this step.

2. At the "Select Coverage Type to Edit" prompt, enter the coverage type and press the Enter key.

To see a list of existing coverage types for this insurer, type a question mark (**?**) at the prompt.

There can be more than one coverage type for the specified insurer. For each coverage type selected the user is prompted for additional information. Use the following table as a guide for the prompts to add or edit information.

Coverage Type Prompt:	Action:
Name	When editing an existing coverage type, the system repeats the coverage type name after the prompt. Press the Enter key to accept the name displayed. To change the coverage type name, (a) Type the text to be replaced after the "REPLACE" prompt and press the Enter key. (b) Type the replacement text after the "WITH" prompt and press the Enter key.
Plan Code	Type the 1-3 character plan code, or leave blank. **Note:** If the insurer is Medicaid, the value of this field **must** match the value given to the coverage type in the Patient Registration system. If these two values do not match, the system does not continue checking if the claim is unbillable and assumes that everything is billable.
Plan Type	Type **S** (Self) or **F** (Family). If left blank, the system defaults to Self.
Supplemental to Medicare (Y/N)	Type **Y** (Yes) if the insurer is private and should be billed secondary to Medicare. If left blank, the system defaults to No.

The system continues to prompt for Coverage Type, until the user presses the Enter key at the "Select Clinics Unbillable" prompt.

3. At the "Select Clinics Unbillable" prompt, enter the name of a clinic that is considered **unbillable** for this coverage type and insurer. The clinic specified must exist in the Clinic Stop file.

> **Note:** The clinic specified here remains unbillable, regardless of CPT or ICD codes, until it is deleted from the list using the "at" symbol (@).

To view a list of unbillable clinics for this coverage type/ insurer, type a question mark (**?**) at the prompt.

Before adding/removing an unbillable clinic, the system asks the user to verify his/her selection/decision.

There can be more than one unbillable clinic for the specified Coverage Type/Insurer, and the system continues to prompt for unbillable clinics, until the user presses the Enter key at the "Select Clinics Unbillable" prompt.

4. At the "Select Unbillable Diagnosis (ICD9)" prompt, type the ICD9 diagnosis code that is considered **unbillable** for this Coverage Type and Insurer. The ICD9 code specified must exist in the ICD Diagnosis file.

> **Note:** The diagnosis specified here remains unbillable until it is deleted from the list, using the "at" symbol (@).

To view a list of unbillable Diagnosis (ICD9) codes for this Coverage Type/Insurer, type a question mark (**?**) at the prompt.

Before adding/removing an unbillable diagnosis, the system asks the user to verify his/her selection/decision.

There can be more than one diagnosis for the specified Coverage Type/Insurer field, and the system continues to prompt for unbillable ICD9 codes, until the user presses the Enter key at the "Select Unbillable Diagnosis (ICD9)" prompt.

> **Important**
>
> If a patient with this Coverage Type has at least one billable diagnosis, regardless of whether another diagnosis is unbillable, the entire the claim is considered billable. The patient's claim will be flagged as unbillable (through this part of the system) only if **all** of the diagnoses listed on the claim are currently specified as unbillable in the Unbillable Diagnoses list.

5. At the "Select PROV CLASS (UN)BILLABLE" prompt, type the name of a provider class that is considered unbillable under this coverage type. The provider class specified must exist in the Provider Class file.

There can be more than one provider class for the specified coverage type. For each provider class selected, you are prompted for the following information:

- Billable/Unbillable

- Select CPT Low and CPT High to define a range

- Select ICD Diagnosis Low and ICD Diagnosis High to define a range

Use the following table as a guide for the prompts.

Provider Class Prompt:	Action:
Billable/Unbillable	Type **B** (Billable) or **U** (Unbillable) and press the Enter key.
	The response to this prompt must be answered in a way that requires the least amount of data entry. For example, if only one procedure is allowed by the coverage type for the ambulance driver provider class, type:
	• **Ambulance Driver** at the "Select PROVIDER CLASS (UN)BILLABLE" prompt,
	• **B** at the "Billable/Unbillable" prompt, and
	• The only allowed CPT code at the "Select CPT LOW" and "Select CPT HIGH" prompts.
	As this example illustrates, it is easier to type the number for the one procedure allowed by the coverage type than to type the numbers for all of the procedures disallowed by the coverage type
Select CPT Low	Type the lowest CPT code of the range.
CPT High	Type the highest CPT code of the range.
	Notes:
	• Together, the "Select CPT LOW" and "CPT HIGH" prompts establish a range of billable/unbillable CPT codes.
	• To enter a single CPT Code (e.g., 90010), type the same value at the "Select CPT LOW and "CPT HIGH" prompts.
	• Because there can be more than one CPT code range for the specified Provider Class, the system continues to prompt for CPT Low and High values, until the user presses the Enter key at a blank "Select CPT LOW" prompt.
Select ICD Proc Low	Type the lowest ICD Procedure code of the range.
ICD Proc High	Type the highest ICD Procedure of the range.

Provider Class Prompt:	Action:
	Notes: • Together, the "Select ICD PROC LOW" and "ICD PROC HIGH" prompts establish a range of billable/unbillable ICD Proc codes. • To enter a single ICD Proc Code (e.g., 90010), type the same value at the "Select ICD Proc Low and "ICD Proc High" prompts. • Because there can be more than one ICD Proc code range for the specified Provider Class, the system continues to prompt for ICD Proc Low and High values, until the user presses the Enter key at a blank "Select ICD PROC LOW" prompt.
Select ICD Diagnosis Low	Type the lowest ICD9 code of the range.
ICD Diagnosis High	Type the highest ICD9 code of the range.
	Notes: • Together, the "Select ICD DIAGNOSIS LOW" and "ICD DIAGNOSIS HIGH" prompts establish a range of billable/unbillable ICD9 codes for the coverage type. • To enter only one ICD9 Code (e.g., 292.81.), type the same value at both the "Select ICD DIAGNOSIS LOW" and "Select ICD DIAGNOSIS HIGH" prompts. • V and/or E codes can be typed at the ICD Diagnosis prompts, but if the low ICD9 code is a V or E code, the high ICD9 code should also be a V or E code. • Because there can be more than one ICD diagnosis code range for the specified provider class, the system continues to prompt for ICD Proc Low and High values, until the user presses the Enter key at the "Select ICD DIAGNOSIS LOW" prompt.

6. When the system prompts for another Provider Class,

- If there is an additional Provider Class for the specified Coverage Type, repeat step 5.

- If finished, press the Enter key at the "Select PROV CLASS (UN)BILLABLE" prompt.

```
Select INSURER: TEST <Enter>
( TEST )

NEW MEXICO TEST INS                        123 MAIN
                                           ANYWHERE, NM 12345
 OK? Y//Y <Enter>

Select COVERAGE TYPE to Edit: COVERAGE TYPE 10 <Enter>        NEW MEXICO
TEST INS
   A     SELF

NAME: COVERAGE TYPE 10  Replace <Enter>
PLAN CODE: A// <Enter>
PLAN TYPE: SELF// F <Enter>  FAMILY
SUPPLEMENTAL TO MEDICARE (Y/N): YES// <Enter>

Select CLINICS UNBILLABLE: EMPLOYEE HEALTH UN <Enter>         68
  Are you adding 'EMPLOYEE HEALTH UN' as
    a new CLINICS UNBILLABLE (the 1ST for this COVERAGE TYPE)? No// Y
<Enter> (Yes)
Select CLINICS UNBILLABLE: <Enter>

Select UNBILLABLE DIAGNOSIS (ICD9): 292.81 <Enter>  292.81       DRUG-
INDUCED DELIRIUM
    DRUG-INDUCED DELIRIUM
         ...OK? Yes// <Enter> (Yes)
  Are you adding '292.81' as a new DIAGNOSIS UNBILLABLE (the 1ST for this
COVERAGE TYPE)? No// Y <Enter>  (Yes)
Select UNBILLABLE DIAGNOSIS (ICD9): <Enter>

Select PROV CLASS (UN)BILLABLE: AMBULANCE DRIVER <Enter>
  Are you adding 'AMBULANCE DRIVER' as
    a new PROV CLASS (UN)BILLABLE (the 1ST for this COVERAGE TYPE)? No// Y
<Enter>  (Yes)
  BILLABLE/UNBILLABLE: UNBILLABLE <Enter>  UNBILLABLE

  Select CPT LOW: 90010 <Enter>  OFFICE/OP VISIT, NEW, LTD
         ...OK? Yes// <Enter> (Yes)
  Are you adding '90010' as a new CPT (the 1ST for this PROV CLASS
(UN)BILLABLE)? No// Y <Enter>  (Yes)
    CPT HIGH: 90020 <Enter>  OFFICE/OP VISIT, NEW, COMPRH
         ...OK? Yes// <Enter> (Yes)
  Select CPT LOW: <Enter>
```

```
   Select ICD PROC LOW: 12.54 <Enter>  TRABECULOTOMY AB EXTERNO
TRABECULOTOMY AB EXTERNO
          ...OK? Yes// <Enter> (Yes)
   Are you adding '12.54' as a new ICD PROCEDURES (the 1ST for this PROV
CLASS (UN)BILLABLE)? No// Y <Enter>  (Yes)
     ICD PROC HIGH: 12.54          TRABECULOTOMY AB EXTERNO
TRABECULOTOMY AB EXTERNO
          ...OK? Yes// <Enter> (Yes)
   Select ICD PROC LOW: <Enter>

   Select ICD DIAGNOSES LOW: 367.9 <Enter>  367.9         REFRACTION DISORDER
NOS    UNSPECIFIED DISORDER OF REFRACTION AND ACCOMMODATION
          ...OK? Yes// <Enter> (Yes)
   Are you adding '367.9' as a new ICD DIAGNOSES (the 1ST for this PROV CLASS
(UN)BILLABLE)? No// Y <Enter>  (Yes)
     ICD DIAGNOSES HIGH: 367.9 <Enter>  367.9         REFRACTION DISORDER NOS
UNSPECIFIED DISORDER OF REFRACTION AND ACCOMMODATION
          ...OK? Yes// Y <Enter>  (Yes)
   Select ICD DIAGNOSES LOW: <Enter>

Select PROV CLASS (UN)BILLABLE: <Enter>

Select INSURER: <Enter>
```

Figure 8-48: Example of adding/editing a provider (EDCO option)

8.6.2   Print Coverage Type Listing (LSCO)

Main Menu > TMTP > COTM > LSCO

Use the Print Coverage Type Listing option to print a list of coverage types for all
insurers currently defined in the Coverage Type file. This report sorts the insurers
alphabetically and displays the coverage type name, plan code, and plan type, and
only those field that contain data are displayed.

To print a coverage type listing, follow these steps:

At the "DEVICE" prompt,

- Press the Enter key to display the list on the screen, or

- Type the name of the printer; and at the "Right Margin" prompt, press the
  Enter key to accept the default value of 80, or type the size of the right
  margin.

The system displays or prints the Coverage Type list; for example,

```
COVERAGE TYPE LIST                        DEC  3,2009  08:40    PAGE 1
                                                            PLAN  PLAN
INSURER                         NAME                        CODE  TYPE
-----------------------------------------------------------------------

AETNA US HEALTHCARE             SELF                        001   SELF
AMER FEDERATION OF GOVT EMPL    HIGH                        301   SELF
AMER FEDERATION OF GOVT EMPL    HIGH                        302   FAMILY
AMER FEDERATION OF GOVT EMPL    STANDARD                    304   SELF
AMER FEDERATION OF GOVT EMPL    STANDARD                    305   FAMILY
AMER POSTAL WORKERS UNION       STANDARD                    471   SELF
AMER POSTAL WORKERS UNION       STANDARD                    472   FAMILY
ARIZONA MEDICAID                1H MN/MI MCR                1H    SELF
```

Figure 8-49: Example of Coverage Type Listing (LSCO option)

8.7   Site Parameter Maintenance (SITM)

Main Menu > TMTP > SITM

The Site Parameter Maintenance option enables users to define and update criteria that are specific to a particular site.

Site parameters must be completed prior to creating or editing claims. Also, if satellite locations are created for billing purposes, the site parameters must be completed.

To set/edit site parameters for a facility, follow these steps:

1. At the Third Party Billing System "Select menu option" prompt, type **TMTP** and press the Enter key.

2.   At the "Select Table Maintenance Menu Option" prompt, type **SITM** and press the Enter key.

3. Use the following table as a guide to setting and/or editing the site parameters. The table lists the site parameters in the order that the prompts appear.

> **Note:** To bypass a site parameter prompt, press the Enter key.

Parameter/Prompt	Description/Action
EMC File Preference	Electronic Billing The type of file that must be created for electronic transfers. • Kermit Holding. This file type creates an entry in the Kermit Holding File (File #8980) for transmission to a third party via Kernel Kermit (see Kernel documentation). • Host. This file type creates a host file containing third party claims in the format specified for the insurer and visit type. This is the most common file type. • Mail Server. This file type generates a network mail message containing claim information for transmission to the IHS or other clearinghouse.
Default EMC Path	This prompt is used to for electronic billing and it used to identify the directory where the claims will be stored. This prompt will display if the EMC File Preference is set to HOST. **Unix**: /*pathname*, for example, /usr/spool/uucppublic/ **Windows**: *drive*:*pathname*, for example.
Send Mail Messages To	This prompt is used to indicate where the claims file will be mailed to. This prompt utilizes the Domain file in RPMS and will send a mailman message containing claim information.
Facility to Receive Payments	The name of the facility that receives payments for services rendered at this site, which is used to determine the payment address and Federal Tax Number. The payment address and Federal Tax Number for the facility specified are obtained from the Location file.

Parameter/Prompt	Description/Action
Printable Name of Payment Site	The name of the facility as it will be printed on the bill. This location name prints in Box 1 of the UB-04 and in Block 33 of the CMS-1500.
Current Default Fee Schedule	The name/number of the user's site's current fee schedule, which is used in itemized billing for those insurers who do not require using their Fee Schedule. To display a list of available fee schedules (as defined in the Fee Schedule Table Maintenance option), type a question mark (**?**) at the prompt.
Create Bill For All Patients	Determines whether the system creates a claim/bill for every visit, whether the patient has third party eligibility or is an Indian Beneficiary. Type one of the following: • **ALL**. Creates a claim for all services for all patients regardless of eligibility or beneficiary status. • **NO**. Creates claims for those patients that have third party eligibility or hold a non-Indian beneficiary status. • **IP**. Creates claims for those patients that have third party eligibility or hold a non-Indian beneficiary status for outpatient services. Inpatient claims will generate for all patients regardless of eligibility or beneficiary status. Printing a claim/bill for every visit (regardless of insurance coverage) can help with reporting on the cost of every patient encounter.
Require that Queuing be Forced	Determines whether all print jobs are queued and sent to a system printer automatically. Queuing a print job will save time for the user because he/she will not need to wait for the report to print before continuing to work in RPMS.
Display Long ICD/CPT Description	Determines whether the system displays the extended description of the ICD or CPT narrative in the claim editor. Typing **No** will display more codes on the claim editor pages.

Parameter/Prompt	Description/Action
Backbilling Limit (Months)	The number of months a facility can go back in time to bill for services. Entries in the Insurer File that contain no back billing limit will default to this value. Type a number between 0 and 99.
Block 31 (HCFA-1500) Print	The name of the Attending/Operating Provider/Approving Official/New Person, which displays in Block 31 on the HCFA-1500 form.
HCFA-1500 Signature	The name of the person printed in the signature box at the bottom of the HCFA-1500 form. Usually, it is the attending physician, but the user may choose any name that exists in the New Person file. This prompt only displays if the Block 31 (HCFA-1500) Print field is set to New Person.
UB-92 SIGNATURE	The name of the person printed in the signature box of the UB-92 or UB-04 form. Usually, it is the attending physician, but you may choose any name that exists in the New Person file.
Place Of Service Code	The code printed in the Place of Service box on the CMS-1500 form. This will default for all claims. The only exception is: • The user can override the entry in the Claim Editor by editing individual charges and modifying the Place of Service code. • Visit Type = 111, POS will be 21 • Visit Type = 831, POS will be 24 • Clinic = 30 (ER), POS will be 23 To display a list of available options, type a question mark (**?**) at the prompt.
Bill Number Suffix (FAC-Code)	The Facility FAC code, which is appended to the bill number to identify the facility that produced the bill. This code is printed on the claim form and is also sent to A/R. Enter from 1-4 characters.

Parameter/Prompt	Description/Action
Append HRN to Bill Number	Determines whether the patient's Health Record Number is appended to the bill number.
Allow for CPT Modifiers Prompt	Determines whether a modifier can be designated for a CPT procedure If the user types **Yes**, the system prompts for a modifier when a user adds or edits a CPT procedure.
Set Prof. Comp. Automatically	Determines whether the minimal level of service will be set automatically on the Medical page (8A), when the attending provider is a physician. If the user types **Yes**, then a default of 99211 will appear in the claim editor.
Days Inactive Before Purging	The number of days a claim is allowed to remain inactive before being automatically purged by the Claim Generator. Purged claims are deleted from the Claim Editor. Type a number between 1 and 730.
Default Version Of HCFA-1500	The version of the CMS-1500 forms that is used by default at a facility. This setting only affects claims with the HCFA-1500 or CMS-1500 mode of export. Currently there are four versions of the HCFA-1500/CMS-1500 form that can be selected: • Old Version 1984 (HCFA-1500A) • New Version 1990 (HCFA-1500B) • Y2K Version 1998 (HCFA-1500 Y2K) • Version 08/05 dated 01/2007 (CMS-1500) The current valid version is the CMS-1500.

Parameter/Prompt	Description/Action
Default Form for Dental Billing	The name of the form used as the default mode of export for Dental billing.
	The ADA-2006 form is currently used.
	To display a list of available forms, type a question mark (**?**) at the prompt.
	Note: The ADA-94 and ADA-99 Dental forms (box 40) have been changed to print the address of service (not payment), and allows cities with spaces in their names to print properly. This change was made assuming that the following is true:
	• The visit location in the Location file retains the physical or mailing address.
	• There is a separate location set up in site parameters to specify the name of the facility to receive payments.
Select Default Unbillable Clinics	The name(s) of any clinics that that the facility always considered unbillable, regardless of insurer or coverage.
	If there are none, press the Enter key at the prompt.
	Add clinic names, one at a time, at this prompt, which continues to display until the Enter key is pressed at the prompt.
	The system continues to prompt for clinic names, until the Enter key is pressed at the "Select Default Unbillable Clinics" prompt.
Select Dflt Invalid Prv Disciplines	The name(s) of any provider disciplines that the facility always considered unbillable, regardless of insurer or coverage.
	If there are none, press the Enter key at the prompt.
	The system continues to prompt for provider disciplines, until the Enter key is pressed at the "Select Dflt Invalid Prv Disciplines" prompt.
Select Display Unbillable Insurer(s)	Enter the name of the insurer to display in claim editor if status is unbillable. This allows the billing technician to see the insurer even though it was marked as unbillable.

Parameter/Prompt	Description/Action
UB-92 Form Locator 38	Specifies the information for box 38 on the UB-92 form: • Policy Holder. If selected, the name and address is printed. • Insurer Address. If selected the name and billing address of the Insurer will be printed • Blank (default). If selected, the field will remain blank.
In-House Default CLIA #	Allows the default CLIA number to be stored for all CLIA certified facilities performing CLIA covered laboratory services. These are normally for lab services performed by the billing or rendering provider of the CLIA number. This field requires a 10-character response. The response must be in an "NNLNNNNNNN" format where "N" is a numeric character and "L" is an alpha character.
Reference Lab Default CLIA #	Allows the default Reference Lab CLIA number to be stored for any laboratory that has referred tests to another laboratory covered by the CLIA Act. A facility may have more than one Reference Lab location to which they send tests but this option allows storage of the most common Reference Lab. Prior to entering the CLIA number into the Reference Lab field of site parameters, the user must first go into the Add/Edit Reference Lab Locations option to add the CLIA numbers for those locations to which labs are sent. Enter the name of the Reference Lab from the Vendor File.

Parameter/Prompt	Description/Action
Orphan Visit Lag Time (Days)	The number of days (between 3-180) that a Lab (radiology, pharmacy, etc.) visit can be entered in the system, before/without a doctor visit; thus creating an orphan. Orphan visits are visits that are missing a provider, clinic or purpose of visit.

The default time is seven days before the claim generator creates a claim.

If PCC requires up to three days to enter doctor visits, the number three should be typed here. With this setting, three days would pass before the claim generator creates a claim for the orphan visit. Within that three day period, the complete doctor visit should have been entered allowing the orphan visit to be linked to the doctor visit. The orphan would no longer exist. If no match to the completed visit is found, the claim will be generated but will be missing data. Users will begin to see duplicate claims generated. |
| **Uncoded DX Lag Time (Days)** | Enter a number between 0 and 180. This number represents the number of days the claim generator will wait to create a claim that contains an uncoded diagnosis code. Uncoded diagnosis codes are visits containing an ICD-9 code of .9999. |

Parameter/Prompt	Description/Action
Use A/R Parent Satellite set-up	This option allows for services performed at a location outside of the primary facility such as home, school, etc to generate claims for billing. Setting this option to YES allows for claims to generate under the primary facility for all locations. There is additional set up for this. The user must: • Ensure the A/R Parent/Satellite Option has been set up in the BAR package. Since this option is usually set up for the parent (or primary) facility, it is assumed that the claims will generate for all satellite locations under the parent (primary facility) • All 3P Table Maintenance options must be set up for each satellite location that claims are generated for. This requires the user to have access to those locations. Typing NO at this option will allow the claims to generate under their own locations.
Use NPI Of	Populate this field with the location from the Institution file that contains the NPI you wish to bill. Entries from this field will override the NPI stored for the location you are billing for. Sites may elect to populate this if they wish to use a different NPI than what is populated in the Institution File for this billing location.

Parameter/Prompt	Description/Action
Medicare Part B	Determines if the site bills only Part B claims to Medicare and will generate claims accordingly. Use the following as guidance when populating this option:
	• **YES** allows the system to generate an Outpatient claim. These claims are generated with a Visit Type of 131 and are usually set up in the Insurer File as All-Inclusive. These are used mainly for FQHC sites that don't have the Part B authority since the all-inclusive rate includes Part B.
	• **NO** allows the system to generate an Outpatient claim **and** a Professional Component claim. There are two claims that generate: Visit Type 131-Outpatient and Visit Type 999-Professional Component. The 131-Outpatient Facilities that are hospital-based will generally set their prompts up for this.
	• **ONLY** allows the system to generate a professional claim. These claims are generated with a Visit Type of 999-Professional Component. These claims are generated with the intention of billing a fee-for-service (itemized) claim for Medicare services. This is used primarily for Freestanding Health Centers.

Parameter/Prompt	Description/Action
ISA08 Value	Select from one of the following values **only if** the MEDICARE PART B field has been populated to only have one claim generate to Medicare rather than two. The value depends on how the facility has been set up to bill to Medicare. • C00400. Used to submit to Medicare Part A prior to June 13, 2008 • C00900. Used to submit to Medicare Part B prior to June 13, 2008 • 04401. Used to submit to Medicare Part A after June 13, 2008 • 04402. Used to submit to Medicare Part B after June 13, 2009 These changes are submitted on the 837 electronic formats and are as a result of CMS naming Trailblazer Health Enterprises LLC as the Medicare Administrative Contractor (MAC) for Jurisdiction 4 which includes most I/T/U facilities.
Default Dental Code Prefix	Type either **O**,.**S** or **D**, if **all** insurers requires a dental code prefix for dental claims: Selecting one of the above will not display when editing the claim but will display when the bill has been printed. Use the Dental Remap Option (TMTP >DMTM) if the prefix is needed just for certain insurers.
Statement Header Print	Adding data to this field will modify the header for the patient statement. Currently, the statement header prints INDIAN HEALTH SERVICE, but may be modified by typing up to 80-characters to replace this text.

Parameter/Prompt	Description/Action
Use POA Indicator?	The Present On Admission (POA) Indicator field was created due to a CMS requirement for all inpatient acute care facilities to submit a POA. It is valid only for the DUZ(2) (location) in which the parameter has been set. This means that any hospitals set up as satellite locations will need to setup this prompt depending on their POA status. If the A/R Parent/Satellite option is set to YES, and the hospital satellite locations are generating under the parent location, the parent location must check the satellite parameter file to confirm that the POA is required. The site needs to determine if the POA requirement applies to their site. If it doesn't apply, the site needs to change the default to NO.
Use the following fields to enter the dispense fees used to bill prescriptions in the claim editor.	

Parameter/Prompt	Description/Action
OP Prescription Dispense Fee	Enter the default prescription dispense fee for outpatient services. Type the price in whole dollar amounts (e.g., 5 equals $5.00).
IV Admixture Dispense Fee	If applicable, enter the default dispense fee for IV Admixture. Type the price in whole dollar amounts (e.g., 5 equals $5.00).
IV Piggyback Dispense Fee	If applicable, enter the default dispense fee for IV Piggyback. Type the price in whole dollar amounts (e.g., 5 equals $5.00).
IV Hyperal Dispense Fee	If applicable, enter the default dispense fee for IV Hyperal. Type the price in whole dollar amounts (e.g., 5 equals $5.00).
IV Syringe Dispense Fee	If applicable, enter the default dispense fee for IV Syringe. Type the price in whole dollar amounts (e.g., 5 equals $5.00).
IV Chemotherapy Dispense Fee	If applicable, enter the default dispense fee for IV Chemotherapy. Type the price in whole dollar amounts (e.g., 5 equals $5.00).
Inpatient Rx Dispense Fee	If applicable, enter the default dispense fee for Inpatient Rx. Type the price in whole dollar amounts (e.g., 5 equals $5.00).

Parameter/Prompt	Description/Action

Select Claim Page(s) to Be Skipped	The list below shows the number that corresponds to a Claim Editor page to be skipped:
	
	    1 (Surgery)
	    2 (Revenue Code)
	    3 (Laboratory)
	    4 (Radiology)
	    5 (Anesthesia)
	    6 (Pharmacy)
	    7 (Dental)
	    8 (Misc. Services)
	    9 (Supplies)
	
	For example, if a facility never performs surgeries, type **1** at the prompt to force the system to skip the Surgery page.
	If there are none, press the Enter key at the prompt.
	The system continues to prompt for claim pages, until the Enter key is pressed at the "Select Claim Page(s) to Be Skipped" prompt.

Page 9 Remarks: **Edit**	The default Remarks text that displays on the UB-92 form. Although the text here is the default text that will appear on the BU-92 form, the user can add claim-specific remarks, on PAGE 9F of the Claim Editor. The system displays the current default Remarks box on the UB-92 form, if any, and then prompts you to edit the text. Type **Y** (Yes) to edit this parameter.
Select Insurers W/O 837 PRV Segment	Enter the name of the insurer that does not require the PRV segment when submitting an 837 export mode. The PRV Segment usually contains the location and/or provider taxonomy data.

```
EMC File Preference.............: HOST FILE//
DEFAULT EMC PATH................: c:\inetpub\ftproot\pub
          Replace
Facility to Receive Payments....: ALBUQUERQUE ADMINISTRATION//
Printable Name of Payment Site..: INDIAN HEALTH HOSP//
Current Default Fee Schedule....: 1//
Create Bills for all Patients...: NO//
Require that Queing be Forced...: YES//
Display Long ICD/CPT Description: NO//
Backbilling Limit (months)......: 48//
Block 31 (HCFA 1500) print......: ATTENDING/OPERATING PROVIDERS//
UB-92 SIGNATURE.................:
Place of Service Code...........: 22//
Bill Number Suffix (fac-code)...: IH//
Append HRN to Bill Number.......: YES//
Allow for CPT Modifiers Prompt..: YES//
Set Prof. Comp. Automatically...: NO//
Days Inactive before Purging....: 730//
Default Version of HCFA-1500....: 08/05 Version dated 01/07//
Default Form for Dental Billing.: ADA-99 v2000//
Select DEFAULT UNBILLABLE CLINICS:
Select DFLT INVALID PRV DISCIPLINES:
Select DISPLAY UNBILLABLE INSURER(S):
UB-92 Form Locater 38: INSURER ADDRESS//
IN-HOUSE DEFAULT CLIA#: 12A3456789//
REFERENCE LAB DEFAULT CLIA#: THE REFERENCE LAB INC.//
ORPHAN VISIT LAG TIME (DAYS)....: 30//
UNCODED DX LAG TIME (DAYS): 30//
USE A/R PARENT SATELLITE SET-UP?:
USE NPI OF:
MEDICARE PART B?...........:
ISA08 VALUE:
DEFAULT DENTAL CODE PREFIX......:
STATEMENT HEADER PRINT:
USE POA INDICATOR?: YES//

RX DISPENSE FEES
================
OP Prescription Dispense Fee....: 5//
IV Admixture Dispense Fee.......: 10//
IV Piggyback Dispense Fee.......: 10//
IV Hyperal Dispense Fee.........: 10//
IV Syringe Dispense Fee.........: 8//
IV Chemotherapy Dispense Fee....: 10//
Inpatient RX Dispense Fee.......: 5//

Select CLAIM PAGE(s) TO BE SKIPPED:
PAGE 9 REMARKS:
Send Payment to Provider (see Block 1)

  Edit? NO//
Select INSURERS W/O 837 PRV SEGMENT:
```

Figure 8-50: Example of editing site parameters (SITM option)

8.8   Error Codes Menu (ERTM)

Main Menu > TMTP > ERTM

The Error Code Menu enables users to

- Designate whether a problem condition is considered an Error or a Warning.

