



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 10
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Preface

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

Please review and distribute this addendum to your Third Party Billing staff prior to installation of the patch. Be aware there are changes that affect electronic billing.

1.0 Introduction

1.1 Summary of Changes

Patch 10 provides some enhancements and minor corrections to Version 2.6 of the Third Party Billing System.

1.1.1 Patch 10

Patch 10 includes the following:

- ICD-10 indicators have been added to the claim editor. Users will now be able to distinguish between ICD-9 and ICD-10 codes that are being used.
- ICD-10 Effective date has been added to 3rd Party Table Maintenance Insurer File menu. This is a required field and will be defaulted to 10/1/2013. Sites should change this date based on when each insurer requires ICD-10 coding to be sent. Post-install for this patch will automatically populate field for all insurers with 10/1/2013.
- Added new Medicare numbers for Medicare Part A and Medicare Part B. Sites will need to enter the Medicare Part A number in the 3rd Party Table Maintenance Insurer File menu.
- A new report option MPRP Medicare Providers CPT report has been added. The report will capture the CPT code G8553, providers listed on the bill, provider type (attending, Rendering, etc.), bill number, date of service and billed amount. The user has the option to run the report by summary or detailed.

Fixes for reported issues logged at the RPMS Helpdesk:

- NOHEAT - Made change for 5010 837I for the Operating provider. Was printing a secondary ID (REF*EI) when the insurer was set to NPI ONLY for said insurer.
- NOHEAT - Changed 5010 837I 2310A loop when sending a secondary identifier for a provider to send GU instead of LU for ND Medicaid.
- NOHEAT - Modified 5010 837I HI segment so it won't send an E-code in HI02 if HI01 is the same E-code.
- NOHEAT - Removed REF*LU segment from loop 2310C (Service Facility Location) for the 5010 formats.
- NOHEAT - Corrected FL Override option for box 24, the shaded line. Override wasn't working correctly.
- HEAT46645 - Modified 5010 loop 2010AA so a REF segment for state license number will print if the Insurer has a Location Assigned w/provider # populated.

- HEAT53137 - Fixed FL overrides to use whatever is setup for the visit location, not what location you are logged into.
- HEAT55555 - Issue with PVP report not having paid visits on report. Found if bill number does not have suffix or HRN, it couldn't find the A/R Bill and payment.
- HEAT56410 - Changed fields COVERED MILEAGE and NON-COVERED MILEAGE on ambulance page 3A to allow tenths of miles to be entered. Fixed display on page 8K for long description (was giving error <UNDEF>EOP+22^ABMDE8K). Also added service line provider for ambulance, and correct non-covered and covered charges so they would populate on page 3A when A0888 or A0425 is used on page 8K.
- HEAT56697 - Made change so PVH Eligible Hospital report would output patient list. Was only printing headers (no data).
- HEAT58915 - When the replacement insurer option was being used, claim was showing two primary insurers in the 837 file. Made change so it would only show the replacement insurer, and as primary.
- HEAT59419 - Made change to CPT check in claim editor. It wasn't comparing the dates correctly, so a DOS in 2011 wasn't allowing codes that were active in 2011 but inactive in 2012.
- HEAT61340 - Made change to 5010 CLM02 billed amount when billing secondary. It will print which ever amount is greater, the original bill amount or the gross amount.
- HEAT61426 - Made change so a temporary chart number would print in an 837 file. Before it would only allow numeric characters.
- HEAT61501 - Made change so multiple FQHC/RHC/Tribal locations could be selected on MU reports. Was only allowing one selection.
- HEAT61723 - When site changed the Insurer CONTRACT CODE REQ'D from yes to no, it was leaving the CONTRACT CODE and CONTRACT TYPE still populated. Changed it so these fields would delete when CONTRACT CODE REQ'D changed to no.
- HEAT61751 - Fixed spacing on MU reports. The Kidscare/Chip Encounter line wasn't lining up with the other lines on the report.
- HEAT61752 - In MU Patient Volume reports, changed all references of FQHC to FQHC/RHC/Tribal.
- HEAT62179 - Added Referring Provider question to page3 of the claim editor for export modes 4010 837I and 5010 837I.

- HEAT65628 - Created new error 242 in claim editor that will display on page 1. This error will not allow the service from or service to dates to be imprecise. Also changed the DD for both the 3P Claim file and the 3P Bill file so an imprecise date cannot be entered in the fields at all.
- HEAT65629 - Correction made to BLRP report. Was not printing anything when the user selected UNPAID BILLS and statistical.
- HEAT65976 - Made change to 1500 (08/05) for outside lab charges. They were being included in the billed amount when they should not be. Also made change so outside lab charge would only print on first page of a multi-page claim.
- HEAT66142 - Updated 5010 for DTP segments for Onset of Current Illness or Symptom Date and Accident Date. Both of these segments were printing when the dates were populated. Added a secondary check to see if there was an accident type before printing either of these dates.
- HEAT67219 - Made a change to UB-04 when printing the original print date. Site had issue where they posted a payment so the status changed to complete before the bill was exported. Made change so it would default to today's date in this case.
- HEAT67469 - Made change to 5010 837I so if the referring provider is the same as the attending provider, the referring provider will not print.
- HEAT67605 - Made change so 5010 837P will use whatever FL overrides are setup for the HCFA-1500 (08/05) format. The 4010 837P will continue to use FL overrides from the HCFA-1500 Y2K format.
- HEAT67774 - E-codes were showing up on claims when they shouldn't be (carrying over from previous claims in the batch). Made code change to remove erroneous codes.
- HEAT68159 - Found that E-code was being filed in E-code field and in POA INDICATOR field. Wrote post-init routine for patch 10 to remove "bad" data from POA INDICATOR field. Was making claims deny due to number in field. ABMFPOA
- HEAT68319 - Made change to UB-04 to print CODE PREFIX from Dental Remap Table Maintenance option if one is setup.
- HEAT68447 - Made change for ISA08 VALUE in 3P Parameter file. It was using what was setup for the parent all the time, instead of the satellite when appropriate. Also made change if the clinic is ambulance and the insurer is Medicare it will make the receiver ID 04402. Also fixed the FL override for ISA06 to make sure it is 15 characters long.
- HEAT68467 - Made change so MSP REASON isn't being populated on bill if the patient is not MSP eligible. Was putting a default reason of 14. Also fixed error 218 on page2. It was displaying all the time.