- View or print a list of the Error Codes

To access the Error Codes Menu:

1. At the Third Party Billing System "Select menu option" prompt, type **TMTP** and press the Enter key.

2. At the "Select Table Maintenance Menu Option" prompt, type **ERTM** and press the Enter key.

The system displays the Error Codes Menu; for example,

```
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      |           THIRD PARTY BILLING SYSTEM - VER 2.6        |
      +                    Error Codes Menu                   +
      |                 INDIAN HEALTH HOSPITAL                |
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      User: TESTER,TEST                      3-DEC-2009 1:11 PM


   EDER   Edit Error Codes
   LSER   Error Codes Listing

Select Error Codes Menu Option:
```

Figure 8-51: Error Codes Menu (ERTM option)

- To edit error codes, see Section 8.8.1
- To view or print the list of Error Codes, see Section 8.8.2

8.8.1   Edit Error Codes (EDER)

Main Menu > TMTP > ERTM > EDER

Use the Edit Error Codes option to edit the Error/Warning status of problem conditions, where

- A claim with an Error status cannot be approved until the error is fixed.

- A claim with a Warning status may be approved.

To edit an Error Code Status of a problem condition, follow these steps:

1. At the "Select Error Codes Menu Option" prompt, type **EDER**.

2. At the "Select 3P Error Code" prompt, type the Error code number or a word contained in the error description.

Since some error codes cannot be edited locally, type **??** to display the list of Error Codes that **can** be edited.

3. At the "Error Status" prompt, type **E** (Error) or **W** (Warning) to set the error code status.

Remember: A claim with an error status cannot be approved until the error is fixed.

> **Note**: If the error is only specific to a handful of insurers, type **W** at the "Error Status" prompt.

4. At the "Display Only When in Error" prompt,

- Type **Y** (Yes) for the Claim Editor to display only problem conditions with an error status.

- Type **N** (No) for the Claim Editor to display problem conditions with both error and warning statuses.

5. At the "Required by Insurer" prompt, type the insurer's name, if the Error/Warning code applies only to a specific insurer.

This prompt continues to appear, until the user presses Enter at the "Required by Insurer:" prompt.

> **Note**: If the Error/ Warning is applicable to **all** insurers (e.g., PATIENT NAME UNSPECIFIED error), leave the "Required by Insurer" prompt blank.

6. At the "Reqd for Export Form" prompt, type the form name if the Error/Warning code only applies to a specific form (mode of export).

This prompt continues to appear, until the user presses Enter at a blank "Reqd for Export Form" prompt.

> **Note**: If the Error/ Warning is applicable to **all** forms or modes of export (e.g., PATIENT NAME UNSPECIFIED error), leave the "Reqd for Export Form" prompt blank.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |             THIRD PARTY BILLING SYSTEM - VER 2.6      |
        +                     Edit Error Codes                  +
        |                   INDIAN HEALTH HOSPITAL              |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                      3-DEC-2009 1:21 PM

Select 3P ERROR CODE: 5  INSURER ASSIGNED PROVIDER NUMBER UNSPECIFIED
ERROR STATUS: WARNING//
DISPLAY ONLY WHEN IN ERROR: YES//
Select REQUIRED BY INSURER: MEDICARE//
Select REQD FOR EXPORT FORM:
```

Figure 8-52: Example of edit error codes (EDER option)

8.8.2   Error Codes Listing (LSER)

Main Menu > TMTP > ERTM > LSER

Use the Error Codes Listing option to view or print the list of errors and warnings.

To view or print the list of errors and warnings, follow these steps:

1. At the "Select Error Codes Menu Option" prompt, type **LSER**.

2. The system will prompt for the device name. Enter the printer name and press the enter key.

```
    ERROR CODE LIST: INDIAN HOSP                                      Page: 1

E#     STATUS    NARRATIVE
==============================================================================

001    ERROR     OPERATIVE PROVIDER ENTERED WITH NO SURGICAL PROCEDURES
002    ERROR     SURGICAL PROCEDURE ENTERED BUT OPERATING PROVIDER IS NOT
003    ERROR     OPERATIVE PROVIDER ENTERED WITH NO ICD PROCEDURES
004    ERROR     CLAIM HAS NO CHARGES (PROCEDURES OR SERVICES) TO BILL
005    WARNING   INSURER ASSIGNED PROVIDER NUMBER UNSPECIFIED
006    ERROR     FEDERAL TAX NUMBER (EIN) UNSPECIFIED
007    WARNING   PROSTHETIC DEVICE CHARGE NOT ENTERED FOR THE INTRAOCULAR LENSE
008    ERROR     FACILITY THAT IS TO RECEIVE PAYMENTS IS NOT ESTABLISHED
010    ERROR     PATIENT NAME UNSPECIFIED
011    WARNING   PATIENT ADDRESS UNSPECIFIED
012    ERROR     PATIENT DATE OF BIRTH UNSPECIFIED
013    ERROR     PATIENT SEX UNSPECIFIED
014    WARNING   PATIENT MARITAL STATUS UNSPECIFIED
015    ERROR     ADMISSION DATE UNSPECIFIED
```

Figure 8-53: Sample error code listing (LSER option)

8.9   Group Insurance Plans Menu (GRTM)

Main Menu > TMTP> GRTM

The Group Insurance Plans Menu enables users to edit, list, assign, and merge group plans in the ABM system.

To access the Group Insurance Plans Menu:

1. At the Third Party Billing System "Select menu option" prompt, type **TMTP** and press Enter.

2. At the "Select Table Maintenance Menu Option" prompt, type **GRTM** and press the Enter key.

The system displays the Group Insurance Plans Menu; for example,

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |           THIRD PARTY BILLING SYSTEM - VER 2.6         |
          +              Group Insurance Plans Menu               +
          |                  INDIAN HEALTH HOSPITAL                |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                       3-DEC-2009 1:24 PM


    EDGR    Add/Edit Group Insurance Plans
    LSGR    Group Insurance Plans Listing
    ASGR    Mass Group Plan Assignment for specified Employer
    MRGR    Merge Duplicate Group Plans

Select Group Insurance Plans Menu Option:
```

Figure 8-54: Group Insurance Plans Menu

- To Add or edit the group insurance plans.

- To view or print a list of the group insurance plans.

- To assign a specified Group Plan to the policies of each employee for a selected employer.

- To merge duplicate group plans.

8.9.1   Add/Edit Group Insurance Plans (EDGR)

Main Menu > TMTP > GRTM > EDGR

If a patient is a member of a group insurance plan, the system needs the group name and numbers for that plan, to automate the billing process. Use the Add/Edit Group Insurance Plan option to add or edit group insurance plans.

The process for adding a group plan and the process for editing a group plan is similar. The main difference is that when editing a group plan, data previously entered displays between the prompt and two slashes (//). The cursor is positioned after the two slashes.

- To keep the existing data, press the Enter key.

- To edit the existing data, type the new data.

> **Note:** To prevent duplication, make sure that the plan the user want to add does not already exist.

To add or edit a Group Insurance Plan, follow these steps:

1. At the "Select Group Insurance Plans Menu Option" prompt, type **EDGR**.

2. At the "Select Employer Group Insurance Group Name" prompt, type the name of the group plan to add or edit.

   When adding a new group plan, the system prompts the user to verify the addition. Then go to step 4.

3. At the "Modify Group Name" prompt, type the new name; otherwise, press the Enter key.

```
SELECT GROUP INSURANCE PLANS MENU OPTION: EDGR <Enter>  ADD/EDIT GROUP INSURANCE
PLANS
Select EMPLOYER GROUP INSURANCE GROUP NAME: TEST GROUP <Enter>

Modify GROUP NAME (if Desired): TEST GROUP// TEST GROUP PLAN <Enter>
```

Figure 8-55: Example of editing group insurance plans (steps 1-3)

4. At the "Do the Group Numbers vary depending on Visit Type (Y/N)?" prompt, Type **Y** or **N**.

   - Type **N**, if the group number is the same, regardless of the patient's visit type, and go to step 5.

- Type **Y**, if the group number changes depending on the patient's type of visit (inpatient, outpatient, dental), and go to step 6.

5. If the group number is the same regardless of visit type,

At the "[5a] Group Number" prompt, type the 3- to 17-character group number assigned to the group plan by the insurer; for example,

```
     NOTE: Some Insurers assign different Group Numbers based upon the
           particular type of visit (dental, outpatient, etc.) that
           occurred.

Do the Group Numbers vary depending on Visit Type (Y/N)? Y// N <Enter>  NO

[5a] Group Number.....: 12345 <Enter>
```

Figure 8-56: Example of editing group insurance plans (step 4a)

6. If the group number changes depending on type of visit,

   a. At the "Select Visit Type" prompt, type a visit type entry. The system will use the entries stored in the Visit type file. Some examples are:

   - 111 (inpatient)

   - 131 (outpatient)

   - 998 (Dental)

   Then verify the entry by typing **Y** at the prompt.

   b. At the "Group Number (Visit Specific)" prompt, type the group plan number associated with the visit type you selected in step 6a

   c. Since there can be more than one visit type, repeat steps 6a and b to add additional visit types for the selected Employer Group Insurance.

   When finished, press the Enter key at a blank "Select Visit Type" prompt.

   Then the system displays the Group Insurance Plans menu.

```
     NOTE: Some Insurers assign different Group Numbers based upon the
           particular type of visit (dental, outpatient, etc.) that
           occurred.

Do the Group Numbers vary depending on Visit Type (Y/N)? N// Y <Enter>  YES

Select VISIT TYPE: 111 <Enter>  (INPATIENT)
  Are you adding 'INPATIENT' as a new VISIT TYPE (the 1ST for this EMPLOYER GROUP
INSURANCE)? No// Y <Enter>  (Yes)
  GROUP NUMBER (VISIT SPECIFIC): 12345A <Enter>
Select VISIT TYPE: 131 <Enter>  (OUTPATIENT)
  Are you adding 'OUTPATIENT' as a new VISIT TYPE (the 2ND for this EMPLOYER GROUP
INSURANCE)? No// Y <Enter>  (Yes)
  GROUP NUMBER (VISIT SPECIFIC): 12345B <Enter>
Select VISIT TYPE: <Enter>
```

Figure 8-57: Example of editing group insurance plans (step 6)

8.9.2   Group Insurance Plans Listing (LSGR)

Main Menu > TMTP > GRTM > LSGR

Use the Group Insurance Plans Listing option to view or print a current listing of
Group Insurance plans. The list includes the

- Insurance plan name and number

- Any visit type/visit-specific group numbers

**To view or print a list of current group insurance plans, follow these
steps:**

1. At the "Select Group Insurance Plans Menu Option" prompt, type **LSGR**.

2. At the "DEVICE" prompt,

    - Press the Enter key to display the list on the screen, or

    - Type the name of the printer; and at the "Right Margin" prompt, press the
      Enter key to accept the default value of 80, or type the size of the right
      margin.

The system displays or prints the current group insurance plans; for example,

```
GROUP INSURANCE PLAN LIST                      DEC  3,2009  13:29    PAGE 1
GROUP NAME                          GROUP NUMBER
                                    VISIT SPECIFIC
   VISIT TYPE                       GROUP NUMBERS
--------------------------------------------------------------------------------

MACOMB COUNTY SHERIFF DEPT     33536
MAIL HANDLERS BENEFIT PLAN
MAILHANDLERS 454               454
MARRIOTT                       21123
MARTIN'S JEWELRY REPAIR        324342
MEDIAMAX                       CMDT-11039
MERLE'S AUTO AND BODY
    MEDICAL/SURGICAL                   003982
MESA PHSYCHIATRIC SERVICES     00384
MESA PSYCHIATRIC SERVICES      00384
MIDAS MUFFLER                  2104004
MIDAS MUFFLER-CO               3986672
MINI MART                      MM123
    OUTPATIENT                      HX2222
    DENTAL                          D3555
```

Figure 8-58: Example of a group insurance plans listing

8.9.3   Mass Group Plan Assignment for Specified Employer (ASGR)

Main Menu > TMTP > GRTM > ASGR

The Mass Group Plan Assignment for Specified Employer option is a utility that enables you to assign a specified group plan policy to all employees of a selected employer.

To assign all employees of a selected employer a specific group plan policy, follow these steps:

1. At the "Select Group Insurance Plans Menu Option" prompt, type **ASGR**.

2. At the "Do you wish to run this utility program?" prompt, type **YES**.

3. At the "Select Employer" prompt, type the name of the employer whose employees the user wants to assign the group plan.

   Any employer in the Employer file can be selected.

4. At the "Select Group Plan" prompt, type the name of the group plan that will be assigned to all employees of specified employer.

   The user can select any Group Plan in the Group Plan file.

   The system displays the selection and prompts the user to verify the selection

5. At the "Is this Correct (Y/N)?" prompt, type **Y**, if the displayed employer and group plan is correct.

    The system changes the policy selected, and displays a count of the policies changed for all patients associated with the employer and group plan combination selected.

6. At the "Do you wish to Select another Employer?" prompt, type **Yes** or **No**.

    - If the user types **Yes**, the "Select Employer" prompt is displayed. Repeat steps 2-5.

    - If the user types **No**, the system displays the Group Insurance Plans menu.

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       |           THIRD PARTY BILLING SYSTEM - VER 2.6        |
       +   Mass Group Plan Assignment for specified Employer   +
       |                  INDIAN HEALTH HOSPITAL               |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: TESTER,TEST                         3-DEC-2009 1:31 PM

This utility allows for the mass assignment of a specified Group Plan to the
policies of each employee for a selected Employer.

Do you wish to run this utility program? yes  YES

Select EMPLOYER: INDIAN HEALTH SERVICE

Select GROUP PLAN: INDIAN HEALTH SERVICE

You have selected to assign all employees of: INDIAN HEALTH SERVICE
                             the Group Plan: INDIAN HEALTH SERVICE

Is this Correct (Y/N)? YES.......................................................
....................

       POLICIES CHANGED: 34


Do you wish to Select another Employer? NO <Enter>
```

Figure 8-59: Example of mass group plan assignment for specified employer (ASGR option)

8.9.4   Merge Duplicate Group Plans (MRGR)

Main Menu > TMTP > GRTM > MRGR

Use the Merge Duplicate Group Plans option to merge duplicate group plans under a single group plan name.

To merge duplicate group plans, follow these steps:

1. At the "Select Group Insurance Plans Menu Option" prompt, type **MRGR**.

2. At the "Select Group Plan (to Search against)" prompt, type the name or keyword for the first plan.

   The system displays the possible matches.

3. At the "Choose" prompt, type the number of the plan to search against.

4. At the "Select (Search) for Duplicate Group Plan" prompt, type the name or keyword for the second plan.

   The system displays the two selected group plans.

5. At the "Are the two Group Plans duplicates?" prompt, type

   • **Y** (Yes) and repeat steps 2-3. or

   • **N** (No) and the system prompts the user to determine if he/she wants to continue checking for duplicates against the first plan name. Repeat steps 1-3.

6. At the "Which of the two is most accurate" prompt, type the number (1 or 2) that corresponds to the more accurate plan.

   The system merges the less accurate group plan file with the more accurate group plan file.

7. At the "Do you wish to continue running this program?" prompt,

   • Type **Y** (Yes)to continue merging duplicate plans

   • Type **N** (No) to return to the Group Plan menu.

```
+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
|           THIRD PARTY BILLING SYSTEM - VER 2.6          |
+    Mass Group Plan Assignment for specified Employer    +
|                 INDIAN HEALTH HOSPITAL                  |
+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
User: TESTER,TEST                        3-DEC-2009 1:31 PM
```

```
Select GROUP PLAN (to Search against): TEST <Enter>
     1    TEST GROUP PLAN
     2    TEST PLAN
CHOOSE 1-2: 1 <Enter>   TEST GROUP PLAN

Dup-Check for: TEST GROUP PLAN
              33456
==================================================
Select (SEARCH) for Duplicate GROUP PLAN: TEST PLAN
_____
[1]  TEST GROUP PLAN                   | [2]   TEST PLAN
     33456                             |       12345
---------------------------------------------------------------------

     Are the two GROUP PLANS duplicates (Y/N)? Y <Enter>

     Select one of the following:

         1             TEST GROUP PLAN
         2             TEST PLAN

     Which of the two is most accurate: 1 <Enter>   TEST GROUP PLAN

Re-directing Pointers...

Do you wish to continue running this program? Y// N <Enter>
```

Figure 8-60: Example of merge duplicate group plans (MRGR option)

8.10   Revenue Codes Menu (RVTM)

Main Menu > TMTP > RVTM

The Error Codes Menu enables users to maintain revenue codes, and create a listing of revenue codes. These options are outlined in this section.

To access the Revenue Codes Menu:

1. At the Third Party Billing System "Select menu option" prompt, type **TMTP** and press the Enter key.

2.   At the "Select Table Maintenance Menu Option" prompt, type **RVTM** and press the Enter key.

The system displays the Revenue Codes Menu; for example,

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
            +                  Revenue Codes Menu                    +
            |                 INDIAN HEALTH HOSPITAL                 |
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            User: TESTER,TEST                      3-DEC-2009 1:37 PM


   EDRV    Revenue Code Maintenance
   LSRV    Print Revenue Code Listing

Select Revenue Codes Menu Option:
```

Figure 8-61: Revenue Codes Menu

- To perform Revenue Code maintenance, see Section 8.10.1.

- To view or print a list of the Revenue Codes, see Section 8.10.2.

8.10.1   Revenue Codes Maintenance (EDRV)

Main Menu > TMTP > RVTM > EDRV

Use the Revenue Codes Maintenance option to perform the following maintenance tasks:

- Indicate whether a code is active or inactive.

- Specify whether a revenue code is selectable in the Visit Type fields of the Insurer file when setting up an all-inclusive mode claim.

To perform Revenue Code maintenance tasks, follow these steps:

1. At the "Select Revenue Codes Menu Option" prompt, type **EDRV**.

2. At the "Select Revenue Code to Edit" prompt, type the revenue code name or number.

3. At the "Activate/Inactivate Code" prompt, type **A** (Activate) to enable selection of the revenue code in the Claim Editor; otherwise, type **I** (Inactivate).

4. At the "All Inclusive Rate" prompt, type **Y** (Yes) to enable the revenue code to be selectable in the Visit Type fields of the Insurer file; otherwise type N (No).

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
            +                Revenue Code Maintenance                +
            |                 INDIAN HEALTH HOSPITAL                 |
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            User: TESTER,TEST                      3-DEC-2009 1:42 PM
```

```
Select REVENUE CODE to Edit: 918        PSYCH/TESTING      TESTING

Activate/Inactivate Code..: A  ACTIVATE CODE
All Inclusive Rate (Y/N)..: Y  YES


Select REVENUE CODE to Edit:
```

Figure 8-62: Example of Revenue Code Maintenance screen (EDRV option)

8.10.2   Print Revenue Code Listing (LSRV)

Main Menu > TMTP > RVTM > LSRV

Use the Print Revenue Code Listing option to view or print a list of the current revenue codes. For each revenue code, the report lists the

- Standard abbreviated description

- Active status

- All-inclusive status

To view or print the list of Revenue Codes, follow these steps:

1. At the "Select Revenue Codes Menu Option" prompt, type **LSRV**.

2. At the "DEVICE" prompt,

- Press the Enter key to display the list on the screen, or

- Type the name of the printer; and at the "Right Margin" prompt, press the Enter key to accept the default value of 80, or type the size of the right margin.

The system displays or prints the Revenue Codes list; for example,

```
REVENUE CODES LIST                         DEC  3,2009  13:44    PAGE 1
REVENUE                                                 ALL
CODE     STANDARD ABBREVIATION              INACTIVATE    INCLUSIVE
-------------------------------------------------------------------------

100      ALL INCL R&B/ANC                   ACTIVATE CODE    YES
101      ALL INCL R&B                       ACTIVATE CODE    YES
110      ROOM-BOARD/PVT
111      MED-SUR-GY/PVT
112      OB/PVT
113      PEDS/PVT
114      PSYCH/PVT
```

```
115      HOSPICE/PVT
116      DETOX/PVT
117      ONCOLOGY/PVT
118      REHAB/PVT
119      OTHER/PVT
120      ROOM-BOARD/SEMI
121      MED-SURG-GYN/2BED
122      OB/2BED
```

Figure 8-63: Example of the revenue code listing (LSRV option)

8.11   UB-92 Codes Menu (UCTM)

Main Menu > TMTP > UCTM

The UB-92 Codes Menu enables users to maintain and list the UB-92 codes.

To access the UB-92 Codes Menu:

1. At the Third Party Billing System "Select menu option" prompt, type **TMTP** and press the Enter key.

2.   At the "Select Table Maintenance Menu Option" prompt, type **UCTM** and press the Enter key.

The system displays the UB-92 Codes Menu; for example,

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |              THIRD PARTY BILLING SYSTEM - VER 2.6          |
        +                    UB-92 Codes Menu                        +
        |                  INDIAN HEALTH HOSPITAL                    |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                         3-DEC-2009 1:45 PM


   EDUB    UB-92 Code Maintenance
   LSUB    UB-92 Codes Listing

Select UB-92 Codes Menu Option:
```

Figure 8-64: UB-92 Codes Menu

8.11.1   UB-92 Code Maintenance (EDUB)

Main Menu > TMTP > UCTM > EDUB

Use the UB-92 Maintenance option to add a new code or edit an existing code.

The process for adding or editing a UB-92/UB-04 code is similar. The main difference is that when editing an entry, data previously entered displays between the prompt and two slashes (//). The cursor is positioned after the two slashes.

- To keep the existing data, press the Enter key.

- To edit the existing data, type the new data.

To add or edit a UB-92/UB-04 code, follow these steps:

1. At the "Select UB-92 Menu Option" prompt, type **EDUB**.

2. The system will display the following list of categories:

```
        1              CONDITION CODES
        2              OCCURRENCE CODES
        3              OCCURRENCE SPAN CODES
        4              SPECIAL PROGRAM CODES
        5              VALUE CODES
        6              BILL TYPE
        7              DELAYED REASON CODES

Select Desired Code:
```

Figure 8-65: Category list for adding/editing a UB-92/UB-04 code

At the "Select Desired Code" prompt, type the number that corresponds to the category of the UB-92 code the user wants to edit.

3. At the "Desired action" prompt, type

- **1** to edit a code for the specified category, and go to step 4.

- **2** to add a code for the specified category, and go to step 5.

- **3** to quit and return to the UB-92 Codes menu.

> **Note**: When adding a code, make sure that the code is legitimate and known by the entities to be billed.

4. To edit a code, type the number of the code to edit at the "Select [category name] code to Edit" prompt.

To see a list of options, type two question marks (**??**) at the prompt.

If editing an existing code, the existing description text will appear after the "Description" prompt, followed by the word Replace.

To edit the entire description, type three periods (**…**) after the "Replace" prompt and type the new description after the word "With" (which displays after typing the three periods).

To edit a portion of the description, type the portion to edit after the "Replace" prompt and type the new portion of the description after the word "With" (which displays after selecting text to replace).

If the description does not need to be edited, press the Return key at the "Replace" prompt.

5. If adding a new code, type the description of the new code at the "Description:" prompt.

    If a new code is added, the system will prompt the user to verify the entry before continuing to step 6.

6. At the "Inactive Flag" prompt, type

    - **0** (Active) for the code to be used on appropriate UB-92/UB-04 forms, or

    - **1** (Inactive) - to indicate that this code is inactive.

```
Select Desired Code: 1  CONDITION CODES
        Select one of the following:

            1           EDIT
            2           ADD
            3           QUIT
Desired Action: 1// <Enter>  EDIT


Select CONDITION CODE to Edit: 18 <Enter>         MAIDEN NAME RETAINED
DESCRIPTION: MAIDEN NAME RETAINED Replace...With PATIENT RETAINED MAIDEN NAME
<Enter>
        Replace
        Patient Retained Maiden Name
 INACTIVE FLAG:  ACTIVE FLAG// 0    ACTIVE FLAG
```

Figure 8-66: UB-92 Code Maintenance

8.11.2   UB-92 Codes Listing (LSUB)

Main Menu > TMTP > UCTM > LSUB

Use the UB-92 Codes Listing option to generate a list of UB-92/UB-04 codes sorted by category.

To view or print the list of Revenue Codes, follow these steps:

1. At the "Select UB-92 Codes Menu Option" prompt, type **LSUB**.

2. At the "DEVICE" prompt,

    *   Press the Enter key to display the list on the screen, or

    *   Type the name of the printer; and at the "Right Margin" prompt, press the Enter key to accept the default value of 80, or type the size of the right margin.

The system displays or prints the UB-92 Codes list, sorted by category; for example,

```
UB-92 CODES LISTING              DEC  3,2009  14:39    PAGE 1
CODE  DESCRIPTION
----------------------------------------------------------------------------


        CODE TYPE: ADMIT SRCE
1     PHYSICIAN REFERRAL
2     CLINIC REFERRAL
3     HMO REFERRAL
4     TRANSFER FROM A HOSPITAL
5     TRANSFER FROM SKILLED NURSING FACILITY
6     TRANSFER FROM ANOTHER FACILITY
7     EMERGENCY ROOM
8     COURT/LAW ENFORCEMENT
9     UNKNOWN
A     Transfer from a Critical Access Hospital
B     Transfer from Another Home Health Agency


        CODE TYPE: BILL TYPE
110   NON COVERED
111   INPATIENT ADMIT THRU DISCHARGE
121   INPATIENT (MCR PART B) ADMIT THRU DISCHARGE
130   ZERO PAY
131   OUTPATIENT
```

Figure 8-67: Example of UB-92 Code listings (LSUB option)

8.12   Employer File Menu (EMTM)

Main Menu > TMTP > EMTM

The Employer File menu enables users to

- Add or edit employer entries

- View or print a list of the employers or a list of all employees by employer

- Merge duplicate employers in the file

To access the Employer File Menu:

1. At the Third Party Billing System "Select Menu Option" prompt, type **TMTP** and press the Enter key.

2. At the "Select Table Maintenance Menu Option" prompt, type **EMTM** and press the Enter key.

The system displays the Employer File Menu; for example,

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |            THIRD PARTY BILLING SYSTEM - VER 2.6       |
        +                   Employer File Menu                  +
        |                  INDIAN HEALTH HOSPITAL               |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                        3-DEC-2009 2:42 PM


   EDEM   Add/Edit an Employer
   LSEM   Employer Listing
   RPEM   List all Employees by Employer
   MREM   Merge Duplicate Employers

Select Employer File Menu Option:
```

Figure 8-68: Employer File Menu (EMTM option)

- To add or edit an employer, see Section 8.12.1.

- To view or print a list of the employers in the Employer file, see Section 8.12.2.

- To view of print a list of all employees by employer, see Section 8.12.3.

- To merge duplicate employers in the Employer file, see Section 8.12.4.

8.12.1   Add/Edit an Employer (EDEM)

Main Menu > TMTP > EMTM > EDEM

Use the Add/Edit an Employer option to

- Add new employers to the Employer file.

- Update information f or existing employers in the Employer file.

The process for adding an employer or editing an employer is similar. The main difference is that, when editing a visit type, any data previously entered displays between the prompt and two slashes (//). The cursor is positioned after the two slashes.

- To keep the existing data, press the Enter key.

- To edit the existing data, type the new data.

> **Note:** To prevent duplication, make sure that the employer you want to add does not already exist in the Employer file.

To add or edit an employer in the Employer file, follow these steps:

1. At the "Select Employer File Menu Option" prompt, type **EDEM**.

2. At the "Select Employer" prompt, type the name of the employer to add or edit.

When adding an employer, the system prompts the user to verify the entry.

To see a list of available employers, type a question mark (**?**) at the prompt.

3. At the "Employer [current name]//" prompt, type the name of the employer to add or edit; otherwise, press the Enter key.

4. At the following prompts, enter the complete **mailing address** for the specified employer.

Prompt:	Action
Street	Type the complete street address.
State	Type the name of the city.
State	Type the name or abbreviation of the state.
Phone	Type the business office phone number, including the area code.
Abbrev	Type an abbreviation that can be used to find the employer.

5. At the "Billing Entity for Workmen's Comp" prompt, type the name of the company the employer uses for Workers Compensation Claims.

```
Select EMPLOYER: TEST

Employer..: TEST// <Enter>
Street....: 1234 ANYWHERE STREET <Enter>
City......: ANYWHERE <Enter>
State.....: NEW MEXICO <Enter>
Zip.......: 87111 <Enter>
Phone.....: 505-555-4545 <Enter>
Abbrev....: TT <Enter>

Billing Entity for Workmen's Comp.: NM BC/BS( BLUE CROSS/CROSSE MEXICO NEW SHIELD )

NEW MEXICO BC/BS INC            - 12800 NATIVE SCHOOL RD NE     Domain: NM
                                  ALBUQUERQUE, NM 87112
 OK? Y// Y
```

Figure 8-69: Example of editing employer information in the Employer file (EDEM option)

8.12.2   Employer Listing (LSEM)

Main Menu > TMTP > EMTM > LSEM

Use the Employer Listing option to display or print a list of the employers in the
Employer File.

To view/print the contents of the Employer file, follow these steps:

1. At the "Select Employer File Menu Option" prompt, type **LSEM**.

2. At the "DEVICE" prompt,

    - Press the Enter key to display the list on the screen, or

    - Type the name of the printer; and at the "Right Margin" prompt, press the
      Enter key to accept the default value of 80, or type the size of the right
      margin.

The system displays or prints the contents of the Employer file; for example,

```
===== EMPLOYER LISTING =====                 DEC  3,2009  14:45    PAGE 1
EMPLOYER                              PHONE
--------------------------------------------------------------------------------


ABC CORPORATION                       505 2222222
  1564 MAIN STREET
  ALBUQUERQUE, NM  87109

ABEL JEWELERS                         505-474-4411
  4329 GREEN MEADOWS DR
  SANTA FE, NM  87528


ABSENT                                909 800 8080
```

```
   003 DONTKNOW
   WHOVILLE, CA  99999

ACADEMY REPROGRAPHICS
   4801-C ALAMEDA NW
   ALBUQUERQE, NM  87102

ACCESS TRAVEL AGENCY                        505-474-4411
   4329 GREEN MEADOWS,DRIVE
   SANTA FE, NM  97528
```

Figure 8-70: Example of Employer Listing screen (LSEM option)

8.12.3   List all Employees by Employer (RPEM)

Main Menu > TMTP > EMTM > RPEM

Use the Employees by Employer option to generate a list of employees sorted alphabetically by employer to view on the screen or print.

To view/print a list of all employees by employer, follow these steps:

1. At the "Select Employer File Menu Option" prompt, type **RPEM**.

2. At the "Do you wish the Run the Program?" prompt, type **Y** (Yes) to generate the list.

2. At the "DEVICE" prompt,

   - Press the Enter key to display the list on the screen, or

   - Type the name of the printer; and at the "Right Margin" prompt, press the Enter key to accept the default value of 80, or type the size of the right margin.

The system displays or prints the list of all employees by employer; for example,

```
================================================================================
EMPLOYEE LISTING for All EMPLOYERS                      DEC 3,2009   Page 1
Billing Location: INDIAN HOSP
================================================================================
Employer                        Employee                       HRN
--------------------------------------------------------------------------------

ABC CORPORATION                 FREEDOM,LIBERTY                502251

ABEL JEWELERS                   DEMO,SHAYLA                    8253
                                RED,SCARLETT                   1253

ACADEMY REPROGRAPHICS           DOE,DOUG                       2105

ACCESS TRAVEL AGENCY            BLACK,OREO                     9236
```

```
                                    OREO,CLEO                        1236

ACCI ENG. CONSTRUCTION             PRESIDENT,HARRY                  19670

ACE HARDWARE                       KERYALL,KITTY                     1510
```

Figure 8-71: List All employees by employer

8.12.4   Merge Duplicate Employers (MREM)

Main Menu > TMTP > EMTM > MREM

Use the Merge Duplicate Employers option to merge two duplicate employers,

To merge duplicate Employers, follow these steps:

1. At the "Select Employer File Menu Option" prompt, type **MREM**.

2. At the "Select Employer" prompt, type the name or keyword for the employer to Search against.

3. At the "OK?" prompt, type

    - **Y** (Yes) if the displayed employer is correct.

    - **N** (No) if the displayed employer is not correct and repeat step 2.

    Note: If the displayed employer is the only one that matches the criteria, the system does not display the "OK?" prompt for verification.

4. At the "Select Duplicate Employer" prompt, type the name or keyword for the duplicate employer.

5. At the "OK?" prompt, type

    - **Y** (Yes) if the displayed employer is the one you want.

    - **N** (No) if the displayed employer is not the one you want and repeat step 4.

    - If the employer found is the only one the system finds to match the user's criteria, the system will not ask for verification.

    Note: If the displayed employer is the only one that matches the user's criteria, the system does not display the "OK?" prompt for verification.

The system displays the two employers and their information.

6. At the "Are the two Employers duplicates?" prompt, type **Y** (Yes) or **N** (No).

    If **N** (No) is typed, the system prompts the user to continue checking for duplicates for the first employer.

    - If the user types **Y** (Yes), repeat steps 4 and 5.

    - If the user types **N** (No), repeat steps 2-4.

7. At the "Which of the two is most accurate" prompt type number, type either **1** or **2**, depending upon which record is accurate for the two employers.

    The system merges the least accurate employer file with the more accurate employer file by redirecting the data pointers to the more accurate data.

8. At the "Do you wish to continue running this program?" prompt,

    - Press the Enter key for the default (Yes) to merge other duplicate employers.

    - Type **N** (No) to return to the Employer File menu.

```
Select EMPLOYER (to Search against): TEST <Enter>

Dup-Check for: TEST
               1234 ANYWHERE ST.
               ANYWHERE, NM 87111
=================================================
Select (SEARCH) for Duplicate EMPLOYER: DEMO <Enter>
_____
[1]  TEST                             | [2]  DEMO
     1234 ANYWHERE ST.                |      1234 ANYPLACE
     ANYWHERE, NM 87111               |      ANYWHERE, NM 87111
-------------------------------------------------------------------------------

     Are the two Employers duplicates (Y/N)? YES <Enter>

     Select one of the following:

          1          TEST
          2          DEMO

     Which of the two is most accurate: 1 <Enter>   TEST

OK, MERGING..

Re-directing Pointers...

Do you wish to continue running this program? Y//
```

Figure 8-72: Example of merging duplicate employers (MREM option)

8.13   Drug File Menu (DRTM)

Main Menu > TMTP > DRTM

Pharmacy is responsible for Drug file maintenance. However, two drug file inquiry options enable users to print a listing of drugs and display a drug file entry.

To access the Drug File Menu:

1. At the Third Party Billing System "Select menu option" prompt, type **TMTP** and press the Enter key.

2. At the "Select Table Maintenance Menu Option" prompt, type **DRTM** and press the Enter key.

The system displays the Drug File Menu; for example,

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       |             THIRD PARTY BILLING SYSTEM – VER 2.6         |
       +                      Drug File Menu                      +
       |                   INDIAN HEALTH HOSPITAL                 |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: TESTER,TEST                      3-DEC-2009 2:51 PM


    LSDR   Drug Listing
    IQDR   Display a Drug File Entry

Select Drug File Menu Option:
```

Figure 8-73: Drug File Menu (DRTM option)

- To view or print an alphabetical list drugs in the Drug file, and their NDC number and dispense fee, see Section 8.13.1.

- To view all information on file for a specific drug, see Section 8.13.2.

8.13.1   Drug Listing (LSDR)

Main Menu > TMTP > DRTM > LSDR

Use the Drug Listing option to generate an alphabetical listing of drugs in the Drug file that includes the NDC Number and dispense fee. Drug synonyms can be included.

To generate and view or print a list of drugs in the Drug file, follow these steps:

1. At the "Select Drug File Menu Option" prompt, type **LSDR**.

2. At the "Do you wish to run the program" prompt, press the Enter key. The default for this prompt is Yes. This will generate the list of drugs in the Drug file.

3. At the "Should the Listing display the Drug Synonyms?" prompt, type **Y** (Yes) to include the Drug synonyms on the list; otherwise, type **N** (No).

4. At the "Device" prompt, type the name of the device to view or print the listing.

The system displays or prints the alphabetically list of drugs in the Drug file; for example,

```
================================================================================
DRUG FILE LISTING                                         DEC 3,2009    Page 1
Billing Location: INDIAN HOSP
================================================================================
                                                      Dispense Fee
     Drug / Synonym                       NDC Number    Per Unit     Units
--------------------------------------------------------------------------------
AMINOPHYLLINE 100MG TAB                                    0.000      TAB
     Ami100
AMIODARONE 50MG/ML INJ 3ML (BEN VENUE)    55390-0057-10   0.425      ML
     Cordarone
AMIODARONE HCL 200MG TAB (SANDOZ)         00781-1203-60   0.150      TAB
     Cor200
AMITRIPTYLINE  25MG TAB U/D               51079-0107-20   0.045      TAB
     Ami25T
AMITRIPTYLINE 25MG TAB (Q/P)              00603-2213-32   0.017      TAB
     Amitr25
AMITRIPTYLINE 25MG TAB (SANDOZ)           00781-1487-10   0.064      TAB
     Amitr25
AMITRIPTYLINE 50MG TAB                                    0.010      TAB
     Endep
AMLODIPINE                                                0.000
AMLODIPINE 10MG TAB                       00069-1540-68   1.740      TAB
     Aml10
AMLODIPINE 5MG TAB                        00069-1530-68   0.800      TAB
     Aml5T
AMLODIPINE 5MG TAB (CARACO)               57664-0569-99   0.015      TAB
     Norvasc
```

Figure 8-74: Example of a Drug File Listing (LSDR option)

8.13.2   Display a Drug File Entry (IQDR)

Main Menu > TMTP > DRTM > IQDR

Use the Drug File Entry option to view all information on file for a specific drug.

To view all information on file for a specific drug, follow these steps:

1. At the "Select Drug File Menu Option" prompt, type **IQDR**.

2. At the "Select Drug" prompt, type the name of number of the drug.

The system displays all of the information on file for the specified drug. Only those fields that contain data are displayed.

```
Select DRUG:    IPRATROPIUM 0.02% NEB U/D SOLN (IVAX)         RE105    -5503
     FOR USE IN ER/POPD FOR ACUTE EXACERBATION OF RAD         00172-6407-44   IHH



                         *** DRUG FILE INQUIRY ***

================================================================================
NUMBER: 85055
GENERIC NAME: IPRATROPIUM 0.02% NEB U/D SOLN (IVAX)
  VA CLASSIFICATION: RE105               DEA, SPECIAL HDLG: 6
  MESSAGE: FOR USE IN ER/POPD FOR ACUTE EXACERBATION OF RAD
SYNONYM: ATROVENT                        INTENDED USE: TRADE NAME
SYNONYM: 000172640744                    NDC CODE: 000172-6407-44
  INTENDED USE: DRUG ACCOUNTABILITY
  PHARMACY ORDERABLE ITEM: IPRATROPIUM  APPLICATION PACKAGES' USE: OXU
  NDC: 00172-6407-44
  CORRESPONDING OUTPATIENT DRUG: IPRATROPIUM 0.02% NEB U/D SOLN (IVAX)
  ORDER UNIT: BX                         PRICE PER ORDER UNIT: 2.56
  DISPENSE UNITS PER ORDER UNIT: 62.5   PRICE PER DISPENSE UNIT: 0.041
  DISPENSE UNIT: ML                      CURRENT INVENTORY: -5503
OLD NAMES: IPRATROPIUM 0.02% NEB SOLN (B/I) (T)
  DATE CHANGED: FEB 21, 2005
OLD NAMES: IPRATROPIUM 0.02% NEB SOLN (IVA)
  DATE CHANGED: SEP 27, 2005
OLD NAMES: IPRATROPIUM 0.02% NEB SOLN (IVAX)
  DATE CHANGED: SEP 27, 2005
  LAST PRICE UPDATE: JAN 31, 2008@08:23:23
  DIVISION: INDIAN HOSPITAL             AWP PER ORDER UNIT: 44.1
  AWP PER DISP UNIT: 00000.705600       AWP EFFECTIVE DATE: FEB 22, 2000
LOCAL POSSIBLE DOSAGE: 125 MCG (1/4 BULLET)
  PACKAGE: Both
LOCAL POSSIBLE DOSAGE: 250 MCG (1/2 BULLET)
  PACKAGE: Both
LOCAL POSSIBLE DOSAGE: 500 MCG (1 BULLET)
  PACKAGE: Both
  NATIONAL DRUG FILE ENTRY: IPRATROPIUM
  VA PRODUCT NAME: IPRATROPIUM BR 0.02% SOLN,INHL,2.5ML
  PSNDF VA PRODUCT NAME ENTRY: IPRATROPIUM BR 0.02% SOLN,INHL,2.5ML
  PACKAGE SIZE: 25 X 2.5 ML             PACKAGE TYPE: UNIT DOSE
  NATIONAL DRUG CLASS: RE105            CMOP ID: I0178
  NATIONAL FORMULARY INDICATOR: YES
================================================================================

Select DRUG:
```

Figure 8-75: Example of displaying the information on file for a specific drug (IQDR option)

8.14 Visit Type Maintenance (VITM)

Main Menu > TMTP > VITM

The Visit Type Maintenance option enables users to establish new visit types or edit existing visit types.

For example, creating a new visit type would be necessary if the local Medicaid Intermediary specified a special program to be billed differently from the existing visit types (outpatient, inpatient and dental). After creating the new visit type, billing data for this visit type can be obtained from the Insurer file and could be established for controlling the mode of billing. Each claim to be billed in this manner would require manual linking to this visit type.

The process for adding a visit type and the process for editing a visit type are similar. The main difference is that, when editing a visit type, any data previously entered displays between the prompt and two slashes (//). The cursor is positioned after the two slashes.

- To keep the existing data, press the Enter key.

- To edit the existing data, type the new data.

To add or edit a Visit Type, follow these steps:

1. At the Third Party Billing System "Select menu option" prompt, type **TMTP** and press the Enter key.

2. At the "Select Table Maintenance Menu Option" prompt, type **VITM** and press the Enter key.

3. At the "Select Visit Type" prompt, type the name of the visit type to add or edit.

   When adding a new visit type, the system prompts the user to verify the addition.

4. At the "3P Visit Type Number" prompt,

   - If the user adds a visit type, the next available visit type number displays between the prompt and two slashes (//).

     Press the Enter key to accept the default number assignment, or type a number.

   Note: The Visit Type number must be unique, but is user-specific and has no intrinsic meaning to the billing system.

- When editing a visit type, the number currently assigned to the visit type displays between the prompt and two slashes (//).

5. At the "Name" prompt,

   - When adding a visit type, type a name that describes the services that will be billed.

   - When editing a visit type, select the visit type entry and modify the name.

6. At the "UB-92 Bill Type" prompt, type one of the following:

   - **111** (inpatient)

   - **131** (outpatient)

   - **711** (rural clinic)

   > **Note:** The UB-92 Bill Type field determines how the system will process the claim. If the visit type is for an inpatient visit, it must be specified as such, so that the Claim Editor will allow access to Inpatient data fields.

7. At the "Select Clinic" prompt, type the clinic type number that applies to the specified visit type.

   > **Note:** When the Clinic field is specified for a visit type, all automatically created claims from a visit at the same clinic contains this visit type, as defined for the primary insurer.

   If the user adds a new clinic type, the system prompts him/her to verify the entry.

8. The system continues to prompt for clinic types for the specified visit type, until the user presses the Enter key at the "Select Clinic" prompt.

9. The Auto-Link to PCC file is not used at this time. It will be used in the future for creating multiple claims and allowing the generated claim to be linked to certain visit files.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
        +                   Visit Type Maintenance                +
        |                   INDIAN HEALTH HOSPITAL                |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                       3-DEC-2009 3:08 PM

Select VISIT TYPE:    EMERGENCY ROOM
NAME: EMERGENCY ROOM//
UB-92 BILL TYPE: OUTPATIENT//
Select CLINIC: EMERGENCY MEDICINE//
```

```
AUTO-LINK to PCC file:
```
Figure 8-76: Example of adding a visit type (VITM option)

8.15 Charge Master Add/Edit (CMTM)

Main Menu > TMTP > CMTM

The Third Party Charge Master File is used to bill for supplies, and only those products that exist in the Charge Master file can be selected on page 8J of the Claim Editor. The Charge Master Add/ Edit option enables the user to add new or modify existing entries in the Third Party Charge Master file.

The process for adding or editing entry in the Charge Master file is similar. The main difference is that, when editing an entry, data previously entered displays between the prompt and two slashes (//). The cursor is positioned after the two slashes.

- To keep the existing data, press the Enter key.

- To edit the existing data, type the new data.

> **Note:** To prevent duplication, make sure that the Charge Master
> entry does not already exist in the file.

To add or edit an item in the Charge Master file, follow these steps:

1. At the "Select Table Maintenance Menu Option" prompt, type **CMTM** and press the Enter key.

2. At the "Select 3P Charge Master Item Description" prompt, type the name of the supply item to add or edit.

   When adding a new entry, the system prompts the user to verify the addition.

3. At the "Item Description" prompt, type the new description/name, add or change the description/name of the item; otherwise press the Enter key.

4. At the "Revenue Code" prompt, type the revenue code number used to bill for this item.

   To see a list of options, type two question marks (**??**) at the prompt.

5. At the "HCPCS code" prompt, type the HCPCS code to be associated with the item.

   To see a list of options, type two question marks (**??**) at the prompt.

6. At the "UPC" prompt, type the UPC code of the item.

   The UPC code cannot be more than 10 characters.

7. At the "Other Identifier" prompt, Type any additional identifiers for the item.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |             THIRD PARTY BILLING SYSTEM - VER 2.6          |
          +                  Charge Master Add/Edit                   +
          |                  INDIAN HEALTH HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                          3-DEC-2009 3:14 PM

Select 3P CHARGE MASTER ITEM DESCRIPTION: MED SUPPLY
  Are you adding 'MED SUPPLY' as a new 3P CHARGE MASTER (the 8TH)? No// YES
  (Yes)
ITEM DESCRIPTION: MED SUPPLY// <Enter>
REVENUE CODE: 270       MED-SUR SUPPLIES     GENERAL CLASSIFICATION
HCPCS CODE: E1360 (E1360)
UPC: 1324657890
OTHER IDENTIFIER: 0987654321 <Enter>
```

Figure 8-77: Charge Master Add/Edit screen

8.16 Dental Remap Table Maintenance (DMTM)

Main Menu > TMTP > DMTM

The Dental Remap Table Maintenance option enables the user to map IHS dental codes to the appropriate dental codes.

For example, if a facility's insurers do not accept the IHS dental code, 8160, the IHS dental code must be mapped to a standard dental code such as 8110.

To remap an IHS dental code, follow these steps:

1. At the "Select Table Maintenance Menu Option" prompt, type **DMTM** and press the Enter key.

2. At the "Select 3P Dental Recode Table Name (Insurer)" prompt, type the name of the insurer or name of the table to remap the dental codes. If all dental insurers need to be modified, select IHS STANDARD TABLE. Selection of this entry will allow the changes to be made to all payers.

3. At the "Code Prefix" prompt type **O**, **S**, or **D**, if the insurer requires a dental code prefix for dental claims. These prefixes will print on the claim forms but does not display in the claim editor.

4. At the "Select IHS Code" prompt, type the IHS code number to remap.

5. At the "IHS Code" prompt, press the Enter key to confirm the selection.

6. At the "Remap to Code" prompt, type the code number that the system should remap the table to.

7. The system will continue to prompt for IHS dental codes to remap for the specified Third Part Dental Recode Table, until the user presses the Enter key at the "Select IHS Code" prompt.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |          THIRD PARTY BILLING SYSTEM - VER 2.6       |
         +              Dental Remap Table Maintenance         +
         |                  INDIAN HEALTH HOSPITAL             |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: TESTER,TEST                         3-DEC-2009 3:31 PM

Select 3P DENTAL RECODE TABLE NAME (INSURER): DELTA DENTAL OF NEW MEXICO INC
                                  - 2500 LOUISIANA SUITE 600       Domain: NM
                                    ALBUQUERQUE, NM 87110
 OK? Y// <Enter>

CODE PREFIX: 0 <Enter>
Select IHS CODE: 8160 <Enter>
  Are you adding '8160' as a new IHS CODE (the 1ST for this 3P DENTAL
RECODE)? No// Y <Enter> (Yes)
  REMAP TO CODE: 8110 <Enter>
Select IHS CODE: <Enter>
```

Figure 8-78: Example of Dental Remap Table Maintenance screen (DMTM option)

8.17 Form Locator Override (FLTM)

Main Menu > TMTP > FLTM

The Form Locator Override option enables users to customize insurer and visit type information on the CMS-1500 forms. This information is site, insurer, and form specific.

To customize insurer and visit type information on CMS-1500 forms, follow these steps:

1. At the "Select Table Maintenance Menu Option" prompt, type **FLTM** and press the Enter key.

2. At the "Select 3P Insurer" prompt, type the name of the insurer to edit.

The system prompts the user to verify the selection.

3. At the "Select 3P Export Mode Format" prompt, type the name or number of the form to edit.

4. At the "Select Form Locator" prompt, type the number from the displayed list that corresponds to the box on the selected form to add/edit data.

5. At the "Enter visit type, or leave blank for all" prompt, type the number or name of the visit type which the user wants to restrict this change. Multiple visit type entries may be added but the user will need to keep entering this menu option to do so.

   The system prompts the user to verify the selection (if a specific visit type was selected).

   To make this override change on all claims for the specified insurer and form, regardless of visit type, press the Enter key to leave this prompt blank.

6. At the "Add or Delete Entry?" prompt, type

   - **1** to **add** a new value **or edit** the data in the specified form field, and at the "Data Value" prompt, type the new value.

     The system adds the data value to the form.

   - **2** to **delete** the current entry in the specified form field.

     The system deletes the data value in the form.

```
Select 3P INSURER: TEST( TEST ) <Enter>
.LINDA TEST INS                           - 123 MAIN
                                            ANYWHERE, NM 12345
 OK? Y// <Enter>

Select 3P EXPORT MODE FORMAT: 14 <Enter>  HCFA-1500 Y2K       HCFA 1500 Y2K version

     Select one of the following:
          10         RESERVED FOR LOCAL USE
          11         BOX 11C - INSURANCE PLAN/PROGRAM NAME
          19         RESERVED FOR LOCAL USE
          24         LINE ITEMS
          32         WHERE SERVICES RENDERED
          33         BILLING INFO

Select Form Locator: 19 <Enter>  RESERVED FOR LOCAL USE
Enter visit type, or leave blank for all. 550 <Enter>  TEST

Current Value: TEST DATA VALUE
Visit Type: 550

     Select one of the following:
          1          ADD/EDIT
          2          DELETE

Add or Delete Entry?: ADD/EDIT// 1 <Enter>  ADD/EDIT
DATA VALUE: TEST DATA VALUE <Enter>
```

Figure 8-79: Example of customizing information on HCFA-1500 forms (FLTM option)

8.18 Initialize New Facility (SSTM)

Main Menu > TMTP > SSTM

The Initialize New Facility option enables users to initialize a facility that is new to the ABM package. The user can initialize only the facility to which he/she are logged in. The computer initializes the necessary files, and notifies the user when the site initialization is complete.

To initialize a new facility, follow these steps:

1. At the "Select Table Maintenance Menu Option" prompt, type **SSTM** and press the Enter key.

2. At the "Initialize Site [current site name]" prompt, type **Y** (Yes) to initialize a new facility. For example,

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |            THIRD PARTY BILLING SYSTEM - VER 2.6          |
          +               Initialize New Facility                   +
          |                 INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                        3-DEC-2009 3:40 PM

This option will initialize a new location for the Third Party
Billing Package. You are logged in as  INDIAN HEALTH HOSPITAL
HEADQUAR
TERS WEST        ALBUQUERQUE        01    NM   IHS  202810


Initialize Site INDIAN HOSP? NO// YES <Enter>  Yes

Initializing 3P Claim Data file
Initializing 3P Bill file
Initializing 3P Parameter file
Initializing 3P TX Status file
Initializing 3P Area Office Export file

Site Initialized.
```

Figure 8-80: Example of initializing a new facility (SSTM option)

8.19 Manager Reports (TMRP)

Main Menu > TMTP > TMRP

The Manager Reports option allows for the generation of reports that allow for
auditing and measuring revenue operations. Currently, there are two reports available
for use.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |              THIRD PARTY BILLING SYSTEM - VER 2.6          |
          +          Table Maintenance Site Parameters Report         +
          |                   INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                       4-DEC-2009 10:14 AM


   AUTM   Table Maintenance Site Parameters Report
   VCBT   Visit/Claim/Bill Tally Report

Select Manager Reports Option:
```

Figure 8-81: Table Maintenance Site Parameters Report screen

8.19.1   Table Maintenance Site Parameters Report (AUTM)

Main Menu > TMTP > TMRP > AUTM

The Table Maintenance Site Parameter Report allows the ability to audit and print changes made to certain Table Maintenance functionality. To fulfill these requirements, certain changes were made to audit fields within the Site Parameters. Changes to the following files will be listed on this report:

- Printable Name of Payment Site

- Facility to Receive Payments

Managers will be able to access this menu option which is located in the Table Maintenance section of the billing application. Only users with access to ABMZ SITE SETUP will be able to access this option.

The report identifies the date and time a value was changed, the old and the new value and the user that made the change. The following steps allow the user to access this option. An example of the screen is also provided.

- Select the Reports Menu Option for Table Maintenance Site Parameters Report (TMRP).

- Select 2, the Date Range.

- Type the beginning and ending dates for the date range.

- When prompted to again select either LOCATION or DATE RANGE, press the Enter key, and a listing of audited fields will be displayed.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |            THIRD PARTY BILLING SYSTEM - VER 2.6           |
           +         Table Maintenance Site Parameters Report        +
           |                 INDIAN HEALTH HOSPITAL                   |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: TESTER,TEST                          4-DEC-2009 10:10 AM

     EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
     =======================================================================

       Select one of the following:

             1             LOCATION
             2             DATE RANGE

Select ONE or MORE of the above EXCLUSION PARAMETERS: 2  DATE RANGE

 =========== Entry of EDIT DATE Range =============

Enter STARTING EDIT DATE for the Report:  1/1/09  (JAN 01, 2009)

Enter ENDING DATE for the Report:  T  (DEC 04, 2009)

     EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
     =======================================================================
     - Edit Date Range....:01/01/2009  to: 12/04/2009

       Select one of the following:

             1             LOCATION
             2             DATE RANGE

Select ONE or MORE of the above EXCLUSION PARAMETERS:


Output DEVICE: HOME//
```

Figure 8-82: Table Maintenance Site Parameters Report with exclusion parameters

```
================================================================================
LISTING of Audited fields                              DEC 4,2009    Page 1
================================================================================
Date/Time          User                Old Value              New Value
--------------------------------------------------------------------------------

     3P INSURER   Fld: FORM LOCATOR OVERRIDE
05/27/2009@13:43 SISNEROS,GINA                                 ZZ282N00000X


     3P PARAMETERS  Fld: FACILITY TO RECEIVE PAYMENT
04/13/2009@11:26 TESTER,TEST    ALBUQUERQUE ADMINISTRA INDIAN HEALTH HOSP
04/13/2009@11:26 TESTER,TEST    INDIAN HEALTH HOSPITAL ALBUQUERQUE ADMIN
04/28/2009@14:26 RENDER,SHONDA    ALBUQUERQUE ADMINISTRA TEST HOSPITAL


     3P PARAMETERS  Fld: PRINTABLE NAME OF PAYMENT SITE
10/07/2009@09:07 VALENCIA,TINA M   INDIAN HEALTH HOSP
10/07/2009@09:10 VALENCIA,TINA M                              INDIAN HEALTH
10/07/2009@09:14 VALENCIA,TINA M   INDIAN HEALTH        INDIAN HEALTH HOSP

(REPORT COMPLETE):
```

Figure 8-83: Listing of audited fields screen

8.19.2   Visit/Claim/Bill Tally Report (VCBT)

Main Menu > TMTP > TMRP > VCBT

This report is designed to count totals for visits, claims and bills by a date ranges. The goal is to create a report that will identify which clinics are generating services more than others in order to accommodate budgets.