- HEAT68575 - Made change so page 9E would display in Claim Editor for all HCFA formats (paper and electronic).
- HEAT68832 - fix for programming error <UNDEF>GO+7^DIE. Occurs when user is editing either HCPCS codes A0425 or A0888 for covered mileage.
- HEAT69121 - Made change to SBR segment of 837 to put "16" when the insurer type is Medicare HMO.
- HEAT69379 - Made change to page 6 of Claim Editor. When user types "D" for delete and the "^" instead of selecting an entry, they would get kicked out of RPMS.
- HEAT69623 - Added check when printing onset of current illness or symptom. It must be different than the admission date and the service from date before it will print.
- HEAT70085 - Made change for COB page when billing secondary insurer. It was using the A/R Account from the transactions instead of the A/R Account from the bill, so if transactions were posted to a batch with a different insurer they weren't showing up correctly on the COB page.
- HEAT70634 - 4010 837 was showing primary insurer payer ID for secondary insurer. Made change so it would use the correct insurer to look up the payer ID no matter which insurer it is on the bill.
- HEAT70844 - Added Condition Code G0 for Distinct Medical Visit.
- HEAT70933 - Service Date To was printing incorrectly in 5010 837I file. Made correction so date would print correctly when populated.
- HEAT71651 - Added check to claim editor error 178. Will not display the error if the visit type is 999.
- HEAT72307 - Made another change to 5010 837 for medications. There was an error when sending the RX# (REF*XZ).
- HEAT72503 - Added new prompt in Add/Edit Insurer option under visit type for BLOCK 28 if the export mode is 1500 (08/05). You can now select C for CONT and it will print CONT on a multi-page claim with the claim total on the last page. The default is what it does now, total each page separately.
- HEAT72789 - Made change to 5010 837P so line item CLIA number REF segment will not print if it is the same as the claim level CLIA number REF segment.
- HEAT72979 - Updated claim editor error #19 for accident hour unspecified. Will now display as an error instead of a warning if type of accident is populated and the accident hour is not. Also added code for error 19. If the ACCIDENT TYPE is OTHER, and there is no accident date/time, the error will display on page 3.

- HEAT72987 - Fix to patient statement for programming error when a medication is present. Error is <UNDEF>23+14^ABMEHGR2. Also made fix to medication description so it would display correctly.
- HEAT73336 - Made change for North Carolina Medicaid. When the line item is HCPCS T1015, it will automatically place the modifier SE to that line item in the 837 file. You will not see the change in the claim editor.
- HEAT73780 - Made change to insurer type checks to use new field for expanded insurer type file.
- HEAT74059 - Added code so new Medicare numbers for Part A and Part B will work as previous numbers have. Numbers should be entered WITHOUT the leading zero. They are:

State	Part A	Part B
Colorado	04111	04112
New Mexico	04211	04212
Oklahoma	04311	04312
Texas/IHS	04411	04402 (before 11/19/2012) 04412 (after 11/19/2012)

- HEAT74291 - Made change for error <UNDEF>E2+6^ABMDEMLE. Occurs when site has codes on page 8A of claim editor. Note: site reporting issue had CPTs that should have been on another page on page 8A.
- HEAT74624 - Added ability to do SGTM override for ISA14.
- HEAT74646 - Made change so Omnicell will populate NDC number on page 8D of the claim editor.
- HEAT75327 - Made change to page 8C of claim editor to prompt for the date for the revenue code.
- HEAT75684 - Made change to exclude PAT07 and PAT08 for the 5010 formats.
- HEAT76189 - Made change so Place of Service prompt showed on all 8-pages. Change in patch 9 removed a duplicate prompt but caused problem with prompt not showing at all.
- HEAT78335 - Made change to 1500 (08/05) format so AOB date will print in box 12 instead of today's date.
- HEAT78446 - Made change to 5010 837I to print CPT code for prescriptions. Also made change so prescription will print correctly.
- HEAT78833 - Made change to SUEM Summary of Bills Ready for submission for Clearinghouse. Was printing bill type instead of visit type.
- HEAT79287 - Added value codes 82 CO-INSURANCE DAYS and 83 LIFETIME RESERVE DAYS.

- HEAT79778 - Added Date Last Seen segment to 5010 837.
- HEAT80154 - Made change so supervising provider and NPI entered on page 3 of the claim editor would display correctly in 501 837P file.
- HEAT80275 - Made correction for Closed Claims Report. Received programming error <UNDEF>CLM+24^ABMDRCHK if it was run without selecting a date range.
- HEAT82967 - Modified UB-04 box 81D to check USE NPI OF field when getting the taxonomy so it looks at the correct location.
- HEAT83791 - Made change for Nebraska Medicaid for UB-04 box 81D. Now it will print the taxonomy without a qualifier, and the zip code.
- HEAT85281 - Made change for tribal self-insured. Checks if not Medicare and tribal self-insured and then displays Page A to allow user to review SARs for the payer.
- HEAT86634 - Made change to MU PVP report. Was not finding bills in A/R if the site didn't have the suffix or HRN affixed to the bill number.
- New Report - Added new option MPRP Medicare Providers CPT Report: G8553 to Report Menu. Report will prompt user for a DOS range, then look for all bills within that range that use CPT Procedure coding method, have an insurer type of Medicare FI, and one of the Misc Services is G8553. If the bill meets these criteria, all providers on that bill will be reported, along with their provider type from the bill. If Summary output is selected, it will display a count by provider and type, including the bill amount. If detail is selected, the user will see a list of bills sorted by provider, provider type, and DOS, will the bill number and the bill amount.