A search can be done by selecting one or more of the exclusion parameters LOCATION, DATE RANGE OR CLINIC. The system will default to ALL for the Clinic and Visit Location.

In the following example, exclusion parameters are set for the DATE RANGE, and the default ALL is used for LOCATION and CLINIC.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |           THIRD PARTY BILLING SYSTEM - VER 2.6        |
          +              Visit/Claim/Bill Tally Report            +
          |                 INDIAN HEALTH HOSPITAL                |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                       4-DEC-2009 8:21 AM


EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
========================================================================
   - Visit Location.....: ALL
   - Clinics...:ALL

      Select one of the following:

           1            LOCATION
           2            DATE RANGE
           3            CLINIC

Select ONE or MORE of the above EXCLUSION PARAMETERS: 3  CLINIC
Select Clinic: ALL// ALL

EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
========================================================================
   - Visit Location.....: ALL
   - Clinics...:ALL

      Select one of the following:

           1            LOCATION
           2            DATE RANGE
           3            CLINIC

Select ONE or MORE of the above EXCLUSION PARAMETERS: 2  DATE RANGE

 =========== Entry of DATE Range =============

Enter STARTING DATE for the Report:  080106  (AUG 01, 2006)

Enter ENDING DATE for the Report:  090106  (SEP 01, 2006)

EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
========================================================================
   - Visit Location.....: ALL
   - Date Range....:08/01/2006  to: 09/01/2006
   - Clinics...:ALL
```

Figure 8-84: Visit/Claim/Bill Tally Report screen

After the desired exclusion parameters have been selected for the report, the system returns to the Exclusion Parameters Menu, at which time the user should respond to all remaining prompts. The DEVICE will default to Host file server (HFS) and should not be sent to a printer. The system will automatically assign a file name in the format of FACILITY and DATE with a .txt extension.

```
Select one of the following:

          1         LOCATION
          2         DATE RANGE
          3         CLINIC

Select ONE or MORE of the above EXCLUSION PARAMETERS:
DEVICE: HFS// <Enter>  Virtual
HOST FILE TO USE: c:\inetpub\ftproot\pub\NOTAREALFACILITY3061004.txt <Enter>
  ADDRESS/PARAMETERS: "NWS"// <Enter>

Requested Start Time: NOW// <Enter> (OCT 04, 2006@14:33:24)
Task # 17356 queued.
File to be created:c:\inetpub\ftproot\pub\NOTAREAL FACILITY3061004.txt
Enter RETURN to continue or '^' to exit:
```

Figure 8-85: Exclusion Parameters Menu

Importing the Report to Excel

In order to read the Visit/Claim/Bill Tally Report, it must be imported to Microsoft Excel and opened in a worksheet.

To import the report to Excel:

1. Open Microsoft Excel, and go to File > Open.

2. On the Open dialog box,

   - For the Look in field, display the dropdown list, and select the folder location of the TaskMan report.

   - For the Files of type field, display the dropdown list, and select Text Files (*.prn; *.txt; *.csv) to display the report file (.txt).

   - Select the requested report file, for example, NOT-NOT-A-REAL-FACILITY3061004.txt, and click the Open button.
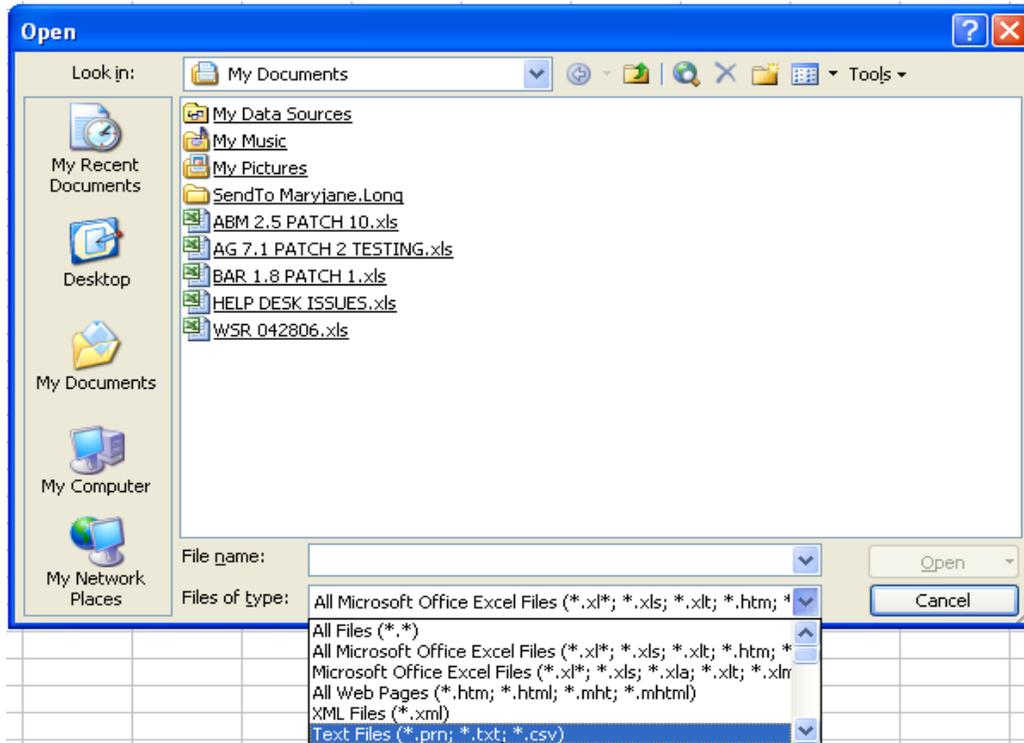
Figure 8-86: Import report to Excel

The Text Import Wizard – Step 1 of 3 dialog box displays.

- Step 1, choose the Delimited file type and click the Next button. For example,
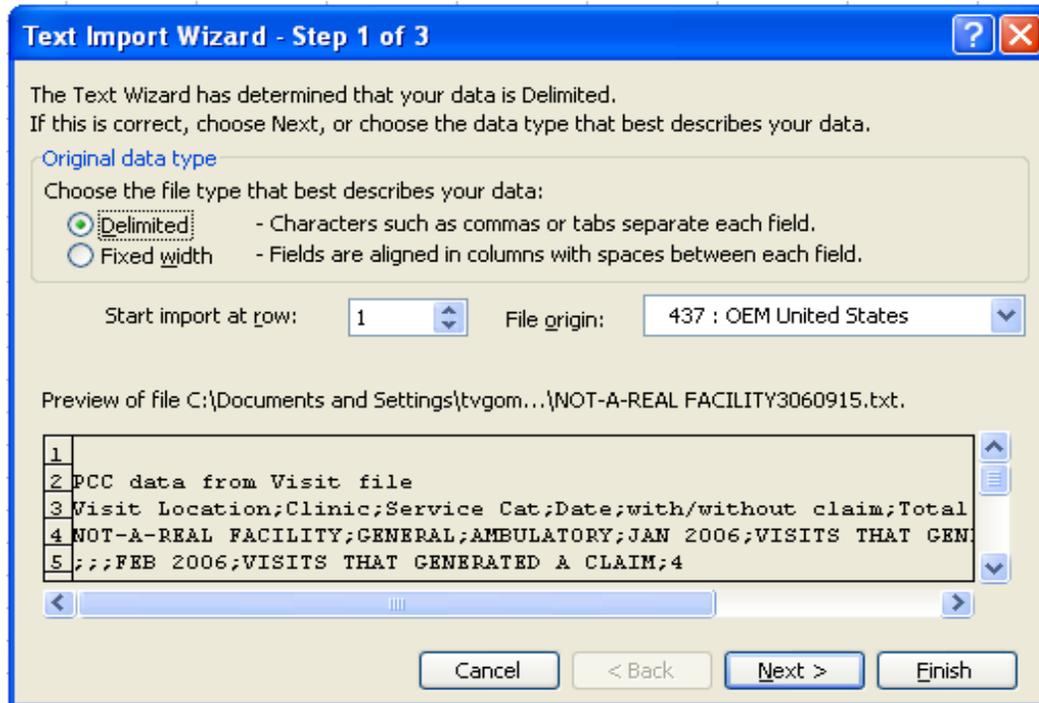
Figure 8-87: Excel Text Import Wizard (step 1 of 3)

- Step 2, select the Tab and Semicolon Delimiters checkboxes, and press the Next button. For example,
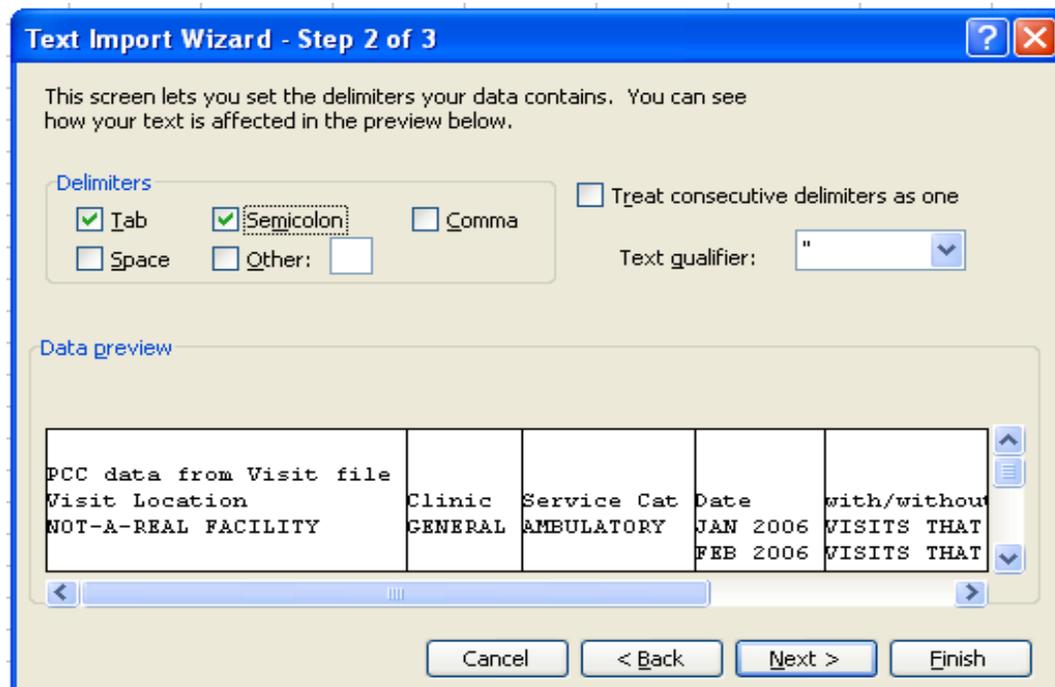
Figure 8-88: Excel Text Import Wizard (step 2 of 3)

- Step 3, press the Finish button.

Figure 8-89: Excel Text Import Wizard (step 3 of 3)

The report displays in the Excel spreadsheet. To review all of the data, adjust the Excel columns.
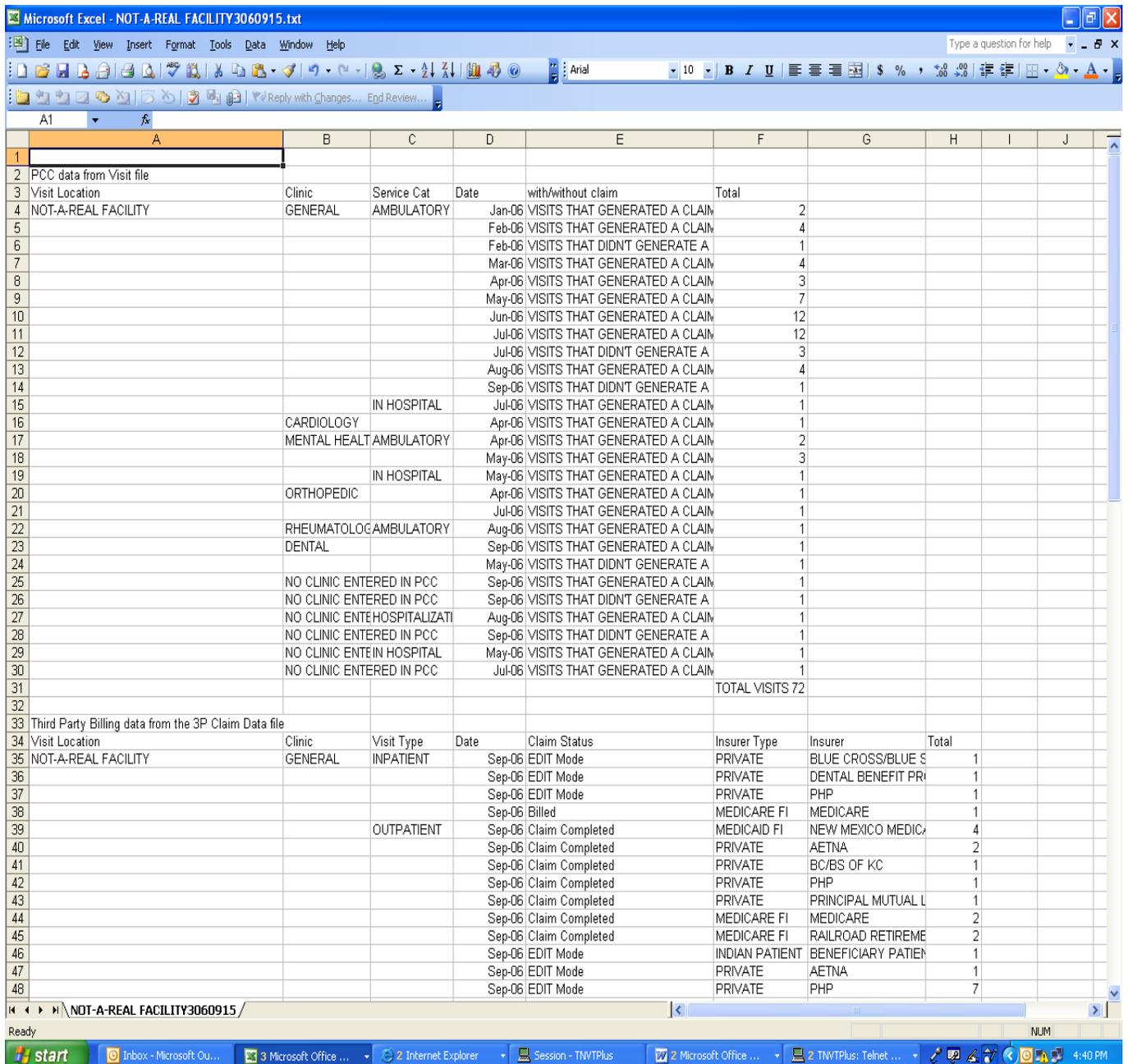
Figure 8-90: Visit/Claim/Bill Tally Report in Excel

9.0   Eligibility Menu (ELTP)

Main Menu > ELTP

The Eligibility Menu enables the user to access a selection of eligibility options in the Patient Registration package (AG). Using this menu, the user can

- Maintain the private insurance policy file.

- View eligibility reports.

Editing a registration page can be done in the Patient Registration application.

To access the Eligibility Menu:

At the Third Party Billing System "Select menu option" prompt, type **ELTP** and press the Enter key.

The system displays the Eligibility Menu; for example,

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |            THIRD PARTY BILLING SYSTEM - VER 2.6            |
        +                    Eligibility Menu                        +
        |                 INDIAN HEALTH HOSPITAL                     |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                         4-DEC-2009 10:16 AM


    POEL    Private Insurance Policy Maintenance Menu ...
    RPEL    Eligibility Reports Menu ...

Select Eligibility Menu Option:
```

Figure 9-1: Eligibility Menu screen (ELTP option)

- To add or edit a private insurance policy, merge duplicate insurance policies, or list the policies and member by insurer, see Section 9.1.

- To view or print eligibility reports, see Section 9.2.

9.1   Private Insurance Maintenance Menu (POEL)

Main Menu > ELTP > POEL

The Private Insurance Maintenance Menu enables users to add or edit a private insurance policy, generate a list of all policies and members by insurer, and merge duplicate insurance policies in Patient Registration through the Third Party Billing system.

To access the Private Insurance Maintenance Menu, follow these steps:

At the "Select Eligibility Menu Option" prompt, type **POEL** and press the Enter key.

The system displays the Private Insurance Maintenance Menu; for example,

```
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      |              THIRD PARTY BILLING SYSTEM - VER 2.6          |
      +          Private Insurance Policy Maintenance Menu         +
      |                    INDIAN HEALTH HOSPITAL                  |
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      User: TESTER,TEST                         6-DEC-2009 2:22 PM


   LSPO   Listing of Policies and Members by Insurer

Select Private Insurance Policy Maintenance Menu Option:
```

Figure 9-2: Private Insurance Policy Maintenance Menu (POEL option)

- To view or print a list of policies and members by insurer, see Section 9.1.1.

9.1.1   Listing of Policies and Members by Insurer (LSPO)

Main Menu > ELTP > POEL > LSPO

Use the Listing of Policies and Members by Insurer option to generate a list of the private insurance policies that displays the members associated with each policy, sorted by the insurer in the Patient Registration system.

For information and instructions on editing the Medicare Eligibility page, see the *Patient Registration (AG) User Manual*.

9.2   Eligibility Reports Menu (RPEL)

Main Menu > ELTP > RPEL

The Eligibility Reports Menu enables users to access the eligibility reports in Patient Registration through the Third Party Billing system. Reports include lists of eligible

- Medicare enrollees (Part A, Part B and/or Part D)

- Medicaid enrollees

- private insurance patients

- VA patients

- Commissioned officers and dependents, and PCC visits by commissioned officers and dependents

To access the Eligibility Reports Menu, follow these steps:

At the "Select Eligibility Menu Option" prompt, type **RPEL** and press the Enter key.

The system displays the Eligibility Reports Menu; for example,

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |             THIRD PARTY BILLING SYSTEM - VER 2.6          |
          +                   Eligibility Reports Menu                +
          |                    INDIAN HEALTH HOSPITAL                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                          4-DEC-2009 1:07 PM


   MARP    Listing of Medicare Part A Enrollees
   MBRP    Listing of Medicare Part B Enrollees
   MRDP    Listing of Medicare Part D Enrollees
   MDRP    Listing of Medicaid Enrollees
   PIRP    Private Insurance Eligibility Listing
   VARP    VA Eligibility Listing
   CORP    Listing of Commissioned Officers and Dependents
   VCRP    Visits by Commissioned Officers and Dependents
   PMRP    Listing of Policies and Members by Insurer

Select Eligibility Reports Menu Option:
```

Figure 9-3: Eligibility Reports Menu

9.2.1   Listing of Medicare Part a Enrollees (MARP)

Main Menu > ELTP > RPEL > MARP

Use the Listing of Medicare Part a Enrollees option to print an alphabetical list of patients registered at a selected facility and actively enrolled in Medicare Part A.

For information and instructions on editing the Medicare Eligibility page, see the *Patient Registration (AG) User Manual*.

9.2.2   Listing of Medicare Part B Enrollees (MBRP)

Main Menu > ELTP > RPEL > MBRP

Use the Listing of Medicare Part B Enrollees option to print an alphabetical list of patients registered at a selected facility and actively enrolled in Medicare Part B.

For information and instructions on editing the Medicare Eligibility page, see the *Patient Registration (AG) User Manual*.

9.2.3   Listing of Medicare Part D Enrollees (MBRP)

Main Menu > ELTP > RPEL > MBRP

Use the Listing of Medicare Part D Enrollees option to print the number of eligible Medicare Part D recipients by Plan Name and is sorted by Service Unit.

After selecting the MBRP - Listing of Medicare Part D Enrollees option, the system displays a brief description of the report's search criteria and a list of insurers classified as a Medicare Part D insurance carrier.

The system will screen the Part D payers by the name of the plan and/or the type of insurer. This means that the report will print data for insurers that have a "D" in the name or contain the insurance type code "MD" (Medicare Part D).

The system prompts, "Do you wish to include any other insurers?" This prompt defaults to No. Typing **Yes** allows the user to add additional Part D plan names that were not included in the generated list of plans.

```
             +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
             |           THIRD PARTY BILLING SYSTEM - VER 2.6          |
             +           Listing of Medicare Part D Enrollees          +
             |                  INDIAN HEALTH HOSPITAL                  |
             +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
             User: TESTER,TEST                      4-DEC-2009 1:14 PM
 This option will print a list of Patients who are registered at the
 facility you select who are currently enrolled in a Medicare Part D
 plan.

 You will be asked to enter an "As of" date to be used in determining
 those patients who are "actively" enrolled in a plan.

 The report will be sorted alphabetically by Plan Name.

 The following insurers contain the Insurer Type code of "MD" or contain
 "D-" in the name of the plan:

         D-AARP                               MCR PART D
         D-BETTER HEALTH                      MCR PART D
         D-CRITERION                          PRIVATE
         D-DRUG PLAN USA                      MCR PART D
         D-DRUGS UNLIMITED                    MCR PART D
         D-HEALTHCARE CHOICE                  MCR PART D
         D-HUMANA STANDARD                    MCR PART D
         D-IOWA PHARMACY SERVICE CORP         PRIVATE
         D-LIBERTY SQUARE INSURANCE           MCR PART D
         D-PACIFICARE SAVER                   PRIVATE
         D-PRESCRIPTION SOLUTION              MCR PART D
         D-UNITEDHEALTH RX                    MCR PART D

Do you wish to include any other insurers?? N// YES

Select INSURER NAME: MEDCO
( MEDCO )
..

The following matches were found:

  1: MEDCO HEALTH PRESCRIPTION          - PO BOX 2187
                                          LEE SUMMIT, MO 64063-2187
  2: MEDCO RX                           - MAILSTOP 10, 399 JEFFERSON RD
                                          PARSIPPANY, NJ 07054

Select 1-2: 2  MEDCO RX
```

Figure 9-4: Listing of Medicare Part D Enrollees screen

The system prompts the user to "Display eligibility as of what date?"

```
Display eligibility as of what date?:  Today//   (DEC 4,2009)
```

Figure 9-5: System prompt for eligibility

The default date is Today, but the user can enter a different date.

Next, the system prompts the user to exclude any inactive or deceased patients. Answer this question to proceed to the next prompt, which asks if a detail view of patients should be displayed. For example,

```
Do you wish to EXCLUDE inactive and deceased patients? YES// NO
```

Figure 9-6: System prompt to exclude patients

If the user accepts the default NO, the system will print a report that displays only a count of the number of entries by plan name. If the answer to this prompt is YES, the system will print a report that displays each patient's eligibility under the Plan Name and include the Subscribers Name, Policy Holder ID, and Effective dates.

```
Do you wish to view detail (patients)? NO//
DEVICE: HOME//
```

Figure 9-7: System prompt for printing the report

When the system prompts for a device, enter a device name and press the Enter key.

When the report prints, it will display the Medicare Part D information, which includes a

- Total Number of Medicare/Railroad Eligible Enrollees per Service Unit

- Total Number of Active Medicare Part D Enrollees: for All Service Units

  Note: The report will not allow the user to print by location

The report includes the date the report was printed, which can be used for tracking purposes.

The following example of an MRDP report is based on a request for total number counts for two Service Units (SU) and is not a detailed report with patient information.

The SU for Central Arkansas Region has a total Part D count of **69** Medicare eligible enrollees and the Southwest SU has a total Part D of **4** Medicare eligible enrollees. The user takes the numbers from his/her SU. If patients were enrolled at an outside SU, they may be duplicates from the user's home SU.

Notice that the report has a count for every enrollee by plan name registered at each SU.

```
DEC 4,2009                                                             Page 1
           REGISTERED PATIENTS - ACTIVE MEDICARE PART D ENROLLEES
                     Actively enrolled as of DEC 4,2009

  Service Unit: CENTAL ARKANSAS REGION  LITTLE ROCK, AR

  PLAN NAME                          INS TYPE           COUNT
------------------------------------------------------------------------------

  D-AARP                             MCR PART D             8
  D-BETTER HEALTH                    MCR PART D             6
  D-CRITERION                        PRIVATE                4
  D-DRUG PLAN USA                    MCR PART D             4
  D-DRUGS UNLIMITED                  MCR PART D             1
  D-HEALTHCARE CHOICE                MCR PART D             6
  D-HUMANA STANDARD                  MCR PART D             6
  D-IOWA PHARMACY SERVICE CORP       PRIVATE                1
  D-LIBERTY SQUARE INSURANCE         MCR PART D             3
  D-PACIFICARE SAVER                 PRIVATE                2
  D-PRESCRIPTION SOLUTION            MCR PART D            16
  D-UNITEDHEALTH RX                  MCR PART D             7
  MEDCO RX                           PRIVATE                4

          TOTAL PART D FOR CENTRAL ARKANSAS REGION SERVICE UNIT:  69
          TOTAL NUMBER OF MEDICARE/RAILROAD ELIG ENROLLEES:     504

  Service Unit: SOUTHWEST  ALBUQUERQUE, NM

  PLAN NAME                          INS TYPE           COUNT
------------------------------------------------------------------------------

  D-AARP                             MCR PART D             3
  D-BETTER HEALTH                    MCR PART D             0
  D-CRITERION                        PRIVATE                0
  D-DRUG PLAN USA                    MCR PART D             0
  D-DRUGS UNLIMITED                  MCR PART D             0
  D-HEALTHCARE CHOICE                MCR PART D             0
  D-HUMANA STANDARD                  MCR PART D             0
  D-IOWA PHARMACY SERVICE CORP       PRIVATE                0
  D-LIBERTY SQUARE INSURANCE         MCR PART D             0
  D-PACIFICARE SAVER                 PRIVATE                0
  D-PRESCRIPTION SOLUTION            MCR PART D             0
  D-UNITEDHEALTH RX                  MCR PART D             0
  MEDCO RX                           PRIVATE                1

          TOTAL PART D FOR SOUTHWEST SERVICE UNIT:              4
          TOTAL NUMBER OF MEDICARE/RAILROAD ELIG ENROLLEES:    40

  TOTAL NUMBER OF ACTIVE MEDICARE PART D ENROLLEES:            74

(REPORT COMPLETE)
```

Figure 9-8: Report of registered patients active Medicare Part D enrollees by SU

In the report example,

- The totals for the Central Arkansas Region Service Unit include a count of all Medicare Part D enrollees (74).

- The total number of Medicare/Railroad Eligibility enrollees includes all enrollees with Part A and/or B coverage and enrollees with Railroad eligibility (504).

Therefore, this report can be interpreted further as # registered Patients that have only Medicare Part D coverage, and no Medicare A and/or B coverage or no eligibility in a Railroad Retiree program.

The next example is an MRDP Detail Report with patient information by plan name. Please note the date displayed for tracking purposes.

The detail report displays Plan Name and HRN, Subscriber Name, Insurance Type and effective date, Count and End Dates, and Subscriber's ID number.

9.2.4   Listing of Medicaid Enrollees (MDRP)

Main Menu > ELTP > RPEL > MDRP

Use the Listing of Medicaid Enrollees option to print an alphabetical list of patients registered at a selected facility and actively enrolled in Medicaid.

For information and instructions on editing the Medicare Eligibility page, see the *Patient Registration (AG) User Manual*.

9.2.5   Private Insurance Eligibility Listing (PIRP)

Main Menu > ELTP > RPEL > PIRP

Use the Private Insurance Eligibility Listing option to print an alphabetical list of patients registered at a selected facility and actively enrolled in private insurance.

For information and instructions on editing the Medicare Eligibility page, see the *Patient Registration (AG) User Manual*.

9.2.6   VA Eligibility Listing (VARP)

Main Menu > ELTP > RPEL > VARP

Use the VA Eligibility Listing option to print an alphabetical list of all patients who are veterans.

For information and instructions on editing the Medicare Eligibility page, see the *Patient Registration (AG) User Manual*.

9.2.7   Listing of Commissioned Officers and Dependents (CORP)

Main Menu > ELTP > RPEL > CORP

Use the Listing of Commissioned Officers and Dependents option to print an alphabetical list of all patients who are Commissioned Officers and their dependents.

For information and instructions on editing the Medicare Eligibility page, see the *Patient Registration (AG) User Manual*.

9.2.8   Visits by Commissioned Officers and Dependents (VCRP)

Main Menu > ELTP > RPEL > VCRP

Use the Visits by Commissioned Officers and Dependents option to print a list of commissioned officers and their dependents that have had visits after a specified date.

```
        *****Confidential Patient Data Covered by Privacy Act*****

                                           INDIAN HEALTH HOSPITAL
                                 COMMISSIONED OFFICERS & DEPENDENTS
VISITS
                                      10/01/2009 to 11/30/2009
                                         OUTPATIENT VISITS
------------------------------------------------------------------------------
--------------------------------------------
Patient Name          Chart #      SSN     CO or Dep   Sponsor           SSN
Visit Date   No. of Visits
------------------------------------------------------------------------------
--------------------------------------------

COPPER,PENNY           5010    777-22-1110   CO                      10/07/2009
                                                      11/11/2009      2


TOTAL OUTPATIENT VISITS:          2


COPPER,PIPER           5923    888-22-1119   DEP                    10/07/2009      1


TOTAL OUTPATIENT VISITS:          1

        *****Confidential Patient Data Covered by Privacy Act*****

                                            INDIAN HEALTH HOSPITAL
                                 COMMISSIONED OFFICERS & DEPENDENTS
VISITS
```

```
                                        10/01/2009 to 11/30/2009
                                           INPATIENT VISITS
-------------------------------------------------------------------------------
-------------------------------------------------Patient Name        Chart #       SSN
CO or Dep     Sponsor                 SSN              Admit Date   Dsch Date   # of
Days
-------------------------------------------------------------------------------
--------------------------------------------

                                           TOTAL INPATIENT DAYS:       0

          *****Confidential Patient Data Covered by Privacy Act*****

                                           INDIAN HEALTH HOSPITAL
                                   COMMISSIONED OFFICERS & DEPENDENTS
VISITS
                                        10/01/2009 to 11/30/2009
                                            DENTAL VISITS
-------------------------------------------------------------------------------
-------------------------------------------------Patient Name        Chart #       SSN
CO or Dep     Sponsor                 SSN              Visit Date   No. of Visits
-------------------------------------------------------------------------------
--------------------------------------------
COPPER,PENNY               5010    777-22-1110    CO
 10/22/2009       1


TOTAL DENTAL VISITS:                 1


COPPER,PIPER               5923    888-22-1119    DEP
10/22/2009       1


TOTAL DENTAL VISITS:                 1

E N D   O F   R E P O R T
```

Figure 9-9: VCRP Report

10.0   Payment Posting (PPTP)

Main Menu > PPTP

The Payment Posting menu enables users to post payments in the Third Party Billing system.

> **Note:** If the site is using both the RPMS Third Party Billing
> (ABM) and the Accounts Receivable (BAR) systems,
> payment posting should be done in the BAR system.

To post payments, follow these steps:

1. At the Third Party Billing System "Select menu option" prompt, type **PPTP** and press the Enter key.

2. At the "Screen-out the Selection of Bills that are Completed?" prompt, press the Enter key to choose the default (Yes) to make bills with a Completed status (unobligated balance equals zero) not selectable; otherwise, type **No**.

3. At the "Select Bill or Patient" prompt, type the number of the bill or the name of the patient.

   If the text entered at this prompt matches more than one file in the system, the system prompts the user to select from a list of matches.

   The system displays the bill summary.

4. At the "Desired Action" prompt, type one of the following:

   A (add)
   D (Delete)
   E (Edit)
   V (View)
   Q (Quit

   > **Note:** The available options depend on the billing status.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |           THIRD PARTY BILLING SYSTEM - VER 2.6        |
           +                    Payment Posting                   +
           |                 INDIAN HEALTH HOSPITAL                |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: TESTER,TEST                       6-DEC-2009 3:58 PM

NOTE: It displays the new A/R package has been installed.
Payments should be posted in the new A/R package.

Continue? NO// YES

Screen-out the Selection of Bills that are Completed? Y// YES

Select BILL or PATIENT: 31395A

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAYMENT POSTING ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JANE [HRN:9999]                       F   09-14-1967 392847593
............................................................................
Visit: 07-27-2008INDIAN HEALTH HOSPITAL        OUTPATIENT      EMERGENCY MEDI
 Bill: 31395A    NEVERPAY INSURANCE                COMPLETED          $127.00
----------------------------------------------------------------------------

       Amount     Payment                      Deduct    Write Off-
       Billed      Date       Payment          Co-Ins    Adjustment   Balance
     ==========  ========  ==========  ==========  ==========  ==========
[1]      127.00  12-06-2009      95.00       10.00       22.00        0.00


----------------------------------------------------------------------------
Desired ACTION (Edit/View/Quit):
```

Figure 10-1: Example of Payment Posting screen (steps 2-4)

If the user chooses to

- **A**dd a payment, go to Section 10.1.1

- **D**elete a payment, go to Section 10.1.2.

- **E**dit a payment, go to Section 10.1.3

- **V**iew a payment, the selected bill is displayed on the screen.

- **Q**uit the payment posting option, the system returns the user to the main Third
  Party Billing menu.

10.1.1   Adding a Payment

To add a payment,

1. At the "Enter New Payment Date" prompt, type the date of the payment.

2. At the "Payment Amount" prompt, type the amount of the payment.

3. At the "Deductible Amount" prompt, type the amount of the deductible. If the patient does not have a deductible, press the Enter key to leave this field blank.

   The system displays the updated unobligated amount.

   > **Note:** Any deductible or co-insurance amount specified by the billed party should be entered in the Deductible or Co-Insurance Amount fields, accordingly. Late payments can be posted at any time and existing payments can always be edited.

4. At the "Write-off Amount" prompt, type the amount of the write-off (per the facility's agreement with the insurer, up to the unobligated balance amount).

   The system checks for a secondary insurer to bill and if found, displays them. Answer any additional prompts related to the additional insurers/ unbilled resources, as they appear on the screen.

   In the following example, after all anticipated collections for a bill have been received, the remainder of the bill may be written off so that secondary sources can be billed. The amount entered as the write-off can be applied to the next billing entity or discarded as uncollectible.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAYMENT POSTING ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JANE [HRN:9999]                        F    09-14-1967 392847593
.............................................................................
Visit: 07-27-2008INDIAN HEALTH HOSPITAL        OUTPATIENT      EMERGENCY MEDI
 Bill: 31395A     NEVERPAY INSURANCE               BILLED              $127.00
-----------------------------------------------------------------------------

       Amount     Payment                     Deduct     Write Off-
       Billed      Date      Payment          Co-Ins     Adjustment   Balance
     ==========  ========  ==========  ==========  ==========  ==========
        127.00
-----------------------------------------------------------------------------
Desired ACTION (Add/View/Quit): A//

Enter NEW PAYMENT Date: 12/4/2009
   PAYMENT PAYMENT NUMBER: 1//
Payment Amount.....: 95
Deductible Amount..:
Co-Insurance Amount: 10

               (Unobligated Balance: 22.00)

Write-off Amount: 22//

A Sister Bill (31395B) exists with an unobligated balance, it must be
resolved before proceeding to bill a secondary entity.
```

Figure 10-2: Example of adding a payment

> **Note:** The sister bill must be resolved before any unbilled
> secondary sources may be billed.

```
Checking for Secondary Billing...
--------------------------------

Unbilled Sources: [1]  NEW MEXICO MEDICAID

Apply write off to next bill (Y/N)? N// YES

Claim Number: 31395 is now Open for Editing!

Enter CLAIM EDITOR for APPROVAL of Secondary Entity (Y/N)? Y//
```

Figure 10-3: Adding a payment, secondary billing

Once the bill is resolved (unobligated balance equals zero) and unbilled sources exist, the Claim Editor can be reopened ad hoc to bill a secondary entity. If the unpaid balance is zero (no deductible or write-offs were entered), the system prompts the user to cancel the original claim.

10.1.2   Deleting a Payment

> **Note:** Deleting a payment completely removes it from the record.
> If a change to the payment needs to be made, use the edit
> option instead.

To delete a payment,

At the "Do you wish Payment Number 1 Deleted?" prompt, type **Y** (Yes) or **N** (No).

If more than one payment exists, the system prompts the user to select the payment he/she wants to delete.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAYMENT POSTING ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JANICE [no HRN]                          F    01-01-1933 234441170
..........................................................................
Visit: 05-22-1996  ALBUQUERQUE HOSPITAL         OUTPATIENT            DENTAL
 Bill: 43548B   CHICAGO HLTH CENTER ILGW        PARTIAL PAYMENT     $671.00
--------------------------------------------------------------------------

       Amount    Payment                  Deduct    Write Off-
       Billed     Date      Payment        Co-Ins    Adjustment   Balance
     ==========  ========  ==========   ==========  ==========  ==========
[1]     671.00  03-26-2002     0.00         0.00         0.00      671.00
--------------------------------------------------------------------------
NOTE: A Sister Bill (43548A) exists with a balance of $10.00
--------------------------------------------------------------------------
Desired ACTION (Add/Del/Edit/View/Quit): D

Do you wish PAYMENT Number 1 DELETED? Y
```

Figure 10-4: Example of deleting a payment

10.1.3   Editing a Payment

To edit a payment, select the bill to edit. Payment/Adjustment data must exist in order for the bill to be edited. Type **EDIT** to edit fields.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAYMENT POSTING ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JANE [HRN:9999]                           F   09-14-1967 392847593
.............................................................................
Visit: 07-27-2008INDIAN HEALTH HOSPITAL     OUTPATIENT      EMERGENCY MEDI
 Bill: 31395A   NEVERPAY INSURANCE              COMPLETED           $127.00
-----------------------------------------------------------------------------

       Amount    Payment                  Deduct    Write Off-
       Billed      Date     Payment       Co-Ins    Adjustment   Balance
      ========== ======== ========== ========== ========== ==========
[1]      127.00 12-06-2009     95.00      10.00       22.00       0.00


-----------------------------------------------------------------------------
Desired ACTION (Edit/View/Quit): E


[1]  12-06-2009
===================
Payment Amount.....: 95// 85
Deductible Amount..:
Co-Insurance Amount: 10// 15

              (Unobligated Balance: 5.00)

Write-off Amount: 27//

Checking for Secondary Billing...
-------------------------------

Unbilled Sources: NONE

Since there are no unbilled sources no further billing is possible.

Enter RETURN to continue or '^' to exit:
```

Figure 10-5: Payment Posting screen

11.0   Electronic Media Claims (EMTP)

Main Menu > EMTP

The Electronic Media Claims Menu enables users to create files containing claims for electronic submission to insurers. From this menu, users can view a batch summary, create an EMC file, recreate an EMC file, and view a summary of bills ready to be submitted electronically. These options are outlined in this section.

Electronic Claims Transmission

If the facility wants to transmit claims electronically, the user must perform the following steps **before** approving claims:

- Change the Mode of Export for the visit type desired to an electronic format (UB-92-E, HCFA-1500-E or any of the 837 export modes).

- Enter the five-digit receiver identification number in the AO CONTROL NUMBER field.

For example; for Private insurance companies, the five-digit receiver identification number is the unique five-digit number assigned by the National Association of Insurance Commissioners (NAIC).

To access the Electronic Media Claims options,

At the Third Party Billing System "Select menu option" prompt, type **EMTP** and press the Enter key.

The system displays the Electronic Media Claims options; for example,

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |          THIRD PARTY BILLING SYSTEM – VER 2.6           |
        +                Electronic Media Claims                  +
        |                INDIAN HEALTH HOSPITAL                   |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                       6-DEC-2009 6:48 PM


   BSEM   Batch Summary
   CREM   Create EMC File
   RCEM   Re-Create an EMC File
   SUEM   Summary of Bills Ready for Submission

Select Electronic Media Claims Option:
```

Figure 11-1: Electronic Media Claims Menu (EMTP option)

- To review the billing information for batches already created, see Section 11.1.

- To create an EMC file of approved bills that were not included in an EMC batch, see Section 11.2.

- To re-create an EMC file, see Section 0.

- To display or print a summary or detail report of approved bills not included in an EMC batch, see Section 11.4.

11.1   Batch Summary (BSEM)

Main Menu > EMTP > BSEM

Use the Batch Summary option to review the billing information for batches that have already been created.

To view or print a batch summary, follow these steps:

1. At the "Select Electronic Media Claims Option" prompt, type **BSEM**.

2. At the "Select beginning export batch" prompt, type the export batch number to start the summary.

   To display a list of export batches available for review, type two question marks (**??**) at the "Select beginning export batch" prompt.

3. At the "Select ending export batch" prompt, type the export batch number to end the summary.

   To display a list of export batches available for review, type two question marks (**??**) at the "Select ending export batch" prompt.

   To see the summary for a single batch, type the same batch number at this prompt that was typed in step 2.

4. At the "DEVICE" prompt, type the name of the device on which to view or print the summary report.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |           THIRD PARTY BILLING SYSTEM - VER 2.6          |
        +                      Batch Summary                      +
        |                  INDIAN HEALTH HOSPITAL                 |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                        6-DEC-2009 7:01 PM

Select beginning export batch: 1871  12-6-2009@19:00:48   837 INST (UB)  MEDICAR
E                                     MEDICARE                 TESTER,TEST
```

```
Select ending export batch: 1871  12-6-2009@19:00:48   837 INST (UB)  MEDICARE
MEDICARE                                                      TESTER,TEST
Enter DEVICE: HOME//   Virtual
```

Figure 11-2: Example of creating an EMC Batch Summary (BSEM option)

```
                         BATCH SUMMARY                          Page: 1
BATCH DATE: DEC 06, 2009@19:00:48
INSURER: MEDICARE
FORMAT: 837 4010 INSTITUTIONAL
EMC FILE NAME: E0400101.340                 GROUP CONTROL #: 100646
=============================================================================
BILL #      HRN     PATIENT                  SERVICE DATE FROM     AMOUNT
-----------------------------------------------------------------------------


SITE: INDIAN HOSP                       BILL TYPE: 131

   31687A    123567  DEMO,JOHN                    OCT 14, 2009       215.00
   31203B    123567  DEMO,JOHN                    MAR 11, 2008       201.00
   31595A    7020    PAN,PETER                    APR 02, 2009       215.00
   31701A    222466  WEATHERS,STORMY              SEP 12, 2009       215.00
   31580A    11179   BUD,ROSE                     FEB 01, 2009       215.00

BATCH TOTAL:                            5bills                     1,061.00

E N D   O F   R E P O R T
```

Figure 11-3: Batch Summary Report sample

11.2   Create EMC File (CREM)

Main Menu > EMTP > CREM

Use the Create EMC File option to create an EMC file containing bills that have been
approved but were not included in an EMC batch.

The Site parameters, EMC File Preference and Default EMC Path, define the default
file type and pathname, respectively.

Note: If the host file was selected as the EMC file preference, the
facility is responsible for transmitting the file from the
facility to the appropriate third party.

To create an EMC file, follow these steps:

1. At the "Select Electronic Media Claims Option" prompt, type **CREM**.

    The system displays a list of insurers with bill type, export mode, number of bills
    and total amount by sequence number.

2. At the "What sequence number" prompt, type the sequence number that corresponds to the insurer for whom the user wants to create the EMC file.

3. At the "Proceed?" prompt, Type **Y** (Yes) to create the EMC batch; otherwise type **N** (No).

   The system creates an entry in the 3P TX Status file, and displays the location and visit type for which the file is being created.

4. At the "Enter Path" prompt, press the Enter key to accept the displayed pathname, or type the name of the path where the file will be stored.

5. At the "Enter File Name" prompt, press the Enter key to accept the displayed filename, or type a name for the file.

   The file name may not contain more than 13 characters followed by a decimal followed by 3 characters:

   Any value system that is unique and meaningful to the user's facility may be used. For example, the default value in Figure 11-4 is E5538701.265 where

       E = electronic
       55387 = AO Control number
       01 = first transmission
       265 = Julian date transmitted

   The system creates the file.

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
            +                     Create EMC File                    +
            |                  INDIAN HEALTH HOSPITAL                 |
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            User: TESTER,TEST                        6-DEC-2009 7:00 PM

SEQ    INSURER                   BILL TYPE  EXPORT MODE  # OF BILLS    BILL AMT
-------------------------------------------------------------------------------

  1    MEDICARE                     131    837 INST (UB)     5        1,061.00

What sequence number (1 - 1):  1
Proceed? YES//
ENTRY CREATED IN 3P TX STATUS FILE.
LOCATION: INDIAN HOSP@1575
VISIT TYPE: OUTPATIENT

31687A-IH-123567 Previously loaded .. deleting existing A/R Bill items

31687A-IH-123567 Now adding 3P Bill items to A/R Bill

31203B-IH-123567 Previously loaded .. deleting existing A/R Bill items

31203B-IH-123567 Now adding 3P Bill items to A/R Bill

31595A-IH-7020 Previously loaded .. deleting existing A/R Bill items

31595A-IH-7020 Now adding 3P Bill items to A/R Bill

31701A-IH-222466 Previously loaded .. deleting existing A/R Bill items

31701A-IH-222466 Now adding 3P Bill items to A/R Bill

31580A-IH-11179 Previously loaded .. deleting existing A/R Bill items

31580A-IH-11179 Now adding 3P Bill items to A/R Bill

Enter Path: c:\inetpub\ftproot\pub  Replace
Enter File Name: : E0400101.340//
Submission # 100646
Writing bills to file.
.....

Finished.

Enter RETURN to continue or '^' to exit:
```

Figure 11-4: Example of creating an EMC File (CREM option)

Note, upon file creation, the following messages will appear:

- Bill # Previously loaded .. deleting existing A/R Bill items

- Now adding 3P Bill items to A/R Bill

These messages indicate that the bill is being uploaded to A/R and populated with the 3P Print Date/Time. This value is used for reports in A/R and notifies the user of the upload.

```
31687A-IH-123567 Previously loaded .. deleting existing A/R Bill items

31687A-IH-123567 Now adding 3P Bill items to A/R Bill
```

Figure 11-5: Messages displayed upon file creation for an EMC file

11.3   Recreate an EMC File (RCEM)

Main Menu > EMTP > RCEM

Use the Recreate an EMC File option if it is necessary to re-create an EMC file. For example, when an original EMC file is lost or when corrections are made to patient/bill information and the file needs to be recreated.

To re-create an EMC file, follow these steps:

1. At the "Select Electronic Media Claims Option" prompt, type **RCEM**.

2. At the "Select 3P TX Status Export Date" prompt, type the original date of export.

    The system prompts the user to confirm the selection.

3. At the "Enter Path" prompt, press the Enter key to accept the default path, or type the path name location for the new file.

4, At the "Enter File Name" prompt, press the Enter key to accept the default file name, or type a new file name.

    The system creates the new (duplicate) file.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |            THIRD PARTY BILLING SYSTEM - VER 2.6       |
          +               Re-Create an EMC File                  +
          |               INDIAN HEALTH HOSPITAL                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                    6-DEC-2009 7:15 PM

Select 3P TX STATUS EXPORT DATE: 12-6-2009@19:00:48  837 INST (UB)  MEDICARE
                                 MEDICARE                  TESTER,TEST
Enter Path: c:\inetpub\ftproot\pub  Replace
Enter File Name: : E0400102.340//
Submission # 100647
Writing bills to file.
.....

Finished.

Enter RETURN to continue or '^' to exit:
```

Figure 11-6: Example of re-creating an EMC File (RCEM option)

11.4 Summary of Bills Ready for Submission (SUEM)

Main Menu > EMTP > SUEM

Use the Summary of Bills Ready for Submission option to display a summary or detail report of bills that are already approved but not included in an EMC batch.

To display a summary or detail report of bills ready for submission, follow these steps:

1. At the "Select Electronic Media Claims Option" prompt, type **SUEM**.

   The system displays the summary information of possible batches on the screen.

2. At the "Show detail" prompt, type **Yes** to see more details; otherwise, press the Enter key for the default (No).

3. At the "What sequence number" prompt, type the number corresponding to the sequence number/insurer for which you want to review the details. Only one date may be selected.

   The system displays the details.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |           THIRD PARTY BILLING SYSTEM - VER 2.6         |
          +          Summary of Bills Ready for Submission         +
          |                INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                      6-DEC-2009 7:21 PM

SEQ   INSURER                  BILL TYPE  EXPORT MODE  # OF BILLS    BILL AMT
-------------------------------------------------------------------------------

  1   NEW MEXICO MEDICAID        998    837 INST (UB)      1         253.00

Show detail ? NO// YES

What sequence number (1 - 1):  1



                        BILLS READY FOR SUBMISSION              Page: 1
         FORMAT: 837 4010 INSTITUTIONAL


===============================================================================
BILL #       HRN     PATIENT                 SERVICE DATE FROM       AMOUNT
-------------------------------------------------------------------------------

INDIAN HOSP                              VISIT TYPE: DENTAL

  31656A    1180    GLASSES,SUN                 OCT 02, 2009         253.00
                                                                 ----------
                                                                    253.00

                    TOTAL                                           253.00

Enter RETURN to continue or '^' to exit:
```

Figure 11-7: Example of a detailed listing of bills ready for submission (SUEM option)

12.0   Set Site (SSTP)

Main Menu > SSTP

The Set Site menu option enables a user to select a different site to log in to.

> **Note:**   The user can only select a site that has been assigned to
> him/her through the "Select DIVISION" multiple in the
> New Person file.

1. At the Third Party Billing System "Select menu option" prompt, type **ELTP** and
    press the Enter key.

2. At the "Enter your facility's name" prompt, type the name of the facility that the
    user wants to log in to instead of his/her current site.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |          THIRD PARTY BILLING SYSTEM - VER 2.6          |
        +                         Set Site                      +
        |                  INDIAN HEALTH HOSPITAL                |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                       6-DEC-2009 7:24 PM

Enter your facility's name: INDIAN HEALTH HOSPITAL// INDIAN HEALTH CENTER
  ALBUQUERQUE        SOUTHWEST        31    NM
```

Figure 12-1: Set Site screen

13.0   Cashiering Options (UCSH)

Main Menu > UCSH

The cashiering options allow the billing clerk to open a session that records billing functions such as claim approving, claim cancellation, and bill cancellation. Once the billing clerk has completed the activity for the day, the user must then close out his or her session. This session is sent to the billing supervisor for reconciliation and for federal sites, transmission to the financial system.

```
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
       +                  Cashiering Options                     +
       |                  INDIAN HEALTH HOSPITAL                 |
       +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: TESTER,TEST                       7-DEC-2009 2:11 PM


   CIO    Cashiering Sign In/Sign Out
   UVCH   View Cashiering Session
   SUP    Supervisory Functions ...
   RPTS   UFMS Reports ...

Select Cashiering Options Option:
```

Figure 13-1: Cashiering Options screen

13.1   Cashiering Sign In/Sign Out (CIO)

Main Menu > UCSH > CIO

All billing staff must sign in prior to approving claims. Only one billing session per user may be open. This is to avoid confusion in the number of open sessions a user may have. Billing staff that bill under multiple locations will need to have only one session opened. Billing activity performed under each of the satellite locations will display in one session. It is best to open a session under the primary billing location. To log in, access the Cashiering Options menu.

When entering Cashiering mode, the system will require that the user enter his/her Electronic Signature Code. Once entered, the system will notify the user that he/she are "Signing in for Billing." The system will also display the user's current billing activity such as Cancelled Claims, Approved Bills, and Cancelled Bills. Users signing in for the first time will see their totals display as zero counts and zero dollar amounts.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |             THIRD PARTY BILLING SYSTEM - VER 2.6            |
          +               Cashiering Sign In/Sign Out                  +
          |                   INDIAN HEALTH HOSPITAL                    |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: BILLER,FAST                             8-DEC-2009 3:54 PM

Enter your Current Signature Code:    SIGNATURE VERIFIED

YOU ARE SIGNING *IN* FOR BILLING

          Billing Activity                COUNT                 TOTAL

               - Cancelled Claims            0
               - Approved Bills              0               $      0
               - Cancelled Bills             0               $      0

Assigned Session number: 3091208.155446

Enter RETURN to Continue:
```

Figure 13-2: Cashiering Sign In/Sign Out screen

A session number will be assigned to your open session. This number is in a VA
FileMan format of XYYMMDD.HHMMSS where YY is the two-digit year, MM is
the two-digit month, and DD is the two-digit day. The data to the right of the period
indicates hours, minutes, and seconds. This number is used as a reference for the
user's session, and will change each time a new session is opened.

If the user previously signed in (opened a Cashiering session) and attempts to sign in
again by accessing the CIO menu, the system will display his/her activity and ask if
he/she wishes to sign out. To continue in Cashiering Mode, type **No** at the "Do You
Wish to Sign Out" prompt. The system will then ask if the user wants to print a detail
of his/her activity. If the user chooses to display his/her activity, detailed bill data will
display.

```
Do you wish to sign out now? No// NO

View detail? YES
Enter DEVICE: HOME//   Virtual

                    UFMS VIEW CASHIERING SESSION DETAIL           Page: 1
SESSION ID: 3091105.103545
BILLER: LUJAN,A

(*) Indicates bills that will be excluded from export

LOC  BILL#       HRN     PATIENT            APPROVE DT    DOS       BILL AMT
----------------------------------------------------------------------------

MEDICAID FI
  -APPROVED BILLS - 3    $  2,540.00
IH   31677A     65040   SALUD,LALACE       11/05/2009 10/04/2009    476.00
IH   31592A     6670    GREEN,APPLE        12/06/2009 01/01/2009  1,811.00
IH   31656A     1180    GLASSES,SUN        12/06/2009 10/02/2009    253.00*

NON-BENEFICIARY
  -CANCELLED CLAIMS - 1
IH  24595   1122    MEGABUCKS,SYLVIA       11/13/2009 04/02/2004

PRIVATE
  -CANCELLED CLAIMS - 1
IH  31690   123567  DEMO,JOHN              11/16/2009 05/03/2009

  -APPROVED BILLS - 2    $    513.50
IH   31688      123567  DEMO,JOHN          11/16/2009 11/02/2009    450.50
IH   31691A     123567  DEMO,JOHN          12/01/2009 05/03/2009     63.00

MEDICARE FI
  -CANCELLED CLAIMS - 3
IH  31682
IH  31686
IH  31692   123567  DEMO,JOHN              11/16/2009 04/03/2006
  -APPROVED BILLS - 5    $  1,061.00
IH   31687A     123567  DEMO,JOHN          12/06/2009 10/14/2009    215.00
IH   31203B     123567  DEMO,JOHN          12/06/2009 03/11/2008    201.00
IH   31595A     7020    PAN,PETER          12/06/2009 04/02/2009    215.00
IH   31701A     222466  WEATHERS,STORMY    12/06/2009 09/12/2009    215.00
IH   31580A     11179   BUD,ROSE           12/06/2009 02/01/2009    215.00
  -CANCELLED BILLS - 1   $ 10,356.00
IH   31388A     123567  DEMO,JOHN          08/26/2008 07/27/2008  10,356.00

E N D   O F   R E P O R T
```

Figure 13-3: This screen displays if the user previously signed in (opened a Cashiering session) and attempts to sign in again by accessing the CIO menu

The user will also be prompted to print a productivity report. Typing **Yes** will re-direct the user to the Productivity Report. The user may print the report to compare billed amounts to his/her cashiering session. To verify cancelled claim totals, run the Cancelled Claims Report under the Third Party Billing Reports menu. To verify overall cancelled bills, run the Cancelled Bills Report located under the Management Reports option in the Accounts Receivable Manager menu.

```
Do you wish to print the productivity report?
```

Figure 13-4: Productivity Report prompt

Once the user's session has been open, he/she may access the claim editor, etc. The session will remain open until the user chooses to close it.