Changes made for ICD-10:

- Modified page 2 to display "ICD", not "ICD9", if ICD is the selected PROCEDURE CODING METHOD for the active insurer.
- Created new field in Add/Edit Insurer option, ICD-10 EFFECTIVE DATE. It is a required field and will default to 10/1/2013. Site should change based on when each insurer requires ICD-10 coding to be sent. Post-install for patch will automatically populate field for all insurers with 10/1/2013.
- Updated IQIN option so ICD-10 EFFECTIVE DATE will display. Also removed PRIOR APPROVAL fields from display.
- Modified page 5A to include ICD Indicator field.
- Modified view option of page 5A to include ICD Indicator field.
- Modified page 5B to include ICD Indicator field.
- Modified view option of page 5B to include ICD Indicator field.

- Modified Admitting DX question on page 3 and page 7 so it displays the coding system setup for the active insurer.
- Added new cancel bill reason INCORRECT VERSION OF ICD BILLED.
- Added field to 3P Claim and 3P Bill to keep track of original and split claims. In Claim Editor, it will now say SPLIT Claim Number when claim has been split from another claim.
- Removed RPFE CPT-Corresponding ICD-Fee Listing option from Fee Schedule Menu.
- Removed ASFE Update ASC Fee Schedule from Fee Schedule Menu.
- Removed corresponding DX from LSCP Print CPT Procedure File option.
- Removed corresponding DX from IQCP Inquire to CPT File option.

2.0 Patch 10

2.1 Claim Editor Modifications

3PB > EDTP > EDCL

The following changes have been made in the Claim Editor.

2.1.1 Page 0 – Claim Summary Page

2.1.1.1 Split Claim Identifier

A new field was added to the 3P Claim Data file and the 3P Bill file to track when a claim has been split. The user will continue to use the SCMG Split Claim option that already exists, but when used now, the original claim will be flagged as ORIGINAL and the split claim will be flagged as SPLIT. The SPLIT indicator will display on each page of the claim editor, letting the user know it is split.

```

~~~~~ PAGE 0 ~~~~~
Patient: DEMO,DEE [HRN:123456]          SPLIT Claim Number: 31182
..... (CLAIM SUMMARY) .....
```

Figure 2-1: Claim Header Showing Split Claim Number

2.1.2 Page 1 – Claim Identifiers Page

2.1.2.1 Imprecise Dates can no longer be used

Modifications were made to the Billing From and Billing Thru Dates to no longer allow dates to be imprecise. If the user tries to key in an imprecise date, the user will be given a message for valid example dates.

```

~~~~~ PAGE 1 ~~~~~
Patient: DEMO,DEE [HRN:123456]          Claim Number: 31150
..... (CLAIM IDENTIFIERS) .....
```

[1] Clinic.....: GENERAL
[2] Visit Type.....: OUTPATIENT
[3] Bill Type.....: 131
[4] Billing From Date..: 09/30/2012
[5] Billing Thru Date..: 09/30/2012
[6] Super Bill #.....:
[7] Mode of Export.....: 837P (HCFA) 5010
[8] Visit Location.....: INDIAN HEALTH HOSPITAL

```

-----
WARNING:071 - EMPLOYMENT INFORMATION UNSPECIFIED
-----
```

```

Desired ACTION (Edit/View/Next/Jump/Back/Quit): N// E
Desired FIELDS: (1-8): 1-8// 4
[4] Bill From Date..: SEP 30,2012// 09/00/2012??

Examples of Valid Dates:

    JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057
    T (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.
    T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.
    If the year is omitted, the computer uses CURRENT YEAR. Two digit year
    assumes no more than 20 years in the future, or 80 years in the past.
    Date can not be less than ADMIT DATE nor greater than DISCHARGE DATE.

[4] Bill From Date..: SEP 30,2012//
    
```

Figure 2-2: Editing the Date of Service to not Allow the Imprecise Date

2.1.3 Page 2 – Insurer Page

2.1.3.1 Procedure Code field to display ICD

Page 2 was modified to now display the Procedure Code as *ICD* for those insurers that have the Procedure Code set to ICD in the Insurer File Menu. Before, the Procedure Code was displaying *ICD-9*.

```

~~~~~ PAGE 2 ~~~~~
Patient: DEMO,DEE [HRN:123456] Claim Number: 31150
..... (INSURERS) .....

                PAGE 2 - INSURER INFORMATION

To: NORTH CAROLINA MEDICAID          Bill Type...: 131
    789162 EDITH AVE                 Proc. Code..: ICD
    ABERDEEN, NC 87459               Export Mode.: 837P (HCFA) 5010
                                      Flat Rate...: 316.00
.....

                BILLING ENTITY          STATUS          POLICY HOLDER
                =====
[1] NORTH CAROLINA MEDICAID          ACTIVE          DEMO,DEE
-----
WARNING:073 - EMPLOYER NAME UNSPECIFIED
-----

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

Figure 2-3: Display of Insurer Page Showing Procedure Code of ICD

2.1.4 Page 3 – Questions Page

2.1.4.1 Accident State

The Accident Related field was modified to display an error if the Accident Related fields are populated and the Accident State is left blank. If this occurs, the system will display *Error 019 – Accident Hour Unspecified*. This Error Code was updated to now display as *Error 019 – Accident Hour or State Unspecified*.

```

~~~~~ PAGE 3 ~~~~~
Patient: DEMO,DEE [HRN:123456] Claim Number: 31150
..... (QUESTIONS) .....