There may be instances where a user will exit the 3rd Party Billing system while still logged into a cashiering session. The system will notify the user of this open session. The following example displays the message from the system when a user attempts to log off or exit the 3rd Party Billing system with an open cashiering session.

```
Note: You are still logged into your cashiering session. To close your
session select Cashiering Options (UCSH), then Cashiering Sign In/Sign Out
(CIO).
```

Figure 13-5: System notification to a user who tries to exit the 3rd Party Billing system while logged on to a cashiering session

At this time the user can either return to the 3rd Party Billing system and log out of the cashiering session or acknowledge the message and continue any follow up in progress.

13.1.1   Closing an Open Session

Upon completion of billing activity, the session must be closed. Closing a session not only ensures the user's complete activity is captured and accurate, it also ensures the data is ready to be transmitted to the financial system.

To close the session or sign out, access the Cashiering Sign In/Sign Out option from the Cashiering Options menu.

```
CIO Cashiering Sign In/Sign Out
```

Figure 13-6: Example of the Cashiering Sign In/Sign Out option

After selecting the option, the system will display your complete activity.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |             THIRD PARTY BILLING SYSTEM - VER 2.6             |
          +             Cashiering Sign In/Sign Out                      +
          |                   INDIAN HEALTH HOSPITAL                     |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                           9-DEC-2009 7:42 AM

YOU ARE SIGNING *OUT* FOR BILLING


Will now check for any "missing" claims/bills...
No "missing" bills found



          Billing Activity       COUNT          TOTAL

     MEDICAID FI
          - Cancelled Claims      0
          - Approved Bills        3       $  2,540.00 (EXCL. 1 @ 253.00)
          - Cancelled Bills       0       $      0.00
     NON-BENEFICIARY
          - Cancelled Claims      1
          - Approved Bills        0       $      0.00
          - Cancelled Bills       0       $      0.00
     PRIVATE
          - Cancelled Claims      1
          - Approved Bills        2       $    513.50
          - Cancelled Bills       0       $      0.00
     MEDICARE FI
          - Cancelled Claims      3
          - Approved Bills        5       $  1,061.00
          - Cancelled Bills       1       $ 10,356.00



-------------------------------------------------------------------------------
  TOTAL CANCELLED CLAIMS:        5
  TOTAL CANCELLED BILLS:         1       $ 10,356.00
  TOTAL APPROVED:               10       $  4,114.50
  TOTAL EXCLUDED:                1       $    253.00

 Do you wish to sign out now? No// YES <Enter>
```

Figure 13-7: Cashiering Sign In/Sign Out screen

This is the user's opportunity to verify that his/her totals are correct. To verify totals, run the Employee Productivity Listing in the Third Party Billing Reports menu. This should allow the user to verify his/her approved amounts. To verify the cancelled claims total, run the Cancelled Claims Report located under the Third Party Billing Reports menu. To verify overall cancelled bills, run the Cancelled Bills Report located under the Management Reports option in the Accounts Receivable Manager menu. The Sign Out option will also display total excluded bills. These are bills that will not be sent to the financial system. The excluded bills are based on the set up information entered in the exclude data option in the Supervisor Staff Set Up option.

Once entries are verified, type **Yes** to sign out. The system will require the user to re-verify that he/she wishes to sign out. Type **Yes** at the prompt to continue signing out.

```
Do you wish to sign out now? No// YES

  By signing out you are confirming the system balances.
  Are you sure you wish to sign out? YES
```

Figure 13-8: Prompt that displays after the user verifies entries

If the user types **Yes**, the system will sign him/her out of Cashiering and change the session status to Closed. This closed session will be submitted to your supervisor for processing.

```
  Done...
     the session 3091105.103545 will be sent to your manager for processing.

  Signing out of session 3091105.103545


View detail?
```

Figure 13-9: Example of system message when user signs out of Cashiering

The user will also be prompted to view his/her session detail once more. Type **Yes** to view the detail. The detail screen will display and the user will have the chance to print a copy.

If the user selects No at any of the sign out prompts, he/she will be taken back to the Cashiering Options menu.

Following these instructions will ensure the user is signed out of his/her session.

13.1.2   Re-Opening a Closed Session

There may be instances where the user needs to have a session re-opened. Re-opening a session requires the supervisor key. The user will need to request his/her designated supervisor to re-open the session.

For more information, please refer to the Re-Opening a Closed Session section.

13.2   View Cashiering Session (UVCH)

Main Menu > UCSH > UVCH

Users that wish to view their activity may choose the View Cashiering Session option.

When viewing a session, the system displays open sessions first. The user has the ability to see only his/her session. Users that are supervisors can see the sessions of all users. The system will display the Session ID, the name of the Cashier, and the Date the Session was opened. If the session contains no data (approved or cancelled bills, cancelled claims) the system will display an asterisk (*) next to the session. Select the number that corresponds to the entry to view.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |            THIRD PARTY BILLING SYSTEM - VER 2.6       |
          +              View Cashiering Session                 +
          |                 INDIAN HEALTH HOSPITAL               |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: BILLER,FAST                        8-DEC-2009 4:07 PM

The following SESSIONS are currently OPEN =>

   (*)  Indicates no activity in session.

     SESSION ID   CASHIER                      DATE OPENED
--------------------------------------------------------------------------
1.  3091208.155446 BILLER,FAST                 12/08/2009@15:54


Select Session Number to View: :  (1-1):
```

Figure 13-10: View Cashiering Session screen

While each user has the ability to view his or her session, billing staff who hold the supervisor key will have the ability to view all session activity for every user. This may be helpful to the billing supervisor to keep track of user productivity or to see if session data contains information. The following example displays what the user may see if they hold the ABMDZ UFMS SUPERVISOR key.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |           THIRD PARTY BILLING SYSTEM - VER 2.6        |
          +              View Cashiering Session                  +
          |                 INDIAN HEALTH HOSPITAL                |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                      8-DEC-2009 4:08 PM

The following SESSIONS are currently OPEN =>

   (*)  Indicates no activity in session.

      SESSION ID   CASHIER                        DATE OPENED
--------------------------------------------------------------------------
1.  3090722.081036 SISNEROS,GINA              07/22/2009@08:10
2.  3091102.083446 SMITH,CHERYL               11/02/2009@08:34
3.  3091105.103545 TESTER,TEST             11/05/2009@10:35
4.  3091105.144128 VALENCIA,TINA M            11/05/2009@14:41
5.  3091119.150315 RENDER,SHONDA              11/19/2009@15:03
6.  3091208.155446 BILLER,FAST                12/08/2009@15:54


Select Session Number to View: :  (1-6):
```

Figure 13-11: Example of screen user would see if he/she had the ABMDZ UFMS SUPERVISOR key

Regardless of the access the user contains, the session may be viewed. In this mode, the system will display the user's session detail. The information in this session detail lists productivity by insurer type.

```
Session detail for Session ID: 3091105.103545  Date opened: 11/05/2009@10:35
Cashier: TESTER,TEST
--------------------------------------------------------------------------
     MEDICAID FI
               - Cancelled Claims      0
               - Approved Bills        3      $  2,540.00 (EXCL. 1 @ 253.00)
               - Cancelled Bills       0      $      0.00
     NON-BENEFICIARY
               - Cancelled Claims      1
               - Approved Bills        0      $      0.00
               - Cancelled Bills       0      $      0.00
     PRIVATE
               - Cancelled Claims      1
               - Approved Bills        2      $    513.50
               - Cancelled Bills       0      $      0.00
     MEDICARE FI
               - Cancelled Claims      3
               - Approved Bills        5      $  1,061.00
               - Cancelled Bills       1      $ 10,356.00


View detail?
```

Figure 13-12: Example of session detail for one user

To view further session details, type **Yes** at the "View Detail" prompt. This will display bill or claim information for the session.

```
                     UFMS VIEW CASHIERING SESSION DETAIL          Page: 1
SESSION ID: 3091105.103545
BILLER: LUJAN,A

(*) Indicates bills that will be excluded from export

LOC  BILL#       HRN     PATIENT              APPROVE DT   DOS     BILL AMT
-------------------------------------------------------------------------------


MEDICAID FI
  -APPROVED BILLS - 3     $  2,540.00
IH   31677A     65040   SALUD,LALACE         11/05/2009 10/04/2009    476.00
IH   31592A     6670    GREEN,APPLE          12/06/2009 01/01/2009  1,811.00
IH   31656A     1180    GLASSES,SUN          12/06/2009 10/02/2009    253.00*

NON-BENEFICIARY
  -CANCELLED CLAIMS - 1
IH  24595   1122    MEGABUCKS,SYLVIA         11/13/2009 04/02/2004

PRIVATE
  -CANCELLED CLAIMS - 1
IH  31690   123567  DEMO,JOHN                11/16/2009 05/03/2009
  -APPROVED BILLS - 2     $    513.50
IH   31688      123567  DEMO,JOHN            11/16/2009 11/02/2009    450.50
IH   31691A     123567  DEMO,JOHN            12/01/2009 05/03/2009     63.00

MEDICARE FI
  -CANCELLED CLAIMS - 3
IH  31682
IH  31686
IH  31692   123567  DEMO,JOHN                11/16/2009 04/03/2006
  -APPROVED BILLS - 5     $  1,061.00
IH   31687A     123567  DEMO,JOHN            12/06/2009 10/14/2009    215.00
IH   31203B     123567  DEMO,JOHN            12/06/2009 03/11/2008    201.00
IH   31595A     7020    PAN,PETER            12/06/2009 04/02/2009    215.00
IH   31701A     222466  WEATHERS,STORMY      12/06/2009 09/12/2009    215.00
IH   31580A     11179   BUD,ROSE             12/06/2009 02/01/2009    215.00
  -CANCELLED BILLS - 1   $ 10,356.00
IH   31388A     123567  DEMO,JOHN            08/26/2008 07/27/2008 10,356.00


E N D   O F   R E P O R T
```

Figure 13-13: UFMS View Cashiering Session Detail report

This detail can be sent to the printer by typing in a printer device at the "DEVICE" prompt.

Press the Enter key at "Select Session Number to View," and the system will display other session statuses for viewing.

```
Select Session Number to View: :   (1-6):


 Other session statuses available for viewing
 Enter list of session statuses to view or "^" to quit.

    C - CLOSED
    T - TRANSMITTED
    B - BOTH

Session statuses to view:
```

Figure 13-14: Example of menu for viewing other session statuses

Select session statuses to view at the prompt for viewing. The following may be
typed:

- **Closed**. Is used to indicate a session has been closed by the user or by the
  supervisor. Closed sessions need to be reviewed and reconciled or submitted to
  the financial system.

- **Transmitted**. This status is used to indicate a session has been closed and
  transmitted to the financial system. For non-federal locations, this status is meant
  to indicate the session has been reconciled.

- **Both**. Select this option to view both Closed and Transmitted sessions.

13.3   Supervisory Functions (SUP)

Main Menu > UCSH > SUP

The Unified Financial System is used to track financial data for federal health
systems. Facilities that utilize the RPMS Third Party Billing System can bill for a
variety of services. The total amount billed for these services will be recorded in the
financial system on a semi-real time basis.

Supervisory staff plays an important role in setting up the system. Supervisory staff
must also ensure that files are sent to the financial system. Supervisory users may not
be the business office manager, per se, but may be more like the billing supervisor, a
super user, etc. Either way, a Supervisor and an alternate must be identified.

The user can also control the type of and how much data is set to the financial system.
Users that have been identified as supervisors will need to have his/her RPMS
Administrator assign him/her the ABMDZ UFMS SUPERVISOR key. This key
allows the user to access the Supervisor options, as well as accessing the Set Up
option.

If the site is a non-IHS facility the user will get two additional prompts in the SET option. One prompt turns off the export (keeping the cashiering option) and the other prompt turns off the cashiering option (completely turn off UFMS).

In the Supervisor Menu, the user has access to the following:

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |           THIRD PARTY BILLING SYSTEM - VER 2.6          |
        +                  Supervisory Functions                 +
        |                  INDIAN HEALTH HOSPITAL                 |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                        9-DEC-2009 7:54 AM


  OPN    Re-Open a Closed Session
  REC    Reconcile All Sessions
         -----------------------
  VEF    View UFMS Export File
  VHF    View UFMS Host File
         -----------------------
  SET    UFMS Setup

Select Supervisory Functions Option:
```

Figure 13-15: Supervisory Functions menu

13.3.1   Re-Open a Closed Session (OPN)

Main Menu > UCSH > SUP > OPN

A billing clerk may request that his or her session be re-opened after it has been closed. Reasons for this may include forgetting to approve a claim, not canceling a claim prior to closing out the session, etc. Rather than opening a new session, the supervisor may elect to re-open the user's session. This can be accomplished by accessing the Re-Open a Closed Session option located in the Supervisory Functions menu.

Selecting the Re-Open a Closed Session option will display all closed sessions. Sessions that have been previously transmitted (federal) or reconciled (non-federal) will not display. Select the session that the user needs to re-open. Once the session has been re-opened, notify the billing clerk. The user needs to close the session once his or her activity is completed. There is an option for closing the user's session for him/her in the Reconciliation option.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |            THIRD PARTY BILLING SYSTEM - VER 2.6         |
         +               Re-Open a Closed Session                 +
         |                  INDIAN HEALTH HOSPITAL                 |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: TESTER,TEST                         9-DEC-2009 7:59 AM

The following sessions are available for re-opening =>


The following SESSIONS are currently CLOSED =>

     SESSION ID       CASHIER         DATE OPENED     DATE CLOSED       STATUS
-----------------------------------------------------------------------------
1. 3091105.103545  TESTER,TEST   11/05/2009@10:35 12/09/2009@07:45 CLOSED
2. 3091208.155435  BILLER,FAST      12/08/2009@15:54 12/08/2009@15:54 CLOSED

Select Session Number to Re-open:  (1-2): 1

Are you sure you want to re-open session 3091105.103545? N// YES

Ok, session 3091105.103545 has been re-opened and will begin tracking bills
again.
```

Figure 13-16: Re-Open a Closes Session screen

Only one session may be in the Open status at a time. If the system detects another open session, the system will display the following message to the user and will not re-open the session. This is to prevent billing activity being tracked in the incorrect session.

```
Select Session Number to Re-open:  (1-2): 2

Are you sure you want to re-open session 3091208.155435? N// YES

This user has an existing open session so the selected session will not be
  re-opened.

Enter RETURN to Continue:
```

Figure 13-17: Error message displayed if system detects another open session

13.3.2   Reconcile All Sessions (REC)

Main Menu > UCSH > SUP > REC

The sessions that have been created and closed by the billing staff will need to be reviewed and processed to a batch file. Batch files are created by the system, and are used to submit all billing data to the Financial System for federal locations only.

Supervisors or their designees are responsible for ensuring that the data captured in each session is balanced and submitted on a daily basis. Facilities that do not submit on a daily basis will receive messages from the UFMS Integration Engine as a reminder that files need to be submitted. Again, this only affects federal locations.

When working with sessions, different statuses can be assigned. For example, opened sessions are labeled Open, and indicate that the billing staff is performing their billing functions. Sessions closed by the billing staff receive a Closed status. Sessions that have been closed and transmitted to the financial system have a status of Transmitted.

Parent/satellite relationships are included in the sessions that are created. Billing staff who bill in separate satellite locations will have their billing information captured in the session he/she opened under the parent location.

13.3.2.1 Closing the Day

Closing the day ensures that each billing session has been reviewed and transmitted to the financial system. To close the day, the user needs to access the Supervisor Menu. In the Supervisor Menu, select the Reconcile All Sessions option.

Upon entering the Reconcile option, the user will see all closed sessions. This is to notify the user that sessions have been closed and are ready to be reviewed. The system allows the user to select certain sessions to close. To close one session, select the number that corresponds to that entry and press the Enter key. To retrieve all closed entries, select the number that corresponds to the Close All Sessions option. Selecting this option will group all session data for reconciliation (non-federal) or transfer to the financial system (federal locations).

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |            THIRD PARTY BILLING SYSTEM - VER 2.6       |
        +               Reconcile All Sessions                 +
        |                 INDIAN HEALTH HOSPITAL               |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                       9-DEC-2009 8:52 AM

The following SESSIONS are currently CLOSED =>

   (*)  Indicates no activity in session.

     SESSION ID   CASHIER                    DATE CLOSED          STATUS
---------------------------------------------------------------------------
1.   3091105.103545   TESTER,TEST        11/05/2009@10:35     CLOSED
2.   3091208.155435   BILLER,FAST            12/08/2009@15:54    CLOSED   *

3.    RECONCILE ALL SESSIONS

Session number or "^" to not select any sessions:  3//
```

Figure 13-18: Reconcile All Sessions screen

Once the user reviews the closed sessions, the system will display open sessions. Open sessions will display if the billing staff did not close their session. Sites that utilize the Pharmacy Point of Sale application will have one POS CLAIMS user display. Only one session for POS will display, regardless of the number of pharmacists a facility has. POS sessions should be closed out because the session contains billing data. It is okay to close a session even if the pharmacy is still filling scripts. A new session will automatically open with the next POS claim.

If a user has kept a session open, please ensure that the user has completed his or her billing activities prior to closing the session. The session can be kept open by typing a caret (^) at the "Session number or "^" to not select any sessions" prompt.

```
The following SESSIONS are currently OPEN =>

   (*)  Indicates no activity in session.

      SESSION ID  CASHIER                       DATE OPENED
---------------------------------------------------------------------------
1.   3090722.081036  SISNEROS,GINA            07/22/2009@08:10
2.   3091102.083446  SMITH,CHERYL             11/02/2009@08:34
3.   3091105.144128  VALENCIA,TINA M          11/05/2009@14:41
4.   3091119.150315  RENDER,SHONDA            11/19/2009@15:03
5.   3091208.155446  BILLER,FAST              12/08/2009@15:54
6.   3091209.085212  POS CLAIMS               12/09/2009@08:52

7.    CLOSE ALL SESSIONS


Session number or "^" to not select any sessions:  7// ^
```

Figure 13-19: Example of keeping a session open

If the closed sessions have been reviewed and all billed sessions have been closed, the system will notify the user that no open sessions exist. Press the Enter key to proceed.

```
The following SESSIONS are currently OPEN =>

      SESSION ID  CASHIER                          DATE OPENED
---------------------------------------------------------------------------

      There are no OPEN sessions.

Enter RETURN to Continue:
```

Figure 13-20: System notification when no open sessions exist

Sessions that have been selected for reconciliation will display. Press the Enter key to accept the default response (Yes) and proceed to the next screen. If sessions for reconciliation need to be reviewed, type **No**. The system will resume where the user left off next time he/she enters this option.

```
The following SESSIONS have been selected for Reconciliation =>

   (*)  Indicates no activity in session.

     SESSION ID   CASHIER                     DATE OPENED
-------------------------------------------------------------------------
1.   3091105.103545   TESTER,TEST            11/05/2009@10:35    CLOSED
2.   3091208.155435   BILLER,FAST             12/08/2009@15:54    CLOSED  *


-------------------------------------------------------------------------
  6. 3091209.085212   POS CLAIMS             12/09/2009@08:52

Do you wish to proceed ("^" to exit)? YES//
```

Figure 13-21: Sessions selected for reconciliation screen

For the federal locations, after accepting the default response (Yes), the system displays messages notifying the user that pseudo Tax Identification Numbers exist or Tax Identification Numbers are missing for insurers. This is to inform the user that he/she will be sending pseudo Tax Identification Numbers in his/her UFMS invoice file.

Pseudo Tax Identification Numbers need to be researched, corrected, and updated with the user's area office, and need to be reported to the UFMS oracle. Please note POS claims are also screened for this information.

```
IMPORTANT!! IMPORTANT!! Pseudo TINs will be sent in this export!
```

Figure 13-22: Example of Pseudo TIN number

Insurers' with missing Tax Identification Numbers need to be researched, corrected, and updated with the user's area office, and need to be reported to the UFMS oracle. Please note POS claims are also screened for this information. The system notifies the user that an export file will **not** be created. The insurer missing the Tax Identification Number is identified by the session ID and insurer name.

An export file can be created by **excluding** the session identified by the system until all research is done and updated.

```
     IMPORTANT!! IMPORTANT!! TINs are missing in this export!

     DUE TO MISSING TAX IDs, EXPORT FILE WILL NOT BE CREATED. Insurers
     missing TINs will be listed. Please record the name(s) of the Insurer
     for correction.

Enter RETURN to Continue:

Insurers missing Tax IDs in this export selection:
     CIGNA CORPORATION in session ID 3070830.121604
```

Figure 13-23: Report listing insurers with missing TINs

Next, the system provides a summary of the billing detail to be submitted to the financial system. This screen is sorted by the users and his/her sessions. The screen displays the following:

- **Approved Bills** will be counted and submitted to the financial system. Even if a bill was cancelled, it will still file an entry in the financial system.

- **Excluded Bills** are bills that have been excluded. Bills can be excluded by Location, Clinic Stop, and/or Insurer Type. See Set Up to review entries selected to exclude.

- **Cancelled Bills** are counted and displayed. Cancelled bills are not submitted to the financial system.

- **Cxl'd Claims** is used to indicate cancelled claims. Cancelled claims are not submitted to the financial system.

- **Ben Bills** is used to display bills where the beneficiary (Indian) patient is listed as the active insurer. Beneficiary (Indian) patients are not submitted to the financial system.

Typing **No** will not send the export, but will allow the user to print a summary screen. After printing the summary screen, the user is returned to the Supervisory Functions Menu.

```
===============================================================================
Export Summary Print                                     DEC 9,2009    Page 1
Billing Location: INDIAN HOSP
===============================================================================
Please ensure the following information is correct:
                             Approved  | Excluded       Cancelled   Cxl'd    Ben
 Session/User                   Bills  |  Bills             Bills   Claims   Bill
                                       |
3091105.103545/LUJAN,A   10  4,114.50  | 1    253.00  1 10,356.00     5       0
                                       |
3091208.155435/BILLER,F   0      0.00  | 0      0.00  0      0.00     0       0
                                       |
3091209.085212/POS CLAIMS1      63.98  | 1     63.98
-------------------------------------------------------------------------------
TOTALS:                  11  4,178.48  | 3    380.96  1 10,356.00     5       0



Do you want to SEND export now? <yes/no>?
```

Figure 13-24: Example of Export Summary Print screen

If the user selects to send the export file to UFMS, the system displays a default filename. Do **not** change this filename unless notified to change it. The filename contains information about the user's facility, and must never be changed. Changing the filename may result in the financial system being out of balance.

The system notifies the user that a copy of the file is being created in an RPMS directory. This directory is established in the Set Up option. A file is also sent to the Integration Engine (UFMS Hub).

The user has the ability to print a summary and filename of what was transmitted.

```
Do you want to SEND export now? <yes/no>? yes   YES
File will be created using the following name:
     IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT

DOS File Being Created'
Please Standby - Copying Data to DOS File
c:\inetpub\ftproot\pub\IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT

File was sent successfully
Print summary screen?
```

Figure 13-25: Example of default filename created by the system

A copy of the Export Summary should be printed and kept for storage.

```
Output DEVICE: HOME//   Virtual

==========================================================================
Export Summary Print                                    DEC 9,2009    Page 1
Billing Location: INDIAN HOSP
==========================================================================
Please ensure the following information is correct:
                           Approved  | Excluded      Cancelled   Cxl'd  Ben
 Session/User                Bills   |  Bills          Bills   Claims Bill
                                     |
3091105.103545/LUJAN,A   10  4,114.50 | 1    253.00  1 10,356.00    5     0
                                     |
3091208.155435/BILLER,F   0     0.00 | 0      0.00  0     0.00     0     0
                                     |
3091209.085212/POS CLAIMS1    63.98 | 1     63.98
--------------------------------------------------------------------------
TOTALS:                  11  4,178.48 | 5    697.94  1 10,356.00    5     0


EXPORTED IN FILE IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT

File was sent successfully

(REPORT COMPLETE):
```

Figure 13-26: Export summary print screen

13.3.3   View UFMS Export File (VEF)

Main Menu > UCSH > SUP > VEF

Use the View UFMS Export File option to gather data specific to transmitted or reconciled sessions. These reports are helpful when attempting to balance from RPMS to UFMS to assist in end-of-day reconciliation. There are a number of reports to select from.

To run the report, type the transmission/reconciliation date and time. This is the date/time that was recorded when the batch of sessions were transmitted/reconciled.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |            THIRD PARTY BILLING SYSTEM - VER 2.6          |
           +                   View UFMS Export File                  +
           |                  INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: TESTER,TEST                          9-DEC-2009 11:10 AM

Select beginning export:    12-9-2009@09:06:25     TESTER,TEST

Select ending export:    12-9-2009@09:06:25     TESTER,TEST

      Select one of the following:

          S          SUMMARY
          D          DETAIL
          P          SUMMARY WITH EXPORT PAGE
          X          DETAIL WITH EXPORT PAGE
          G          GRAND TOTAL ALL FILES BY TRANSMISSION DATE

SUMMARY OR DETAIL: SUMMARY//
```

Figure 13-27: View UFMS Export File screen

After entering the date/time, select from one of the following report type. Each report denotes the number of Excluded Bill entries. Each report prints the Location the report was printed from, the export date and time, the filename used when the export was created, and the filename of any re-exported files.

The following lists the type of reports that can be printed.

- Summary

    The Summary Report prints session data such as the session identifier and the cashier name and lists the billing activity by allowance category. The bill count and total amount for each allowance category are listed.

```
                          UFMS EXPORT SUMMARY                        Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: DEC 09, 2009@09:06:25
FILE NAME: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
EXPORT(S) RESENT:  <<NONE>>
==============================================================================
    BUDGET ACTIVITY                   BILL COUNT      AMOUNT
------------------------------------------------------------------------------

SESSION ID: 3091105.103545     BILLER: LUJAN,A

  MEDICAID FI                         3 bills          2,540.00
  MEDICARE FI                         5 bills          1,061.00
  PRIVATE                             2 bills            513.50
                         1 excluded bill         253.00


SESSION ID: 3091209.085212     BILLER: POS CLAIMS

  MEDICARE PART D                     1 bill             63.98

TOTAL BILLS FOR THIS EXPORT:        11 bills          4,178.48

E N D   O F   R E P O R T
```

Figure 13-28: UFMS Export Summary screen

- Detail

  The Detail Report prints session data such as the session identifier and the cashier
  name by allowance category, and also prints the detail of each claim or bill that is
  included in each category.

```
                          UFMS EXPORT SUMMARY                    Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: DEC 09, 2009@09:06:25
FILE NAME: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
EXPORT(S) RESENT:  <<NONE>>
===========================================================================
NOTE: "*" by amount means it was excluded from export
                                          APPROVAL     DATE OF
LOC BILL #    HRN     PATIENT             DATE         SERVICE    AMOUNT
---------------------------------------------------------------------------

SESSION ID: 3091105.103545    BILLER: LUJAN,A

  MEDICAID FI
IH  31677A   65040   SALUD,LALACE        11/05/2009 10/04/2009    476.00
IH  31592A   6670    GREEN,APPLE         12/06/2009 01/01/2009  1,811.00
IH  31656A   1180    GLASSES,SUN         12/06/2009 10/02/2009    253.00
*
  MEDICARE FI
IH  31687A   123567  DEMO,JOHN           12/06/2009 10/14/2009    215.00
IH  31203B   123567  DEMO,JOHN           12/06/2009 03/11/2008    201.00
IH  31595A   7020    PAN,PETER           12/06/2009 04/02/2009    215.00
IH  31701A   222466  WEATHERS,STORMY     12/06/2009 09/12/2009    215.00
IH  31580A   11179   BUD,ROSE            12/06/2009 02/01/2009    215.00
  PRIVATE
IH  31688    123567  DEMO,JOHN           11/16/2009 11/02/2009    450.50
IH  31691A   123567  DEMO,JOHN           12/01/2009 05/03/2009     63.00

SESSION ID: 3091209.085212    BILLER: POS CLAIMS


  MEDICARE PART D
IH  31735A   12770   JONES,CHIPPER       12/09/2009 12/08/2009     63.98
*

TOTAL BILLS FOR THIS EXPORT:      11 bills                     4,178.48

E N D   O F   R E P O R T
```

Figure 13-29: UFMS Export Summary screen (Detail report)

- Summary with Export Page

  The Summary with Export Page report prints the same data as the Summary Report, but will be preceded by the UFMS Export Reconciliation Page. This is the same page that is displayed when sessions are being transmitted/reconciled.

```
                  ***** UFMS EXPORT RECONCILIATION PAGE *****        Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: DEC 09, 2009@09:06:25
FILE NAME: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
===========================================================================
                         Approved  |Excluded       Cancelled  Cxl'd   Ben
 Session/User              Bills    | Bills            Bills   Claims  Bills
                                    |
3091105.103545/LUJAN,A   10  4,114.50 | 1    253.00  1 10,356.00   5      0
                                    |
3091209.085212/POS CLAIMS1      63.98 | 1     63.98
---------------------------------------------------------------------------
TOTALS:                  11  4,178.48 | 2    316.98  1 10,356.00   5      0


                        UFMS EXPORT SUMMARY                        Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: DEC 09, 2009@09:06:25
FILE NAME: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
EXPORT(S) RESENT:  <<NONE>>
===========================================================================
---------------------------------------------------------------------------

SESSION ID: 3091105.103545    BILLER: LUJAN,A

  MEDICAID FI                      3 bills         2,540.00
  MEDICARE FI                      5 bills         1,061.00
  PRIVATE                          2 bills           513.50
                        1 excluded bill        253.00


SESSION ID: 3091209.085212    BILLER: POS CLAIMS

  MEDICARE PART D                  1 bill            63.98

TOTAL BILLS FOR THIS EXPORT:      11 bills         4,178.48

E N D   O F   R E P O R T
```

Figure 13-30: UFMS Export Summary screen (summary with export)

- Detail with Export Page

  The Detail with Export Page report prints the same data as the Detail Report, but is preceded by the UFMS Export Reconciliation Page. This is the same page that is displayed when sessions are being transmitted/reconciled.

```
                    ***** UFMS EXPORT RECONCILIATION PAGE *****        Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: DEC 09, 2009@09:06:25
FILE NAME: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
================================================================================
                        Approved    |Excluded     Cancelled  Cxl'd  Ben
 Session/User             Bills     | Bills          Bills    Claims Bills
                                    |
3091105.103545/LUJAN,A   10  4,114.50 | 1    253.00  1 10,356.00  5     0
                                    |
3091209.085212/POS CLAIMS1    63.98 | 1     63.98
--------------------------------------------------------------------------------
TOTALS:                  11  4,178.48 | 2    316.98  1 10,356.00  5     0




                        UFMS EXPORT SUMMARY                        Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: DEC 09, 2009@09:06:25
FILE NAME: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
EXPORT(S) RESENT:  <<NONE>>
================================================================================
NOTE: "*" by amount means it was excluded from export
                                        APPROVAL     DATE OF
LOC BILL #   HRN     PATIENT            DATE         SERVICE      AMOUNT
--------------------------------------------------------------------------------

SESSION ID: 3091105.103545   BILLER: LUJAN,A

  MEDICAID FI
IH  31677A   65040   SALUD,LALACE       11/05/2009 10/04/2009     476.00
IH  31592A   6670    GREEN,APPLE        12/06/2009 01/01/2009   1,811.00
IH  31656A   1180    GLASSES,SUN        12/06/2009 10/02/2009     253.00
*
  MEDICARE FI
IH  31687A   123567  DEMO,JOHN          12/06/2009 10/14/2009     215.00
IH  31203B   123567  DEMO,JOHN          12/06/2009 03/11/2008     201.00
IH  31595A   7020    PAN,PETER          12/06/2009 04/02/2009     215.00
IH  31701A   222466  WEATHERS,STORMY    12/06/2009 09/12/2009     215.00
IH  31580A   11179   BUD,ROSE           12/06/2009 02/01/2009     215.00
  PRIVATE
IH  31688    123567  DEMO,JOHN          11/16/2009 11/02/2009     450.50
IH  31691A   123567  DEMO,JOHN          12/01/2009 05/03/2009      63.00

SESSION ID: 3091209.085212   BILLER: POS CLAIMS

  MEDICARE PART D
IH  31735A   12770   JONES,CHIPPER      12/09/2009 12/08/2009      63.98
*

TOTAL BILLS FOR THIS EXPORT:      11 bills                     4,178.48

E N D   O F   R E P O R T
```

Figure 13-31: UFMS Export Summary screen (detail with export report)

- Grand Total all Files by Transmission Date

The Grand Total Report prints the UFMS Export Reconciliation page along with the Export Summary. The summary lists all sessions included in this transmission/reconciliation including, the location, the allowance category, the bill count, and the dollar amount which displays the excluded bill counts and amounts. This report assists the user in reconciling his/her daily transmissions to what UMFS receives, and should be printed daily.

```
                  ***** UFMS EXPORT RECONCILIATION PAGE *****        Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: DEC 09, 2009@09:06:25
FILE NAME: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
===============================================================================
                          Approved  |Excluded        Cancelled  Cxl'd   Ben
  Session/User              Bills   | Bills            Bills    Claims  Bills
                                    |
3091105.103545/LUJAN,A   10  4,114.50 | 1    253.00  1 10,356.00   5      0
                                    |
3091209.085212/POS CLAIMS1    63.98 | 1     63.98
-------------------------------------------------------------------------------
TOTALS:                  11  4,178.48 | 2    316.98  1 10,356.00   5      0


                        UFMS EXPORT SUMMARY                          Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: DEC 09, 2009@09:06:25
FILE NAME: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
EXPORT(S) RESENT:  <<NONE>>
===============================================================================
    BUDGET ACTIVITY          BILL CNT      AMOUNT     EXCL.CNT    EXCL.AMT
-------------------------------------------------------------------------------
SESSION ID: 3091105.103545     BILLER: TESTER,TEST
SESSION ID: 3091209.085212     BILLER: POS CLAIMS
-------------------------------------------------------------------------------
INDIAN HEALTH HOSPITAL
   MEDICAID                   3 bills    2,540.00     1 bill      253.00
   MEDICARE                   6 bills    1,124.98     0 bills       0.00
   PRIVATE INSURANCE          2 bills      513.50     0 bills       0.00
    Total for facility       11 bills    4,178.48

    TOTAL BILLS:             11 bills    4,178.48     1 bill      253.00


    TOTAL EXPORTED:          10 bills    3,925.48

E N D   O F   R E P O R T
```

Figure 13-32: UFMS Export Summary screen (print daily)

13.3.4   View UFMS Host File (VHF)

Main Menu > UCSH > SUP > VHF

This report provides the user with the ability to view UFMS files on the RPMS Host system. These are files that were transmitted to the financial system. The user needs to know the name of the file but if unknown, he/she can type in a "*" at the Select UFMS Reports Menu Option to display all files in the known directory.

The report can be printed in two ways: file layout or captioned layout. Samples are provided on the following pages for reference.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |            THIRD PARTY BILLING SYSTEM - VER 2.6        |
          +                   View UFMS Host File                  +
          |                  INDIAN HEALTH HOSPITAL                |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                        9-DEC-2009 12:40 PM

CURRENT UFMS DIRECTORY IS c:\inetpub\ftproot\pub
Enter filename : IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT

FILES FOUND:
1.   IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
Enter item number: :   (1-1):


     Select one of the following:

          F          FILE LAYOUT
          C          CAPTIONED

Enter response: FILE LAYOUT
```

Figure 13-33: View UFMS Host File screen

File Layout can be used to view the file in the format it is submitted to UFMS. Viewing with this option will help the user ensure certain bill entries were included in the file to UFMS.

```
Enter response: FILE LAYOUT

                              UFMS HOST FILE VIEW                    PAGE 1
          FILE: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT

       INVOICE#                  DT/TM APP.TAX ID    DESCRIPTION
                                                                    BILL AMT
       CAN       HHS T-CD  OBJCLBUDG. ACT CC MASTER TIN
------------------------------------------------------------------------
1     D2321012321018535                  11/05/2009850327237 2321012321013
1677A
       00000000000000047600              13261704          046232101MCD
2     D2321012321018562                  12/06/2009856000565 2321012321013
1592A
       00000000000000181100              13261704          046232101MCD
3     D2321012321018557                  12/06/2009752784278 2321012321013
1687A
       00000000000000021500              13261704          046232101MCR
4     D2321012321018558                  12/06/2009752784278 2321012321013
1203B
       00000000000000020100              13261704          046232101MCR
5     D2321012321018559                  12/06/2009752784278 2321012321013
1595A
       00000000000000021500              13261704          046232101MCR
6     D2321012321018560                  12/06/2009752784278 2321012321013
1701A
       00000000000000021500              13261704          046232101MCR
7     D2321012321018561                  12/06/2009752784278 2321012321013
1580A
       00000000000000021500              13261704          046232101MCR
8     D2321012321018541                  11/16/2009112323232 2321012321013
1688
       00000000000000045050              13261704          046232101PRV
9     D2321012321018552                  12/01/2009039018392 2321012321013
1691A
       00000000000000006300              13261704          068232101PRV
10    T         90000000000000386150
```

Figure 13-34: Example of File Layout view

Using the Captioned report allows the user to view the report data in greater detail. Each record on the UFMS file is labeled for quick reference.

```
Enter response: CAPTIONED

                              UFMS HOST FILE VIEW                    PAGE 1
          FILE: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
                              CAPTIONED LAYOUT
-----------------------------------------------------------------------------
RECORD #: 1
RECORD TYPE: D
INV#: 2321012321018535
DT/TM APPROVED:
TAX ID:
DESC: 11/05/200985032723723210123210131677A
BILL AMT: .0
CAN: 0000000000
HHS T-CODE: 0000047600
OBJECT CLASS:
BUDGET ACTIVITY:
COST CENTER: 1
MASTER TIN: 3261704

RECORD #: 2
RECORD TYPE: D
INV#: 2321012321018562
DT/TM APPROVED:
TAX ID:
DESC: 12/06/200985600056523210123210131592A
BILL AMT: .0
CAN: 0000000000
HHS T-CODE: 0000181100
OBJECT CLASS:
BUDGET ACTIVITY:
COST CENTER: 1
MASTER TIN: 3261704
```

Figure 13-35: Captioned layout view

13.3.5   UFMS Setup (SET)

Main Menu > UCSH > SUP > SET

The system is set up to send files to the financial system based on a parent-satellite relationship – much like the RPMS Accounts Receivable system. Additional set up needs to be performed for non-federal locations.

The parent location and each of its satellites will need to have the Set Up option completed.

The user will be prompted for the following for the federal locations set up.

- UFMS Directory is used as the location to place a copy of the UFMS Export File. These files are exported to the UFMS via the Integration Engine, but a copy is placed in this directory for troubleshooting errors. Consult with an RPMS administrator to get the name of the RPMS directory where these files are stored.

- UFMS Display Default Number is used to in the View Cashiering Session option, and allows the user to enter the number of days to view open or closed sessions. It is helpful to set this up to the number of days the user needs to view open or closed sessions. Patch 12 defaults the view to five days.

- Use ASUFAC Of is used for satellite locations **only**. Some locations, such as home, school, office, etc., may not have an ASUFAC or the location may not have been set up with a CAN or BACS entry. Use this option to substitute the ASUFAC with the Parent location's ASUFAC. If the user is in the Parent Location, do not complete this prompt.

```
UFMS DIRECTORY: C:\INETPUB\FTPROOT\PUB\UFMS Replace
UFMS DISPLAY DEFAULT NUMBER: 5//
USE ASUFAC OF: INDIAN HEALTH HOSPITAL//
```

Figure 13-36: Prompt for users in satellite locations

- Exclude Data is used if a clinic within the facility is non-IHS, and that clinic is not to be counted in the financial system. This option allows the user to select any combination of location/insurer type/clinic to exclude from the UFMS exports. For example, if a facility's dental program holds a tribal or 638 status, this table allows the rest of the facility data to create an entry in UFMS, but removes the dental data from the UFMS Export File. Use extra care with this option since any bill/invoice marked to be excluded will have the receipts and adjustments excluded in the Accounts Receivable package as well. If there is no information to enter, leave this entry blank.

To enter exclude data, the system displays a warning message followed by a note to press the Enter key to continue. Once the user presses the Enter key to continue, the system defaults to the facility into which the user is logged. Then, the user confirms the location displayed and types an effective date for the desired exclusions criteria. An effective date is the date the user would like to **exclude** financial information from UFMS exports. The "Clinic Code" and/or "Insurer Type" prompts need to be specified to complete the process. The last prompt is "END DATE". End dates are dates that **include** financial information in the UFMS exports. Previously entered exclusion data can be reinstated to the financial reporting process by using this prompt. If **no** exclusion data is required, then the user can press the Enter key through all prompts.

```
    WARNING: Entries into the following file will prohibit data from being
             sent to UFMS.
             Use EXTREME caution when creating entries.

The default to your current location.


Enter RETURN to Continue:
Select Location: INDIAN HEALTH HOSPITAL//        HEADQUARTERS WEST
ALBUQUERQUE        01                        NM   IHS         202810
         ...OK? Yes//    (Yes)


Existing entries for INDIAN HEALTH HOSPITAL:
   Eff. Date   End Date     Clinic                        Insurer Type
--------------------------------------------------------------------------
   01/01/2007                56 DENTAL                    MEDICAID FI
   01/01/2008                39 PHARMACY

Select EFFECTIVE DATE: 1/1/09   JAN 01, 2009
  Are you adding 'JAN 01, 2009' as a new EFFECTIVE DATE (the 3RD for this 3P
UFMS EXCLUSION TABLE)? No// YES  (Yes)
CLINIC: W. I. C.        36
INSURER TYPE: MEDICAID  MEDICAID FI
END DATE:
```

Figure 13-37: Exclude data screen

The billing supervisor needs to set up the following prompts in the Set Up menu if the location is a non-federal facility:

- "UFMS Export" prompt allows the site to utilize the UFMS exporting process. If the user's facility is a tribal location that uses the federal financial system, then this needs to be set to Yes, and the user needs to follow the instructions under the IHS FEDERAL LOCATIONS section. This prompt default is No.

- "UFMS Cashiering" prompt allows the site to take advantage of the Cashiering sessions. Sites that do not wish to perform cashiering functions will need to set this prompt to No.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |            THIRD PARTY BILLING SYSTEM - VER 2.6       |
          +                    UFMS Setup                         +
          |                 TRIBAL HEALTH CENTER                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: TESTER,TEST                    9-DEC-2009 9:25 AM

UFMS EXPORT: NO (DON'T EXPORT)//
UFMS CASHIERING: NO (Don't do Cashiering Sessions)// ??

     Choose from:
      1        YES (Do Cashiering Sessions)
      0        NO (Don't do Cashiering Sessions)
```

Figure 13-38: UFMS Setup screen

13.4   UFMS Reports (RPTS)

Main Menu > UCSH > RPTS

The system contains reports that assist the user in setting up the system. The Reports menu is located in the Cashiering Options. Within the reports menu, the following options are available for printing:

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |           THIRD PARTY BILLING SYSTEM - VER 2.6          |
        +                        UFMS Reports                     +
        |                   INDIAN HEALTH HOSPITAL                 |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                        9-DEC-2009 12:54 PM


   PTIN   Pseudo TIN Listing
   ITIN   Insurer TIN Listing
   CANV   View/Print CAN crosswalk
   GTOT   Grand Total All Files by Transmission Date
   CSPR   Cashiering Session Productivity Report

Select UFMS Reports Option:
```

Figure 13-39: UFMS Reports option menu

13.4.1   Psuedo TIN Listing (PTIN)

Main Menu > UCSH > RPTS > PTIN

The Psuedo TIN Listing is used to print a listing of insurers in the insurer file that contain a pseudo-tax identification number. These numbers are entered by the holders of Table Maintenance. A pseudo-number is also identified as having an alpha suffix.

The report can by printed by either billing address or mailing address. The Billing Address may not always be populated.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |              THIRD PARTY BILLING SYSTEM - VER 2.6          |
        +                      Pseudo TIN Listing                    +
        |                     INDIAN HEALTH HOSPITAL                 |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                        9-DEC-2009 12:57 PM

    Select one of the following:

        B          Billing Address
        M          Mailing Address

Which address would you like to see on the report:
```

Figure 13-40: Pseudo TIN Listing menu

The report prints complete with contact information. The following displays the report printed by mailing address.

```
===========================================================================
===== INSURER LISTING WITH PSEUDO TINS =====            DEC 9,2009   Page 1
at INDIAN HEALTH HOSPITAL
Billing Location: INDIAN HOSP
===========================================================================
  INSURER                           MAILING ADDRESS                 TIN
    Address                           City           ST Zip    Phone
---------------------------------------------------------------------------
  UNITED HEALTH CARE                                            12384759A
    POB 740803                      ATLANTA         GA 30374  (800)410-1922
  UFMS MEDICAID                                                 ABQ00CAID
    5300 HOMESTEAD ROAD             ALBUQUERQUE     NM 87110  (505)888-1010

                              TOTAL INSURERS WITH PSEUDO TIN:  2

(REPORT COMPLETE):
```

Figure 13-41: Mailing Address report

13.4.2   Insurer TIN Listing (ITIN)

Main Menu > UCSH > RPTS > ITIN

The Insurer TIN Listing report provides data on insurers with a Tax Identification Number, insurers that are missing a Tax Identification Number, or a complete listing of insures regardless of whether a TIN is entered or not.

The user can print the report by billing address or mailing address. The Billing Address field may not always be populated.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |               THIRD PARTY BILLING SYSTEM - VER 2.6             |
         +                     Insurer TIN Listing                        +
         |                    INDIAN HEALTH HOSPITAL                      |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: TESTER,TEST                        9-DEC-2009 1:02 PM


     Select one of the following:

          1              Insurers with TIN
          2              Insurers without TIN
          3              Both

Which insurers would you like to see:
```

Figure 13-42: Insurer TIN Listing menu

The report prints a list of active insurers within a user-defined date range. Active insurers are insurers that have been billed in the timeline that the user defines. The system will default back to one year's worth of data.

```
This report prints insurers that have been billed back to a user-selected
date.
Please select date for report:  (12/10/2004 - 12/9/2009): 12/09/2008//
```

Figure 13-43: Example of prompt for user-defined date range

The report prints data sorted by insurer type complete with contact information. The following example lists insurers missing a TIN. The report printc the Internal Entry number (IEN) of the insurer next to the name of the payer. This report can be used to get a list of insurers that are lacking a Tax Identification Number.

```
==============================================================================
Insurers without TIN                               DEC 9,2009    Page 1
Billing Location: INDIAN HOSP
==============================================================================
INSURER (IEN)                      TIN
    Address                        City           ST Zip        Phone
------------------------------------------------------------------------------

    MEDICAID FI
PRESBYTERIAN SALUD(869)
     P.O. BOX 92085                ALBUQUERQUE    NM 87199-2085 (800)977-4222

    PRIVATE
ALLSTATE INS CO GRP(464)
     ALLSTATE PLAZA                NORTHBROOK     IL 60062      (312)402-6872
BC/BS OF UTAH(166)
     PO BOX 30270                  SALT LAKE CITY UT 84130      (801)481-6535
BURNING CANDLE PLANS(981)
     PO BOX 42745                  NEW YORK       NY 57363      (800)483-0394
CRESCENT MUTUAL LIFE(974)
     P.O. BOX 93840                ATLANTA        GA 37474      (800)483-0394
KEY LIFE & HEALTH(919)
     PO BOX 39889                  SALT LAKE CITY UT 84110
LIGHTING INSURANCE COMPANY(936)
     PO BOX 39874                  DALLAS         TX 38747-3948
NEVERHAPPY INSURANCE CO.(967)
     P.O. BOX 7538                 OMAHA          NE 92391      (800)483-0934
OURMONEY INSURANCE(990)
     PO BOX 92998                  DALLAS         TX 38389      (800)483-0394
SPIDERMAN INSURANCE(1085)
     PO BOX 332                    NEBRASKA       IL 33333      (333)222-9999
TELEPHONE HEALTH PLANS(1084)
     P O BOX 332                   NEBRASKA       IL 33333      (333)222-9999
TIME BOMB INSURANCE(935)
     PO BOX 9287                   ALBANY         NY 22892      (800)483-0394

                          TOTAL INSURERS WITHOUT TIN:  12

                          TOTAL INSURER COUNT:  61
(REPORT COMPLETE):
```

Figure 13-44: List of insurers with TIN numbers

The report provides totals for insurers missing a Tax Identification Number, as well as complete insurer counts.

13.4.3   View/Print CAN Crosswalk (CANV)

Main Menu > UCSH > RPTS > CANV

The View/Print CAN Crosswalk option consists of two reports that assist the user in viewing data that goes to UFMS.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |              THIRD PARTY BILLING SYSTEM - VER 2.6             |
         +                    View/Print CAN crosswalk                   +
         |                      INDIAN HEALTH HOSPITAL                   |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: TESTER,TEST                          9-DEC-2009 1:19 PM

     Select one of the following:

         ITBA       Insurer Type to Budget Activity
         CTCC       Clinic Type to Cost Center

Which crosswalk would you like to see:
```

Figure 13-45: View/Print CAN crosswalk menu

Access is provided to the following:

- Insurer type to Budget Activity Report (ITBA)
- Clinic type to Cost Center Report (CTCC)

13.4.3.1 Insurer type to Budget Activity (ITBA)

The Insurer type to Budget Activity report allows the user to see the mapping of the insurer type to the budget activity codes. Budget activities are assigned by the finance office, and are calculated based upon the Area office and the facility code. These codes populate the file that is generated to UFMS.

The example below shows the Budget Activity codes from Albuquerque Indian Health Center. These code are current as of May 1, 2007.

```
Which crosswalk would you like to see: ITBA   Insurer Type to Budget Activity

Output DEVICE: HOME//



=============================================================================
MAPPING of Insurer Type to Budget Activity                  DEC 9,2009    Page 1
at ALBUQUERQUE INDIAN HEALTH CTR
Billing Location: ALBQ INDIAN HC
=============================================================================
  Insurer Type          Budget Activity  EFFECTIVE DATE   END DATE
  CHIP (KIDSCARE)         7122530222      MAY 01, 2007
  HMO                     7132530515      MAY 01, 2007
  MEDICARE SUPPL.         7132530515      MAY 01, 2007
  PRIVATE                 7132530515      MAY 01, 2007
  FRATERNAL ORG           7132530515      MAY 01, 2007
  MEDICAID FI             7122530222      MAY 01, 2007
  MEDICARE FI             7120530121      MAY 01, 2007
  MCR PART D              7120530121      MAY 01, 2007
  MEDICARE HMO            7120530121      MAY 01, 2007
  THIRD PARTY LI          7126530212      MAY 01, 2007
  WORKMEN'S COMP          7100530109      MAY 01, 2007
  CHAMPUS                 7100530109      MAY 01, 2007
  NON-BEN                 7100530109      MAY 01, 2007
  BENEFICIARY             7100530109      MAY 01, 2007
  GUARANTOR               7100530109      MAY 01, 2007

(REPORT COMPLETE):
```

Figure 13-46: Example of Insurer Type to Budget Activity report (ITBA option)

13.4.3.2 Clinic Type to Cost Center (CTCC)

This report displays how the clinic codes used on visits created by PCC and other clinic applications is mapped to Cost Centers that have been established by the finance office. It is important to understand how certain visits are mapped to specific cost centers.

The codes listed below are current as of May 1, 2007.

```
Which crosswalk would you like to see: CTCC  Clinic Type to Cost Center


Output DEVICE: HOME//


============================================================================
MAPPING of Clinic to Cost Center                        DEC 9,2009   Page 1
at ALBUQUERQUE INDIAN HEALTH CTR
Billing Location: ALBQ INDIAN HC
============================================================================
  CC CLINIC                         Cost Center  EFFECTIVE DATE  END DATE
  43 ALCOHOL AND SUBSTANCE              039       MAY 01, 2007
  A3 AMBULANCE                         047       MAY 01, 2007
  35 AUDIOLOGY                         060       MAY 01, 2007
  C4 BEHAVIORAL HEALTH                 061       MAY 01, 2007
  62 CANCER CHEMOTHERAPY               108       MAY 01, 2007
  58 CANCER SCREENING                  108       MAY 01, 2007
  02 CARDIOLOGY                        052       MAY 01, 2007
  77 CASE MANAGEMENT SERVICES          111       MAY 01, 2007
  55 CAST ROOM                         094       MAY 01, 2007
  52 BEHAVIORAL HEALTH                 109       MAY 01, 2007
  03 CHEST AND TB                      057       MAY 01, 2007
  A6 CHIROPRACTIC                      059       MAY 01, 2007
  50 CHRONIC DISEASE                   094       MAY 01, 2007
  C3 COLPOSCOPY                        093       MAY 01, 2007
  A5 COMPLEMENTARY MEDICINE            088       MAY 01, 2007
  71 COMPUTED TOMOGRAPHY               050       MAY 01, 2007
  04 CRIPPLED CHILDREN                 092       MAY 01, 2007
  44 DAY SURGERY                       095       MAY 01, 2007
  82 DAY TREATMENT PROG                061       MAY 01, 2007
  XX DEFAULT CODE FOR NULL/BLANK       094       MAY 01, 2007
  56 DENTAL                            068       MAY 01, 2007
  05 DERMATOLOGY                       094       MAY 01, 2007
  61 DEVEL. ASSESSMENT                 092       MAY 01, 2007
  98 DIABETES EDUCATION-GROUP          034       MAY 01, 2007
  A1 DIABETES EDUCATION-INDIVIDUAL     034       MAY 01, 2007
  06 DIABETIC                          034       MAY 01, 2007
  B7 DIABETIC FOOT CLINIC              102       MAY 01, 2007
  A2 DIABETIC RETINOPATHY              034       MAY 01, 2007
  92 DIALYSIS                          033       MAY 01, 2007
  95 DIALYSIS LABORATORY SERVICES      033       MAY 01, 2007
  67 DIETARY                           063       MAY 01, 2007
  60 EDUCATION CLASSES                 065       MAY 01, 2007
  C7 ELDER CARE                        094       MAY 01, 2007
  30 EMERGENCY MEDICINE                048       MAY 01, 2007
  68 EMPLOYEE HEALTH UN                088       MAY 01, 2007
  69 ENDOCRINOLOGY                     088       MAY 01, 2007
  07 ENT                               044       MAY 01, 2007
  57 EPSDT                             092       MAY 01, 2007
  89 EVENING                           088       MAY 01, 2007
  08 FAMILY PLANNING                   065       MAY 01, 2007
  28 FAMILY PRACTICE                   094       MAY 01, 2007
  47 FETAL ALCOHOL SYNDROME            039       MAY 01, 2007
  53 FOLLOW-UP LETTER                  109       MAY 01, 2007
  B8 GASTROENTEROLOGY-HEPATOLOGY       106       MAY 01, 2007
  01 GENERAL                           046       MAY 01, 2007
  27 GENERAL PREVENTIVE                112       MAY 01, 2007
```

```
73 GENETICS                           088      MAY 01, 2007
09 GROUPED SERVICES                    111      MAY 01, 2007
10 GYNECOLOGY                          091      MAY 01, 2007
C6 HEALTH AIDE CLINIC                  064      MAY 01, 2007
26 HIGH RISK                           093      MAY 01, 2007
11 HOME CARE                           064      MAY 01, 2007
31 HYPERTENSIVE                        088      MAY 01, 2007
12 IMMUNIZATION                        112      MAY 01, 2007
41 INDIRECT                            099      MAY 01, 2007
40 INFANT STIMULATION                  092      MAY 01, 2007
13 INTERNAL MEDICINE                   088      MAY 01, 2007
83 LABOR AND DELIVERY                  087      MAY 01, 2007
76 LABORATORY SERVICES                 051      MAY 01, 2007
42 MAIL                                099      MAY 01, 2007
72 MAMMOGRAPHY                         050      MAY 01, 2007
B1 MATERNITY CASE MGMT SUPP SERV       111      MAY 01, 2007
48 MEDICAL SOCIAL SERVICES             021      MAY 01, 2007
81 MEN'S HEALTH SCREENING              088      MAY 01, 2007
14 MENTAL HEALTH (PSYCHIATRY)          061      MAY 01, 2007
49 NEPHROLOGY                          088      MAY 01, 2007
37 NEUROLOGY                           088      MAY 01, 2007
C1 NEUROSURGERY                        045      MAY 01, 2007
46 NIH CLINIC                          071      MAY 01, 2007
B5 NURSE CLINIC                        094      MAY 01, 2007
15 OBESITY                             088      MAY 01, 2007
87 OBSERVATION                         046      MAY 01, 2007
16 OBSTETRICS                          093      MAY 01, 2007
93 OCCUPATIONAL THERAPY                059      MAY 01, 2007
B9 ONCOLOGY-HEMATOLOGY                 108      MAY 01, 2007
17 OPHTHALMOLOGY                       043      MAY 01, 2007
18 OPTOMETRY                           067      MAY 01, 2007
19 ORTHOPEDIC                          100      MAY 01, 2007
78 OTC MEDICATIONS                     020      MAY 01, 2007
25 OTHER                               046      MAY 01, 2007
84 PAIN MANAGEMENT                     088      MAY 01, 2007
20 PEDIATRIC                           092      MAY 01, 2007
96 PED OUTPT USE OF INP TRTMNT RM      041      MAY 01, 2007
A4 PERINATOGIST                        093      MAY 01, 2007
A9 PH PREPAREDNESS (BIOTERRORISM)      047      MAY 01, 2007
39 PHARMACY                            020      MAY 01, 2007
45 PHN CLINIC VISIT                    064      MAY 01, 2007
34 PHYSICAL THERAPY                    058      MAY 01, 2007
29 PLASTIC SURGERY                     095      MAY 01, 2007
65 PODIATRY                            102      MAY 01, 2007
32 POSTPARTUM                          087      MAY 01, 2007
C2 PULMONOLOGY                         057      MAY 01, 2007
B2 RADIATION EXPOSURE SCREENING        046      MAY 01, 2007
54 RADIO CALL                          109      MAY 01, 2007
63 RADIOLOGY                           050      MAY 01, 2007
21 REHABILIATION                       058      MAY 01, 2007
33 RESPIRATORY CARE                    057      MAY 01, 2007
64 RETINOPATHY                         067      MAY 01, 2007
38 RHEUMATOLOGY                        088      MAY 01, 2007
A7 RYAN WHITE EARLY INTERVENTION       105      MAY 01, 2007
B3 SANDS(STOP ATHR NATV DIA STDY)      071      MAY 01, 2007
22 SCHOOL                              088      MAY 01, 2007
74 SPEECH PATHOLOGY                    104      MAY 01, 2007
88 SPORTS MEDICINE                     088      MAY 01, 2007
```

```
 59 STD                              088        MAY 01, 2007
 23 SURGICAL                         101        MAY 01, 2007
 97 SURG. OUTPT USE INP TRTMNT RM    045        MAY 01, 2007
 85 TEEN CLINIC                      088        MAY 01, 2007
 90 TELEMEDICINE                     076        MAY 01, 2007
 51 TELEPHONE CALL                   109        MAY 01, 2007
 91 TELERADIOLOGY                    050        MAY 01, 2007
 99 THIRD PARTY DENTAL               068        MAY 01, 2007
 94 TOBACCO CESSATION CLINIC         088        MAY 01, 2007
 86 TRADITIONAL MEDICINE             088        MAY 01, 2007
 79 TRIAGE                           046        MAY 01, 2007
 66 ULTRASOUND                       050        MAY 01, 2007
 80 URGENT CARE                      046        MAY 01, 2007
 75 UROLOGY                          088        MAY 01, 2007
 36 W.I.C.                           070        MAY 01, 2007
 24 WELL CHILD                       092        MAY 01, 2007
 A8 WELLNESS                         112        MAY 01, 2007
 B4 WISEWOMAN                        093        MAY 01, 2007
 70 WOMEN'S HEALTH SCREENING         093        MAY 01, 2007
 C5 WOUND CARE                       094        MAY 01, 2007

(REPORT COMPLETE):
```

Figure 13-47: Clinic Type to Cost Center report (CTCC option)

13.4.4   Grand Total All Files by Transmission Date (GTOT)

Main Menu > UCSH > RPTS > GTOT

The Grand Total report prints the UFMS Export Reconciliation page along with the
Export Summary page. The summary lists all sessions included in this
transmission/reconciliation, the location, the Allowance Category, the bill count, and
the dollar amount. This report also displays the Excluded bill counts and amounts.
This report assists the user in reconciling his/her daily transmissions to what UMFS
receives, and should be printed daily.