[1] Release of Information..: YES From: 01/01/2012
[2] Assignment of Benefits..: YES From: 01/01/2012
[3] Accident Related.....: YES OTHER ACCIDENT 09/30/2012 400HRS
[4] Employment Related.....: NO
[5] Emergency Room Required.: NO
[6] Special Program.....: NO
[7] Outside Lab Charges.....: NO $0.00
[8] Date of First Symptom...: 09/30/2012
[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] Delayed Reason Code.....:
[22] Reference Lab CLIA#.....: 12T1234567 THE REFERENCE LAB INC.
[23] In-House CLIA#.....: 12A3456789
[24] Hearing/Vision Prescription Date:
[25] Start/End Disability Dates:
[26] Assumed/Relinquished Care Dates:
[27] Property/Casualty Date of 1st Contact:
[28] Patient Paid Amount:
-----
ERROR:019 - ACCIDENT HOUR OR STATE UNSPECIFIED
-----

```

Figure 2-4: Viewing Error 019 to Indicate Accident Hour or State Unspecified

2.1.4.2 Referring Provider

A Referring Provider question was added back to Page 3 of the Claim Editor for the 837 Institutional export modes for Versions 4010 and 5010. The user will be able to edit the field and enter in the Referring Provider's last name, first name followed by the providers NPI number.

```

~~~~~ PAGE 3 ~~~~~
Patient: SMITH,GRANNY [HRN:1515] Claim Number: 31177
..... (QUESTIONS) .....

[1] Release of Information..: YES From: 10/15/2012
[2] Assignment of Benefits..: YES From: 10/15/2012
[3] Accident Related.....: NO
[4] Employment Related.....: NO
[5] Emergency Room Required.: NO
[6] Special Program.....: NO
[7] Blood Furnished.(pints): NO
[8] Referring Phys. (FL17) :
[9] Case No. (External ID)..:
[10] PRO Approval Number.....:
[11] Type of Admission.....: 2 URGENT
[12] Source of Admission.....: 1 PHYSICIAN REFERRAL
[13] Discharge Status.....: 01 DISCHARGE TO HOME
[14] Admitting Diagnosis.....:
[15] Prior Authorization #...:
[16] Delayed Reason Code.....:

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

Desired FIELDS: (1-16): 1-16// 8

[8] Name of Referring Physician: DOCTOR,ALEXANDRIA

Referring Physician NPI: 1234567891

```

Figure 2-5: Adding the Referring Provider to Page 3 – Questions

2.1.4.3 Admitting Diagnosis

Editing the Admitting Diagnosis now displays the coding system that is being used which is either ICD-9 or ICD-10 and is based on the ICD Indicator Date that is set for the active insurer.

The ICD Indicator is set within the Insurer file in Third Party Billing.

```

~~~~~ PAGE 3 ~~~~~
Patient: DEMO,DEE [HRN:123456] Claim Number: 31150
..... (QUESTIONS) .....

[1] Release of Information..: YES From: 01/01/2012
[2] Assignment of Benefits..: YES From: 01/01/2012
[3] Accident Related.....: NO
[4] Employment Related.....: NO
[5] Emergency Room Required.: NO
[6] Special Program.....: NO
[7] Blood Furnished.(pints): NO
[8] Referring Phys. (FL17) :
[9] Case No. (External ID)..:
[10] PRO Approval Number.....:
[11] Type of Admission.....: 2 URGENT
[12] Source of Admission.....: 1 PHYSICIAN REFERRAL
[13] Discharge Status.....: 01 DISCHARGE TO HOME
[14] Admitting Diagnosis.....:
[15] Prior Authorization #...:

```

```

[16] Delayed Reason Code.....:

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

Desired FIELDS: (1-16): 1-16// 14
** CODING SYSTEM IS ICD-9 **
[14] Admitting DX:

```

Figure 2-6: Viewing the Coding System while Editing the Admitting Diagnosis on Page 3

2.1.5 Page 3A – Ambulance Questions

2.1.5.1 Modification to Mileage Units

A change was made on page 3A to allow for more accurate reporting of mileage when billing for ambulance services. The user will now be able to enter the mileage using a tenth of a mile.

Note: The units to report the mileage on Page 8K have not been updated in this Patch and the units should be rounded to the nearest whole number.

```

~~~~~ PAGE 3A ~~~~~
Patient: HILL,JOE [HRN:99109] Claim Number: 31181
..... (AMBULANCE QUESTIONS) .....

[01] Point of Pickup.....: PATIENT'S HOME
                           3477 BEAR ST
                           TULSA, OKLAHOMA 38846
[02] Modifier.....: R RESIDENCE
[03] Destination.....: INDIAN HEALTH HOSPITAL
                           PO BOX 30990
                           ALBUQUERQUE, NEW MEXICO 87125-0990
[04] Modifier.....: H HOSPITAL

[05] Mileage (Covered).....: 75.5
[06] Mileage (Non-Covered)..: 2.5
[07] Medical Necessity Ind.: Y
      Condition Indicator...: 06 Pt was transported in an emergency sit
[08] Patient Weight (lbs)...: 180
[09] Patient Count.....:

Transfers Only:
[10] Type of Transport.....: INITIAL TRIP
[11] Transported To/For....: NEAREST FAC.-CARE OF
SYMPTOMS/COMPLAINTS/BOTH

```

Figure 2-7: Display of Mileage on Page 3

2.1.6 Page 5 – Diagnosis

2.1.6.1 ICD Indicator added to page display

An ICD indicator has been added to help the user distinguish the coding method that is being used. If ICD-10 codes are used the user will be able to view these codes by typing “V” to view.

```

~~~~~ PAGE 5A ~~~~~
Patient: HILL,JOE [HRN:99109] SPLIT Claim Number: 31167
..... (DIAGNOSIS) .....

ICD INDICATOR: ICD-9

BIL ICD
SEQ CODE IND Dx DESCRIPTION PROVIDER'S NARRATIVE
=== =====
1 401.9 9 HYPERTENSION NOS HTN
2 530.81 9 ESOPHAGEAL REFLUX ESOPHAGEAL REFLUX

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

Figure 2-8: Display of ICD Indicator on Page 5A - Diagnosis

2.1.7 Pages 8A > 8K – CPT Pages

2.1.7.1 Place of Service Prompt

The Place of Service prompt was modified to now display on all pages that have a CPT or HCPCS code in the claim editor. Changes in patch 9 removed a duplicate prompt but caused the problem with the Place of Service prompt to stop displaying at all.

```

~~~~~ PAGE 8A ~~~~~
Patient: HONEYCOMB,HAZEL [HRN:3916] SPLIT Claim Number: 31166
Mode of Export: 837P (HCFA) 5010
..... (MEDICAL SERVICES) .....

      REVN                               UNIT      TOTAL
      CODE          CPT - MEDICAL SERVICES    CHARGE QTY  CHARGE
      =====
[1] CHARGE DATE: 09/01/2012@12:00-09/01/2012 (BROOKS,KENNETH H-R)
      0510 99213 OFFICE/OUTPATIENT VISIT EST                62.00 1    62.00
                                                                =====
                                                                $62.00

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

[1] 99213
Select 1st MODIFIER:

      Seq      ICD      DIAGNOSES
    
```

```

Num      Code      Diagnosis Description
===      =====      =====
1      989.5      TOXIC EFFECT VENOM
2      E905.3      HORNET/WASP/BEE STING

Enter Principle Corresponding DX:

SERVICE FROM DATE/TIME: SEP 1,2012@12:00//
SERVICE TO DATE/TIME: SEP 1,2012//
UNITS: 1//

PLACE OF SERVICE: 22//
    
```

Figure 2-9: Editing the Place of Service (POS) Code on Page 8A - Medical

2.1.7.2 Page 8C – Revenue Code Date Addition

A correction was made to page 8C of Claim Editor to prompt for the date when a Revenue Code is used.

```

~~~~~ PAGE 8C ~~~~~
Patient: SMITH,GRANNY [HRN:1515] Claim Number: 31177
Mode of Export: 837I (UB) 5010
..... (REVENUE CODE) .....

TOTAL
REVENUE CODE      CPT      CHARGE      DAYS      UNITS      CHARGE
=====      ===      =====      =====      =====      =====
[1] CHARGE DATE: 10/01/2012@10:45
0710 RECOVERY ROOM      230.00      0      1      230.00
                               =====
                               0      $230.00

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

Select REVENUE CODES: 710      RECOVERY ROOM      GENERAL CLASSIFICATION
UNITS: 1
UNIT CHARGE: 230.00//
CPT CODE:
DATE/TIME: 10012012@10:45 (OCT 01, 2012@10:45:00)
    
```

Figure 2-10: Display of Revenue Code Page (Page 8C) Displaying Date/Time Field

2.1.7.3 Page 8K – Ambulance Services

The Service Line Provider prompt has been added to this page. To enter the provider type “E” to edit. The user will be able to enter in the provider’s last name, first name.

```

~~~~~ PAGE 8K ~~~~~
Patient: HILL,JOE [HRN:99109] Claim Number: 31181
Mode of Export: 837P (HCFA) 5010
..... (AMBULANCE SERVICES) .....

REVN      UNIT      TOTAL
CODE      HCPCS - AMBULANCE SERVICES      CHARGE QTY      CHARGE
    
```

```

=====
[1] CHARGE DATE: 10/01/2012
      A0425 Ground mileage                5.10 25      127.50
[2] CHARGE DATE: 10/01/2012
      A0888 Noncovered ambulance mileage  5.00  5       25.00
[3] CHARGE DATE: 10/01/2012
      A0427 ALS1-emergency                400.00  1      400.00
                                           =====
                                           $552.50

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

[3] A0427

Select 1st MODIFIER:

                DIAGNOSES
Seq   ICD
Num   Code           Diagnosis Description
=====
  1   250.00         DMII WO CMP NT ST UNCNTR

SERVICE FROM DATE/TIME: OCT 1,2012//
SERVICE TO DATE/TIME:  OCT 1,2012//
UNITS: 1//
HCFA POS: 41//
UNIT CHARGE: 400//
Select SERVICE LINE PROVIDER:
    
```

Figure 2-11: Display of the Service Line Provider on Page 8K - Ambulance

2.1.7.4 Page 9C – New Condition Codes Added

A new condition code was added to this page. Users will now be able to key in *G0 – Distinct Medical Visit*.

```

~~~~~ PAGE 9C ~~~~~
Patient: HILL,JOE [HRN:99109] Claim Number: 31183
..... (CONDITION CODES) .....

COND
CODE           CONDITION CODE DESCRIPTION
=====
[1]  G0         DISTINCT MEDICAL VISIT

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

Figure 2-12: Display of the “GO” Condition Code on Page 9C – Condition Codes

2.1.7.5 Page 9D – New Value Codes Added

New value codes have been added to Page 9D. Users are now able to key in *82 – Co-Insurance Days* and *83 – Lifetime Reserve Days*.

```

~~~~~ PAGE 9D ~~~~~
Patient: HILL,JOE [HRN:99109] Claim Number: 31183
..... (VALUE CODES) .....

      VALU
      CODE          VALUE CODE DESCRIPTION          AMOUNT
=====
[1]   82          CO-INSURANCE DAYS                25.00
[2]   83          LIFETIME RESERVE DAYS             5.00

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

Figure 2-13: Display of Value Codes on Page 9D – Value Codes

2.2 Claim/Bill Management

ABM > MGTP

The following describes the changes in the Claim/Bill Management menu.

2.2.1 Added new Cancelled Bill Reason

ABM > MGTP > CLMG

A new cancellation reason has been added: *16 – INCORRECT VERSION OF ICD BILLED.*

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p10          |
+-----+-----+-----+-----+-----+-----+-----+-----+
|          Cancel an Approved Bill                          |
|          INDIAN HEALTH HOSPITAL                          |
+-----+-----+-----+-----+-----+-----+-----+-----+
User: STOUT,CINDY                                     23-OCT-2012 3:58 PM

Select BILL to CANCEL:      31058A

      Visit: 05-01-2012 PROFESSIONAL CMAMMOGRAPHY          INDIAN HOSP
      Bill:  MEDICARE                                     837P (HCFA) 5010   166.00

Do you wish Bill Number 31058A CANCELED (Y/N)? y  YES

Canceling...
REASON FOR CANCELLATION: ??

Choose from:
1          INCORRECT EXPORT MODE
2          INCORRECT 837 STRUCTURE
3          TEST CLAIM
4          INCORRECT CODING
5          CHART REVIEW
6          837 RESUBMIT
7          INCORRECT CHARGES
8          WRONG INSURER SELECTED
9          WRONG DOS
10         BACKBILLING
    
```

11	BILL PRIMARY PAYOR
12	PROVIDER UPDATE
13	MISSING CHARGES
14	PAT REG CORRECTIONS
15	INCORRECT INFORMATION
16	INCORRECT VERSION OF ICD BILLED
REASON FOR CANCELLATION:	

Figure 2-14: Display of New Cancelled Bill Reason

2.3 Reports

ABM > RTPP

The following describes the changes in the Reports menu.

2.3.1 New Report: Medicare Providers CPT Report: G8553

ABM > RTPP > MPRP

A new report has been added to the Reports Menu and allows the user to view bills with the HCPCS code G8553 and if the bill was submitted to Medicare or Railroad Retirement.

This report was added to aid facilities in determining their volume of claims submitted to Medicare to help them achieve the goals successful reporting for ePrescribing (eRx). This also helps to determine if a reduction in payment is in store for billing providers. Additional information may be found on:

<http://www.trailblazerhealth.com/Publications/Training%20Manual/E-Prescribing.pdf>

Note: The HCPCS Code G8553 will only display on the report if the code has been entered in through PCC Data Entry and billed out on the claim.

Initiate the report by keying in a starting date of service and end date.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p10          |
+          Medicare Providers CPT Report: G8553          +
|          INDIAN HEALTH HOSPITAL          |
+-----+-----+-----+-----+-----+-----+-----+-----+
User: STOUT,CINDY                                     19-OCT-2012 1:32 PM

This report will look for bills with HCPCS G8553 as one of the line items.
It will report either a detail or summary report by provider of bills with
this HCPCS code.

===== Entry of DOS Range =====

Enter STARTING DOS for the Report: 010110 (JAN 01, 2010)

```

```
Enter ENDING DATE for the Report: t (OCT 19, 2012)
```

Figure 2-15: Selecting Date Ranges for the Medicare CPT Providers Report

After entering the date range, select from “A” to print all bills with the HCPCS code G8553 within the date range or “P” to print paid bills only with the HCPCS code G8553.

```
Select one of the following:
      A      ALL BILLS
      P      PAID BILLS ONLY

Enter response: ALL BILLS

Select one of the following:
      S      SUMMARY
      D      DETAIL

SUMMARY OR DETAIL:
```

Figure 2-16: Display of Report Criteria

The user can choose to print the report by summary or detailed. A summary report will sort by provider, the provider type, the bill count and the dollar amount.

In the example below, a summary report was generated using *A - Print All Bills*.

```
=====
ALL MEDICARE PROVIDER COUNTS FOR CPT: G8553   OCT 19,2012@14:07:42   Page 1
for MEDICARE with VISIT DATES from 01/01/2010 to 10/19/2012
Billing Location: INDIAN HOSP
=====
PROVIDER                                TYPE                                COUNT    AMOUNT
-----                                -
DOCTOR,ALEXANDRA                        ATTENDING  NOT PD      3        8,176.00
                                           -----
                                           3        8,176.00

MEDS,DEBORA                             ATTENDING  NOT PD      1        166.00
                                           -----
                                           1        166.00

MYCUDDLY,ALLEN                         ATTENDING  NOT PD      1        166.00
                                           -----
                                           1        166.00

TOTAL                                    -----
                                           5        8,508.00

(REPORT COMPLETE):
```

Figure 2-17: Display of Summary Report using Print All Bills

A detailed report will sort by provider, provider type, bill number, date of service and bill amount.

In the example below, a detailed report was generated using *Print All Bills*.

```

=====
ALL MEDICARE PROVIDER COUNTS FOR CPT: G8553    OCT 19,2012@14:07:42  Page 1
for MEDICARE with VISIT DATES from 01/01/2010 to 10/19/2012
Billing Location: INDIAN HOSP
=====

```

PROVIDER	TYPE	BILL NUMBER	DOS	BILL AMOUNT
DOCTOR, ALEXANDRA	ATTENDING	31028B	FEB 08, 2012	4,057.00
DOCTOR, ALEXANDRA	ATTENDING	31028C	FEB 08, 2012	4,057.00
DOCTOR, ALEXANDRA	ATTENDING	31064A	MAY 09, 2012	62.00
SUBTOTAL		3		8,176.00
MEDS, DEBORA	ATTENDING	31058A	MAY 01, 2012	166.00
SUBTOTAL		1		166.00
MYCUDDLY, ALLEN	ATTENDING	31038A	FEB 29, 2012	166.00
SUBTOTAL		1		166.00
TOTAL		5		8,508.00

(REPORT COMPLETE) :

Figure 2-18: Display of a Detailed Report using Print All Bills Option

2.3.2 Meaningful Use Reports: Added FQHC/RHC/Tribal Label

ABM > RPTP > MURP > MUPV

All references of *FQHC* have been changed to *FQHC/RHC/Tribal* in the Patient Volume reports for Eligible Professional and Eligible Hospitals.

```

+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p10          |
+-----+-----+
| Patient Volume Report for Eligible Professionals          |
+-----+-----+
|          TRIBAL HEALTH CENTER                            |
+-----+-----+
User: LUJAN,ADRIAN M                                     31-OCT-2012 8:47 AM

Select one of the following:

1          TRIBAL HEALTH CENTER
2          SIX THREE EIGHT HC (FQHC/RHC/Tribal)

Note: you cannot select a combination of FQHC/RHC/Tribal and non-
data on
this report

```

Select one or more facilities to use for calculating patient volume:

Figure 2-19: Display of Patient Volume Report Showing Modified FQHC Description

2.4 Electronic Media Claims

ABM > EMTP

2.4.1 Summary of Bills Ready for Submission

The header labeled *BILL TYPE* was changed to *VISIT TYPE* to better describe the data in the column. No other changes have been made to this report.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p10          |
+          Summary of Bills Ready for Submission          +
|                   INDIAN HEALTH HOSPITAL                   |
+-----+-----+-----+-----+-----+-----+-----+-----+
User: STOUT,CINDY                                     19-OCT-2012 3:41 PM

```

SEQ	INSURER/CLEARINGHOUSE	VISIT TYPE	EXPORT MODE	# OF BILLS	BILL AMT
1	RAILROAD RETIREMENT	111	837 INST (UB)	1	4,338.00
2	RAILROAD RETIREMENT	131	837 INST (UB)	1	273.00

Show detail ? NO//

Figure 2-20: Display of Summary of Bills Ready for Submission with Modified Headers

2.5 Table Maintenance Changes

ABM > TMTP

2.5.1 Fee Schedule Options

ABM > TMTP > FETM

Two Menu options in the Fee Schedule Menu have been removed. The *RPFE - CPT-Corresponding ICD-Fee Listing* option and *ASFE - Update ASC Fee Schedule* are no longer available for use.

2.5.2 Add/Edit Insurer

ABM > TMTP > INTM > EDIN

2.5.2.1 Novitas Medicare Submitter ID

The transition from TrailBlazer Health Enterprises, LLC to Novitas Solutions, Inc. as a Medicare Fiscal Intermediary begins in October, 2012. New Payer Identifiers have been provided for both Part A and Part B. The numbers, assigned by Novitas Solutions Inc., will automatically be changed over once Patch 10 is installed. These new numbers will work as previous numbers have.

State	Part A	Part B
Colorado	04111	04112
New Mexico	04211	04212
Oklahoma	04311	04312
Texas/IHS	04411	04402 (before 11/19/2012) 04412 (after 11/19/2012)

The Medicare numbers will be keyed in without the leading zero. Sites that receive a notice from Novitas with the Submitter ID will need to key this into the Medicare and Railroad Retirement insurer.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p10          |
+                   Add/Edit Insurer                   +
|                   INDIAN HEALTH HOSPITAL                 |
+-----+-----+-----+-----+-----+-----+-----+-----+
User: STOUT,CINDY                                     19-OCT-2012 3:06 PM

WARNING: Before ADDING a new INSURER you should ensure that it
         does not already exist!

Select one of the following:

      1          EDIT EXISTING INSURER
      2          ADD NEW INSURER

Select DESIRED ACTION: 1//  EDIT EXISTING INSURER

Screen-out Insurers with status of Unselectable? Y// ES

Select INSURER: MEDICARE

<----- MAILING ADDRESS ----->
Street...: 12800 INDIAN SCHOOL RD, NE  Replace
City....: ALBUQUERQUE//
State...: NEW MEXICO//
Zip Code.: 87125//

<----- BILLING ADDRESS ----->
          (if Different than Mailing Address)
Billing Office.: TRAILBLAZER HEALTH ENT.LLC  Replace
Street...: PO BOX 660030//
City...: DALLAS//
State...: TEXAS//

```

```

Zip....: 75266-0030//

Phone Number.....: (888)763-9836//
Contact Person.....:
Federal Tax ID#....: 752784278//
AO Control Number..: 4001// 4411   ENTER '4411'
All Inclusive Mode.: YES//
Backbill Limit (months): 72//
Dental Bill Status.: DENTAL VISITS ARE UNBILLABLE
//
Rx Billing Status..: UNBILLABLE//

Select CLINIC UNBILLABLE:

EMC SUBMITTER ID: V00233//   ENTER NEW SUBMITTER ID HERE
EMC PASSWORD: IHS233//     DELETE ENTRY
EMC TEST INDICATOR:
USE PLAN NAME?: NO//
72 HOUR RULE:
NPI USAGE: NPI ONLY//
TRIBAL SELF-INSURED?:
ICD-10 EFFECTIVE DATE: OCT 1,2013//

```

Figure 2-21: Display of Novitas Modifications in the Insurer File

2.5.2.2 ICD-10 Effective Date Field

The ICD-10 Effective Date field has been added to let the site determine which version of ICD codes will be seen by the biller and be sent to the payer. This field is required and will automatically be auto-populated with the date October, 13, 2013 when Patch 10 is installed. Deleting the data or leaving the field blank will default the date to October 13, 2013.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p10          |
+-----+-----+-----+-----+-----+-----+-----+-----+
|                      Add/Edit Insurer                      |
+-----+-----+-----+-----+-----+-----+-----+-----+
|                      INDIAN HEALTH HOSPITAL                 |
+-----+-----+-----+-----+-----+-----+-----+-----+
User: STOUT,CINDY                                     17-OCT-2012 3:48 PM

WARNING: Before ADDING a new INSURER you should ensure that it
does not already exist!

Select one of the following:

1          EDIT EXISTING INSURER
2          ADD NEW INSURER

Select DESIRED ACTION: 1//   EDIT EXISTING INSURER

Screen-out Insurers with status of Unselectable? Y// ES

Select INSURER:      INSURER NAME HERE      NEW MEXICO      87125
...OK? Yes//   (Yes)

<----- MAILING ADDRESS ----->

```

```

Street...: 12800 INDIAN SCHOOL RD, NE  Replace
City.....: ALBUQUERQUE//
State....: NEW MEXICO//
Zip Code.: 87125//
<----- BILLING ADDRESS ----->
      (if Different than Mailing Address)
Billing Office.:

Phone Number.....: (888)763-4452//
Contact Person.....:
Federal Tax ID#....: 123456789//
AO Control Number..:
All Inclusive Mode.: YES//
Backbill Limit (months): 72//
Dental Bill Status.: DENTAL VISITS ARE UNBILLABLE//
Rx Billing Status..: UNBILLABLE//

Select CLINIC UNBILLABLE:

EMC SUBMITTER ID:
EMC PASSWORD:
EMC TEST INDICATOR:
USE PLAN NAME?: NO//
72 HOUR RULE:
NPI USAGE: NPI ONLY//
TRIBAL SELF-INSURED?:
ICD-10 EFFECTIVE DATE: OCT 1,2013//

```

Figure 2-22: Display of ICD-10 Effective Date field

Note: Although the date entered is defaulted to October 1, 2013, Patch 11 will change the default to October 1, 2014.

2.5.2.3 New “Continued” Prompt Added

A new prompt has been added in the Insurer file under the Visit Type for BLOCK 28 if the export mode is 1500 (08/05). Selecting *C* or *CONT* and it will print the word *CONT* on a multi-page claim with the claim total on the last page. If left blank the field will total each page separately.

```

Select VISIT TYPE..: OUTPATIENT
Billable (Y/N/E)....: YES//
Reporting purposes only:
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before)..:
Procedure Coding....: CPT//
Fee Schedule.....:
Add Zero Fees?....:
Multiple Forms?....:
Payer Assigned Provider Number.....: 850105601//
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.....:
Mode of Export.....: CMS-1500 (08/05)//
Block 24K.....: MD PROVIDER NUMBER//
Block 28.....: ??

```

```

Choose from:
      C      CONT
Block 28.....: C  CONT
Block 29.....:
    
```

Figure 2-23: Editing Block 28 in the Visit Type Section of the Insurer File

2.5.3 Display Insurer Info (Inquire) (IQIN)

The Insurer inquiry was modified to display the ICD-10 Effective date. No other changes have been made to this option.

```

*** INSURER FILE INQUIRY ***

=====
NAME: INSURER NAME HERE          STREET: P.O. BOX 2546
CITY: SHERMAN                    STATE: TEXAS
ZIP: 75091-2546                  PHONE: (800)257-4574
FEDERAL TAX ID #: 665544112     STATUS: BILLABLE
TYPE OF INSURER: PRIVATE        RX BILLING STATUS: OUTPATIENT DRUGS ONLY
INSURER TYPE: PRIVATE          LONG NAME: CIGNA

INSURER: CIGNA                   NPI USAGE: NPI ONLY
ICD-10 EFFECTIVE DATE: OCT 01, 2013
    
```

Figure 2-24: Display of Insurer File Inquiry Option Showing the ICD-10 Effective Date

2.5.4 837 Segment Override Change – ISA14

ABM > TMTP > ECTM > SGTM

The 837 Segment Override option was modified to allow the ability to enter in a segment override for ISA14. Section C of the ASC X12N 837 Implementation Guide for Institutional, Professional and Dental claims allows for the following values to be added for the Acknowledgment Requested element:

- 0 - No Interchange Acknowledgment Requested
- 1 – Interchange Acknowledgment Requested (TA1)

The system will default to 1 – Interchange Acknowledgment Requested (TA1) but some sites have reported that some payers want for this value to be 0.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p10          |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          837 Segment Override          |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          INDIAN HEALTH HOSPITAL          |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
User: STOUT,CINDY                                     23-OCT-2012 4:39 PM

Select INSURER NAME:      INSURER NAME

                               ...OK? Yes//  (Yes)
    
```

```
Select 3P EXPORT MODE FORMAT:      837P (HCFA) 5010      837 5010 PROFESSIONAL
Enter visit type, or leave blank for all. ALL

      Select one of the following:

          1          HEADER
          2          1000A
          3          1000B
          4          2010AA
          5          2010BB
          6          2000B

Select Loop: 1  HEADER

      Select one of the following:

          S          Send
          N          Don't Send

Select: Send

      Select one of the following:

          1          ISA
          2          GS

Select Segment: 1  ISA

      Select one of the following:

          1          ISA02
          2          ISA03
          3          ISA04
          4          ISA05
          5          ISA06
          6          ISA07
          7          ISA08
          8          ISA14
          9          ISA15

Select Element: 8  ISA14

Are you adding 'FM32 HEADER ISA14 9999' as
a new 837 SEGMENT OVERRIDE (the 1ST for this 3P INSURER)? No// Y (Yes)

DATA VALUE:  ADD NEW VALUE HERE

EDIT ANOTHER SEGMENT?? N// NO
```

Figure 2-25: Displaying the 837 Segment Override Option for Editing ISA14

Acronym List

ADA	American Dental Association
CPT	Common Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System
IHS	Indian Health Service
NDC	National Drug Class
NPI	National Provider Identifier
OIT	Office of Information Technology
PCC	Patient Care Component
POS	Place of Service
RPMS	Resource and Patient Management System
TPB	Third Party Billing

Contact Information

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Email: support@ihs.gov