```
                    ***** UFMS EXPORT RECONCILIATION PAGE *****        Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: DEC 09, 2009@09:06:25
FILE NAME: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
================================================================================
                        Approved   |Excluded       Cancelled   Cxl'd   Ben
 Session/User            Bills      | Bills            Bills    Claims  Bills
                                    |
3091105.103545/LUJAN,A   10  4,114.50 | 1    253.00  1 10,356.00  5      0
                                    |
3091209.085212/POS CLAIMS1     63.98 | 1     63.98
--------------------------------------------------------------------------------
TOTALS:                  11  4,178.48 | 2    316.98  1 10,356.00  5      0


                          UFMS EXPORT SUMMARY                       Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: DEC 09, 2009@09:06:25
FILE NAME: IHS_TPB_RPMS_INV_232101_20091209_090625_2.06.00k.DAT
EXPORT(S) RESENT:  <<NONE>>
================================================================================
    BUDGET ACTIVITY          BILL CNT      AMOUNT     EXCL.CNT     EXCL.AMT
--------------------------------------------------------------------------------
SESSION ID: 3091105.103545     BILLER: TESTER,TEST
SESSION ID: 3091209.085212     BILLER: POS CLAIMS
--------------------------------------------------------------------------------
INDIAN HEALTH HOSPITAL
   MEDICAID                 3 bills   2,540.00      1 bill    253.00
   MEDICARE                 6 bills   1,124.98      0 bills     0.00
   PRIVATE INSURANCE        2 bills     513.50      0 bills     0.00
    Total for facility     11 bills   4,178.48

   TOTAL BILLS:            11 bills   4,178.48      1 bill    253.00


   TOTAL EXPORTED:         10 bills   3,925.48
E N D   O F   R E P O R T
```

Figure 13-48: Grand Total All Files by Transmission Date report (GTOT option)

13.4.5   Cashiering Session Productivity Report (CSPR)

Main Menu > UCSH > RPTS > CSPR

This report allows the user to view cashiering productivity. The data on the report is based on the date the cashiering session was opened. The user can select a variety of exclusion parameters when printing the report.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |              THIRD PARTY BILLING SYSTEM - VER 2.6            |
        +          Cashiering Session Productivity Report        +
        |                    INDIAN HEALTH HOSPITAL                    |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: TESTER,TEST                          9-DEC-2009 1:33 PM

   EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
   =======================================================================
   - Users..............: ALL
   - POS Claims.........: Included
   - Session status.....: ALL

      Select one of the following:

            1            DATE RANGE
            2            USERS
            3            POS CLAIMS
            4            SESSION STATUS

Select ONE or MORE of the above EXCLUSION PARAMETERS:
```

Figure 13-49: Cashiering Session Productivity Report menu

Printing the summary of this report will display the following

```
================================================================================
Cashiering Session Productivity Report           12/09/2009@13:36    Page 1
For Location: INDIAN HEALTH HOSPITAL
For ALL users Including POS Claims
================================================================================
Statistics for BILLER,FAST
     BILLED
          MEDICARE                          0                0.00
          MEDICAID                          1              216.00
          PRIVATE INSURANCE                 0                0.00
          OTHER                             0                0.00
                                       ------          ----------
                    Total Bills            1              216.00

     CANCELLED CLAIMS
          MEDICARE                          0
          MEDICAID                          0
          PRIVATE INSURANCE                 0
          OTHER                             0
                                       ------
                    Total Claims           0

     CANCELLED BILLS
          MEDICARE                          0                0.00
          MEDICAID                          0                0.00
          PRIVATE INSURANCE                 0                0.00
          OTHER                             0                0.00
                                       ------          ----------
                    Total Bills            0                0.00


Cashiering Sessions used:
     3091208.155435 (TRANSMITTED)
     3091208.155446 (OPEN)

(REPORT COMPLETE):
```

Figure 13-50: Summary of Cashiering Session Productivity Report

14.0   Glossary

Accident/TORT Related Insurance

Insurance covering accidents resulting from a third party's action. Party's action may involve a civil court process in an attempt to require payment by the Third party, other than no fault liability. Also includes no fault automobile insurance.

Ambulatory Care

All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are hospital inpatients.

Ambulatory Surgery

Surgery performed as an outpatient visit.

Auto Approve

An option available in this package that automatically approves claims and generates bills without user intervention.

Centers for Medicare & Medicaid Services

The HHS agency responsible for Medicare and parts of Medicaid. Centers for Medicare & Medicaid Services has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Claim

A set of codes and fees grouped together to bill the responsible party for services rendered.

Claim Editor

Software that allows users to make modifications to third party insurance claims and to approve those claims within the third party billing software.

Claim Generator

Software that runs in the background that gathers data from PCC and patient registration in order to generate claims.

Claim Number

Number assigned to the claim, which will be sent to a billable entity.

Claim Summary

Abbreviated summary of key information in the claim.

CMS-1450

The uniform institutional claim form.

CMS-1500

The uniform professional claim form.

Code Set

Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions. Also see Part II, 45 CFR 162.103.

Coinsurance

The portion of percentage of the Medicare-approved amount that a beneficiary is responsible for paying.

Coordination of Benefits

Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called cross-over.

Covered Days

Number of days covered by the primary payer, as qualified by the payer organization.

Current Dental Terminology (CDT)

A medical code set of dental procedures, maintained and copyrighted by the American Dental Association (ADA), and adopted by the Secretary of HHS as the standard for reporting dental services on standard transactions.

Data Element

Under HIPAA, this is the smallest named unit of information in a transaction.

Deductible

The amount of expense a beneficiary must pay before insurance benefits begin payment for covered services.

Diagnosis

Identifying a disease from its signs and symptoms.

Discipline

Code indicating discipline(s) order by physician.

Drug File

List of drugs that can be dispensed to a patient during a visit. The medications available for selection are restricted to whatever entries exist in the Drug file at each site. This file is maintained by the Pharmacy and should reflect all locally prescribed take home drugs.

Electronic Data Exchange

Refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.

Electronic Media Claims (EMC)

A flat file format used to transmit or transport claims, such as the 192-byte UB-92 Institutional EMC format and the 320-byte Professional EMC NSF.

Eligibility

A defined period of time that a patient is enrolled in prepaid health programs.

Fee-for service

A payment system by which doctors, hospitals, and other providers are paid a specific amount for each service performed as identified by a claim for payment.

Fee Schedule

Medicare's system for paying physicians fees. The schedule, which went into effect on January 1, 1992, assigns a dollar value to each physician service based on work, medical practice costs, and malpractice insurance costs. Each of these three factors is adjusted for the geographic variation in costs.

Group Health Plan

A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.

Health Care Clearinghouse

A public or private entity that does either of the following (Entities, including but not limited to, billing services, repricing companies, community health management information systems or community health information systems, and value-added networks and switches are health care clearinghouses if they perform these functions): (1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; (2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.

HCPCS Procedure Code

Procedure codes that identify services so that appropriate payment can be made. These codes are required for many specific types of outpatient services and a few inpatient services.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

Healthcare Provider Taxonomy Codes

An administrative code set that classifies health care providers by type and area of specialization. The code set will be used in certain adopted transactions. (Note: A given provider may have more than one Healthcare Provider Taxonomy Code.)

ICD-9 Code

Diagnosis code which describes the principle diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization).

Implementation Guide

A document explaining the proper use of a standard for a specific business purpose. The X12N HIPAA IGs are the primary reference documents used by those implementing the associated transactions, and are incorporated into the HIPAA regulations by reference.

Insurer File

File consisting of Insurance companies which IHS has authorization to bill for services provided to IHS patients.

Itemized Bill

A bill generated with a detailed description of each item and cost of the item.

Medicaid

A federally aided, state operated program that provides medical benefits for certain low-income persons.

Medicare

A national health insurance program for people 65 years of age and older, certain younger disabled people, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Medicare Remittance Advice Remark Codes

A national administrative code set for providing either claim-level or service-level Medicare-related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice transaction.

Medicare Part A Coverage

Insurance that pays for medically necessary inpatient hospital care, skilled nursing facility or psychiatric hospital and for hospice and home health care for eligible patients.

Medicare Part B Coverage

Insurance that pays for medically necessary doctor services and many other medical services and supplies for eligible patients.

Medicare Supplement Policy

A health insurance policy that pays certain costs not covered by Medicare, such as coinsurance and deductibles.

Modifier

Two position codes serving as modifiers to HCPCS procedures.

National Provider Identifier (NPI)

The name of the standard unique health identifier for health care providers that was adopted by the Secretary in January 2004.

Non-Beneficiary

Person not eligible to receive services at IHS or tribal facilities due to regulation, policies, and procedures.

Non-Covered Days

Days of care not covered by the primary payer.

Payment Posting

The entering of payment information related to a bill by category, such as payment amount, deductible amount, co-insurance amount, etc. in order to account for the entire amount billed.

Preferred Providers

Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.

Primary Care Provider

The provider that serves as the initial interface between the member and the medical care system. The PCP is usually a physician, selected by the member upon enrollment, who is trained in one of the primary care specialties who treats and is responsible for coordinating the treatment of members assigned to his/her panel.

Private Insurance

Health insurance other than Medicare or Medicaid. Coverage is usually based on current employment or current employment of a family member.

Procedure Codes

Codes that identify the principal procedure(s) performed during the period covered by a bill.

Revenue Code

Code used for outpatient ancillary services provided.

Segment

Under HIPAA, this is a group of related data elements in a transaction.

Self Insured

An individual or organization that assumes the financial risk of paying for health care.

Table Maintenance

Managing table files associated with the billing system.

Third Party Administrator

Business associate that performs claims administration and related business functions for a self-insured entity.

Trading Partner

External entity with whom business is conducted, i.e. customer. This relationship can be formalized via a trading partner agreement. (Note: a trading partner of an entity for some purposes may be a business associate of that same entity for other purposes.)

Transaction

Under HIPAA, this is the exchange of information between two parties to carry out financial or administrative activities related to health care.

UB-92

An electronic format of the CMS-1450 paper claim form that has been in general use since 1993.

Washington Publishing Company

The company that publishes the X12N HIPAA Implementation Guides and the X12N HIPAA Data Dictionary. It developed the X12 Data Dictionary, and that hosts the EHNAC STFCS testing program.

15.0   Appendix A: Third Party Billing EMC Preparation

Step 1: Contact the Site Manager.

The Site Manager must verify that **dossavex** is part of his/her UNIX path.

Step 2: Change EMC file preference to HOST FILE

1. At the Third Party Billing System Main Menu prompt, type **TMTP**.

2. At the "Select Table Maintenance Menu Option" prompt, type **SITM**.

3. At the "EMC File Preference" prompt, type **HOST FILE**.

4. Type a caret (^) at prompts, until the system returns to the Main Menu prompt.

Step 3: Update the mode of export for all desired visit types in the insurer file

> **Note:** Repeat this Step, as visit types are added.

1. At the Third Party Billing System Main Menu prompt, type **TMTP**.

2. At the Table Maintenance Menu option prompt, type **INTM**.

3. At the Insurer File Menu option prompt, type **EDIN**.

4. At the "Select Desired Action" prompt, type **1**.

5. At the "Screen-out Insurers with status of Unselectable?" prompt, type **Y** (Yes).

6. At the "Select Insurer" prompt, type Medicare (or the name of the desired insurer).

7. Press the Enter key at the prompts until the "Select Visit Type" prompt is displayed.

8. At the "Select Visit Type" prompt, type Outpatient (or the name of the desired visit type).

9. Press the Enter key at the prompts until the "Mode of Export" prompt is displayed.

10. At the "Mode of Export" prompt, type **837**.

11. Repeat steps 8-10 until all visit types are updated.

12. Type a caret (**^**) at prompts, until the system returns to the Main Menu prompt.

Step 4: Update AO control number in insurer file.

1. At the Third Party Billing System Main Menu prompt, type **TMTP**.

2. At the Table Maintenance Menu option prompt, type **INTM**.

3. At the Insurer File Menu option prompt, type **EDIN**.

4. At the "Select Desired Action" prompt, type **1**.

5. At the "Screen-out Insurers with status of Unselectable?" prompt, type **Y** (Yes).

6. At the "Select Insurer" prompt, type **Medicare** (or the name of the desired insurer).

7. Press the Enter key at the prompts until the "AO Control Number" prompt is displayed.

8. At the "AO Control Number" prompt, type **00400**, the usual number for Medicare, (or type the number assigned by the NAIC).

9. Type a caret (**^**) at prompts, until the system returns to the Main Menu prompt.

Step 5: Enter EMC Data in the Insurer File

1. At the Third Party Billing System Main Menu prompt, type **TMTP**.

2. At the Table Maintenance Menu option prompt, type **INTM**.

3. At the Insurer File Menu option prompt, type **EDIN**.

4. At the "Select Desired Action" prompt, type **1**.

5. At the "Screen-out Insurers with status of Unselectable?" prompt, type **Y** (Yes).

6. At the "Select Insurer" prompt, type **Medicare** (or type the name of the desired insurer).

7. Press the Enter key at the prompts until the "EMC Submitter ID" prompt is displayed.

8. At the "EMC Submitter ID" prompt, type the ID number assigned by the third party (i.e., Medicaid).

9. At the "EMC Password" prompt, type the password assigned by the third party.

10. At the "EMC Test Indicator" prompt, type **T** for test mode or **P** for production mode.

11. Type a caret (**^**) at prompts, until the system returns to the Main Menu prompt.

Step 6: Verify that the user has a "V" for his file manager access code

1. Open the FileMan program.

2. At the "Select Option" prompt, type **1** (Enter Or Edit File Entries).

3. At the "Input to what File" prompt, type **NEW PERSON**.

4. At the "Edit which Field" prompt, type **FILE MANAGER ACCESS CODE**.

5. At the "Edit Field" prompt, press the Enter key.

6. At the "Select New Person Name" prompt, type the user's name.

7. At the "File Manager Access Code" prompt, type **V**.

8. Type a caret (**^**) at prompts to exit.

Step 7: After completing Steps 1-6, approve the claims.

15.1   RPMS File (Batch) Creation

Step 1: View the summary of bills ready for electronic submission.

1. At the Third Party Billing System Main Menu prompt, type **EMTP** to display the Electronic Media Claims Menu.

2. At the "Select Electronic Media Claims Option" prompt, type **SUEM**.

The system displays the following message:

```
Summary information about batches ready to submit.
```

Figure 15-1: Message system displays after typing SUEM at the "Select Electronic Media Claims Option" prompt

3. At the "Show Detail?" prompt, type

- **Y** (Yes) to see an itemized list and go to step 4.

- **N** (No) and go to step5.

4. At the "What sequence number" prompt, type the number of the insurer/visit.

The system displays each bill in the batch.

5. If everything looks OK, proceed to "Step 2: Create the EMC File." Otherwise, return to the Edit a Claim option and make the necessary corrections.

Step 2: Create the EMC File

1. At the "Select Electronic Media Claims Option" prompt, type **CREM**.

The system displays a list of insurers with bill type, export mode, number of bills, and total amount by sequence number.

2. At the "What sequence number" prompt, type the sequence number that corresponds to the insurer for whom the user wants to create the EMC batch file.

3. At the "Proceed?" prompt, Type **Y** (Yes) to create the EMC batch; otherwise type **N** (No).

The system displays the following message on your screen:

```
ENTRY CREATED IN 3P TX STATUS FILE .
LOCATION:  ALBUQUERQ HO@1546        (or your site)
VISIT TYPE:  OUTPATIENT
```

Figure 15-2: Message displayed after system creates an EMC file

If the system displays the "Cannot create entry in 3P TX STATUS FILE" message, verify that the user has a "V" in his/her FileMan Access.

4. At the "Enter Path" prompt, press the Enter key to accept the displayed pathname, or type the name of the path where the file will be stored.

5. At the "Enter File Name" prompt, press the Enter key to accept the displayed filename, or type a name for the file.

The system displays the following message on the screen:

```
BATCH #1460087

Writing bills to file. . . .
Finished.
```

Figure 15-3: Example of system message when bills are written to file

Step 3: View Batch Summary

1. At the "Select Electronic Media Claims Option" prompt, type **BSEM**.

2. At the "Select beginning export batch" prompt, type the export batch number to start the summary.

3. At the "Select ending export batch" prompt, type the export batch number to end the summary.

4. At the "DEVICE" prompt, type the name of the device on which to view or print the summary report.

Step 4: Recreate an EMC File

1. At the "Select Electronic Media Claims Option" prompt, type **RCEM**.

2. At the "Select 3P TX Status Export Date" prompt, type the original date of export.

3. At the "Enter Path" prompt, press the Enter key to accept the default path, or type the path name location for the new file.

4, At the "Enter File Name" prompt, press the Enter key to accept the default file name, or type a new file name.

The system creates the new (duplicate) file, and displays the following messages on your screen.

```
Writing bills to file. . . .
Finished.
```

Figure 15-4: Message displayed by system after creation of new (duplicate) file

15.2   Save File on UNIX to Diskette

1. Obtain a PC formatted diskette.

> **Note:** Do **not** format diskette on UNIX machine.

2. Ask someone with root access (usually the site manager) on the UNIX machine to meet the user in the computer room.

3. Take the list of files created in RPMS, and the diskette to the computer room.

4. Give the list and diskette to the Site Manager (SM).

5. The SM logs on to the UNIX (RISC) machine as root, and inserts the diskette in the disk drive.

6. At the UNIX prompt, the SM types the filename, **dossavex**.

7. The SM repeats step 6 for each file created. This process must be done one file at a time.

8. The SM logs off the UNIX machine, removes the diskette, and returns it to the user.

9. The diskette now contains the files for transmission.

15.3 Transmit Files to Medicare if FI Is Trailblazers Healthcare LLC

1. Take the diskette that contains the files to a PC with Modem and ProComm.

2. Access ProComm software.

3. Dial Medicare through the ProComm software.

4. Log in to the Medicare system; for example,

```
Welcome to rEDI - link Blue ! ! !  (PROD2)
Customer Support: TX - CO - NM  (972) 766 - 5480
                                        MD  (410) 527 - 5654
Please Login:  type in login number (usually 6 numerics) <Enter>
Password? type in password (IHSIHS?) <Enter>
                              user logged in at date_time
                              last login at date_time

Press <RETURN> to continue  -> <Enter>
```

Figure 15-5: Example login screen for the Medicare system

The use of PKZIP V 2.04g or compatible compression software is strongly recommended, which will REDUCE data transmission costs significantly.

5. At the "Selection" prompt, type **2** and press the Enter key to select the (U) pload option from the main menu; for example,

```
                              Welcome to rEDI-link Blue
                               ========================

            1.  (D) ownload
            2.  (U) pload
            3.  (L)  ist Files in Mailbox
            4.  (H)  elp
            5.  (Q)  uit

            Selection:  2 <Enter>
```

Figure 15-6: Example of selection of the (U) pload option

6. Upload the file by following the instructions that appear on your screen.

    a. Click the Open File Folder icon.

    b. Select the file to send. (Only one can be sent at a time).

    c. Click the OK button.

```
<<<<   UPLOAD A FILE   >>>>

**** Select Protocol:
                K   for Kermit
                X   for XMODEM
                Y   for YMODEM
                Z   for ZMODEM

                or  Q   for QUIT      Z <Enter>

**** Please place your PC in ZMODEM mode to send the file.
**B0100000027fed4
```

Figure 15-7: Upload file instruction screen

7. When the upload is complete, ProComm displays the message "Transfer Completed Successfully" on the bottom Status bar.

```
**** Transfer COMPLETED SUCCESSFULLY ****
Press <Return> to continue
Application Finished - Returning to Menu
```

Figure 15-8: ProComm system message when upload is complete

15.4   To Download Medicare's Response to the Transmission

1. Log into the Medicare system.

2. At the "Selection" prompt type **1** to Download.

```
                    Welcome to rEDI-link Blue
                    =========================

                    1.  (D) ownload
                    2.  (U) pload
                    3.  (L)  ist Files in Mailbox
                    4.  (H)  elp
                    5.  (Q)  uit

                    Selection:  1 <Enter>
```

Figure 15-9: Medicare system menu

3. At the "or Q to Quit" prompt, type **Z** to select the ZMODEM protocol for the user's computer.

```
>>>>   DOWNLOAD A FILE   <<<<

**** Select Protocol:
                    K   for Kermit
                    X   for XMODEM
                    Y   for YMODEM (BATCH)
                    Z   for ZMODEM

                    or  Q  to QUIT    Z <Enter>
```

Figure 15-10: Example of prompt that allows user to transmit

4. At the "Do you wish to download all of the files in the mailbox?" prompt, type **Y** (Yes).

The computer downloads the files, the "Transfer Completed Successfully" message displays, and the user is returned to the main menu.

```
Do you wish to download all of the files in the mailbox? (Y/N) Y <Enter>
Press Y/N to continue or q to quit

**** Please place your computer in ZMODEM to receive the files.
**** Transfer COMPLETED SUCCESSFULLY ****
Press <RETURN> to continue
Application Finished - Returning to Menu
```

Figure 15-11: Example of message when download of all files is complete

5. At the "Selection" prompt, type **5** to Exit the Medicare System; for example,

```
                 Welcome to rEDI-link Blue
                 =======================

            1.  (D) ownload
            2.  (U) pload
            3.  (L)  ist Files in Mailbox
            4.  (H)  elp
            5.  (Q)  uit

            Selection:  5 <Enter>
User (username) logged out at date and time
```

Figure 15-12: Menu to logout of Medicare system

6. Exit ProComm.

> **Note:** When DOWNLOADING the response file to the user's PC, the files are placed in C:\PROWIN\DNLOAD.
> Each day a transmission is sent to Medicare, the response files overwrite the files from previous days. The numbering scheme re-starts with one (1). To keep the downloaded response files, move them to a different directory on the user's PC.

Appendix B: Third Party Billing Location Setup

Set up the Billable Location in Accounts Receivable

1. Open the Accounts Receivable package.

2. At the Main Menu prompt, type **MAN** to select the Manager option.

3. At the Manager Menu prompt, type **PSE** to select the Parent/Satellite Edit option.

4. Select the home location that pertains to the user's area and set up.

For more information on this setup, see the IHS *Accounts Receivable User Manual*.

Set up the Site Parameter Function in Third Party Billing

1. At the Main Menu prompt, type **TMTP** to select the Table Maintenance option.

2. At the Table Maintenance Menu prompt, type **SITM** to select Site Parameters option.

3. Press the Enter key at the prompts that follow, until the "Use A/R Parent Satellite Setup?" prompt is displayed.

4. At the "Use A/R Parent Satellite Setup?" prompt, type **Y** (Yes) or **N** (No).

Appendix F: Cancelled Claim Reasons

The following contains a list of cancelled claim reason codes:

- Orphan Claim Created in Error
- Duplicate Claim Created
- Eligibility Not Found
- Manually Billed Claim
- Beyond Filing Limit
- Unbillable Provider
- Unbillable Diagnosis
- Unbillable Clinic Type
- Unbillable Visit Type
- Workman's Comp/Third Party Case
- Other
- Return to Stock
- Over the Counter Meds
- Left without being seen
- Telephone Consult
- POS Plan Limitation Exceeded
- POS Refill Too Soon
- Unbillable Professional Claim (Medicare Part B)
- 72-Hour Outpatient Visit
- Visit Unrelated to Accident/Injury
- Claim Created for Wrong Patient
- Paternity Eligible
- Within Global Period
- Incorrect Charges
- Wrong Insurer Selected
- Wrong DOS

Cancelled claim reasons are added by the Third Party Billing developer. Requests for canceling claim reasons must be requested to the RPMS Helpdesk.

Closed Claim Reasons

The following contains a list of closed claim reasons:

- Orphan Claim Created in Error
- Duplicate Claim Created
- Eligibility Not Found
- Manually Billed Claim
- Beyond Filing Limit
- UnBillable Provider
- Unbillable Diagnosis
- Unbillable Clinic Type
- Unbillable Visit Type
- Workman's Comp/Third Party Case
- Return to Stock
- Over the Counter Meds
- Left Without Being Seen
- Telephone Consult
- POS Plan Limitation Exceeded
- POS Refill too soon
- Unbillable Professional Claim (Medicare B)
- 72-Hour Outpatient Visit
- Visit Unrelated to Accident/Injury
- Claim Created for Wrong Patient
- Paternity Eligible
- Within Global Period
- Incorrect Charges
- Wrong Insurer Selected
- Wrong DOS
- Re-Opened in Error
- Test Claim

- Triage Only

- Did Not Keep Appointment

Closed claim reasons are added by the Third Party Billing developer. Requests for closed claims reasons must be requested to the RPMS Helpdesk.

Contact Information

For any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov