RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 11
September 2013

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

Table of Contents

Preface

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

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

1.1.1 Patch 11

The following section details the modifications made in Patch 11. This includes fixes for reported issues logged at the RPMS Helpdesk. For some line items, the modified routine name is listed:

- **NOHEAT1** - Modified UNITS field on Page 8K - Ambulance to allow for a tenth of a mile to be entered.
- **NOHEAT3** - Made change to remove dash from Tax ID number. This is for all insurers for all 837s, and UB-04. ABMUTLF
- **NOHEAT4** - Modified 837 to not send condition information. These are sent in an HI segment with a BG qualifier. ABME5L4
- **NOHEAT5** - Error when using the MRMG option to merge claims and the user chooses to delete the merged claims. It would kick the user out with programming error <UNDEF>DIK+3^DIK ABMDEMRG
- **NOHEAT6** - Made change to do Universal look up of patient, instead of local lookup (where it only looks in the current DUZ (2)). ABMDRPCC, ABMDVPAT
- **NOHEAT7** - Added PRIOR AUTHORIZATION NUMBER question on page3 of claim editor for export mode CMS-1500 (08/05). ABMP2611
- **HEAT30524** - Included modifications for PHC Medicaid for the CMS 1500(08/05). Will check Group Health Plan in box 1 and remove the decimals from all diagnoses. Also corrected to print the ROI date with the SIGNATURE ON FILE. ABMDF27A, ABMDF27B, ABMDF27D, ABMDF27E, ABMDF27X
- **HEAT66367** - Added parameter to Add/Edit Insurer under visit type for block 48 of ADA-2006 format. It gives the user the ability to change what address prints, either the physical or the mailing address for the facility. ABMDTIN1, ABMDE1X1
- **HEAT71638** - Made change to patient statement so the second page of the statement would print correctly. It wasn't including all the charges on the second page. ABMPTSMT
- **HEAT73780** - Updated UFMS Reconciling option to use the new insurer type file for displaying the insurer type. ABMURCON
- **HEAT74309** - Added Admission Sources 05 BORN INSIDE THIS HOSPITAL and 06 BORN OUTSIDE THIS HOSPITAL for Newborn. ABMP2611

- **HEAT78400** - Made changes to the 5010 837D to include a segment for the appliance date (DTP*452) as well as the segment for treatment length and months remaining (DN1). ABME5L13, ABME5DN1
- **HEAT78969** - Added code to put Medicaid number in REF segment for 5010 formats for North Dakota Medicaid. ABME5REF
- **HEAT81017** - Made change to stop error <SYNTAX>GETPRV+10^ABMDFUTL when approving a claim. Occurs when there isn't a provider on page 4. Now the user will receive an error, 244, letting them know there isn't a provider. ABMP2611, ABMDE4, ABMDE4X
- **HEAT81561** - When reprinting claims, added the ability to select from today's date, the Original Print Date, or the Approval Date. ABMDFRDO, ABMDF12A, ABMDF27D, ABMDF28Y, ABMDF29B
- **HEAT83923** - Made change to bring over anesthesia start and stop date/time from the V CPT file of visit if populated and put on page 8G of the claim editor. ABMFCPT, ABMDVS13
- **HEAT85498** - Made change for both in-house and referring CLIA number not printing on line item for 5010 837s. ABME5L12
- **HEAT86014** - Made change to CMS 1500(08/05) for Workmen's comp claim number. If the insurer type is 'W' or 'T' it will first look at the PROPERTY/CASUALTY CLAIM NUMBER from 3B and use that. If it isn't populated it will then check the CASE NUMBER on page 3 and use that. If both are blank, it will do what it did before as the default. ABMDF27C
- **HEAT86262** - Corrected code for errors 47 and 48 in the claim editor. ABMDE2X
- **HEAT86425** - Made changes to claim generator for scenario where the IEN of a satellite location is lower than the IEN of the parent location. When the USE A/R PARENT/SATELLITE SETUP was answered YES, the claims for the satellite were still generating under the satellite, not the parent. ABMDVCK, ABMDVCK0
- **HEAT87226** - Made correction for programming error <UNDEF>LOOP+1^ABMDE9C. Occurs when there is an occurrence code on page 9C and the users selects the Add option, but then types '^' to skip adding. ABMDE9C
- **HEAT87757** - Made change to correct programming error <SUBSCR>CONT+15^ABMDE0. Occurs when user changes status to pending and no reason is entered. ABMDE0
- **HEAT88243** - Made changes to correct programming error <SUBSCR>INS+19^ABMDF29B. Error occurs when secondary insurance has been deleted and the user is trying to export their ADA-2006 claims. ABMDF29B

- **HEAT88601** - Made change to correct programming error <SUBSCR>MILEAGE+6^ABMDEML. Occurs when the clinic is ambulance and the user entered A0888 or A0425 on page 8K and then typed "^" at the remaining prompts to exit instead of completing entry. ABMDEML
- **HEAT89093** - Made it so a reason for cancellation must be entered when cancelling a bill. ABMDECAN
- **HEAT89676** - Made change to correct value codes being sent on 5010 837 files. Also updated the display of the value codes on page 9D to display correctly. ABME5HI, ABMUTL8, ABMDE9A
- **HEAT89722** - Updated MU report to reflect bills that were paid by Medicaid when it was the secondary insurer. ABMMUPV1
- **HEAT90370** - Made change so dental remap code will print in 5010 837I file along with ADA code. ABMERGR2
- **HEAT91321** - Made change for Iowa Medicaid. If the export mode is UB-04 and there is a T1015 on the claim, it will print that line first on the claim. ABMDF28Y
- **HEAT91425** - Modified 1500(08/05) to not print NO CODE SELECTED if it is a medication and there isn't a CPT code linked to it. ABMDF27E
- **HEAT92505** - Made change to look for an active PERSON CLASS entry, not just the first entry that is available. It will use the active entry to calculate the provider taxonomy. ABMEEPRV
- **HEAT92863** - Changed default dental revenue code from 510 to 512. ABMDVST6
- **HEAT92962** - Added parameter under the visit type in the Add/Edit Insurer option so user can leave block 44 blank on the UB-04 form if they want. ABMDTIN1, ABMDF28Y
- **HEAT93699** - Expanded SUPERVISING PROVIDER field on page 3 of the claim editor to allow 30 characters for the name.
- **HEAT94153** - Made change to how TPB looks up HCPCS codes for claim editor. There was a problem returning the correct code if the HCPCS was in the CPT file more than once (it would return the wrong code). ABMFCPT
- **HEAT94967** - Made change to FEIR report. It was reporting the wrong location as the Billing Location if there is more than one parent location on the database. ABMMUFAC
- **HEAT95824** - Made change so Mammography cert number would show up for all mammography CPT codes in all 837 files. ABME5L12
- **HEAT96284** - Made change to ADA-2006 form for OTHER COVERAGE. Was printing patient instead of secondary policy holder info. ABMDF29B

- **HEAT96776** - Fix for error <SUBSCR>ABMDEVAR+23^ABMDEVAR. Occurs when the active insurer has been deleted or the only insurer on the claim is unbillable and it is trying to find the ICD-10 effective date. ABMDEVAR
- **HEAT96809** - Fix for error <UNDEF>SOP+24^ABMUTLP2. Occurs due to insurer type not being mapped for SOP. ABMUTLP2
- **HEAT97406** - Made change to 1500 (08/05) to move units to the left. ABMDF27X
- **HEAT97421** - Added code for Iowa Medicaid. If there is a HCPCS code T1015 on the 1500(08/05) it will print it as the first line. ABMDF27X
- **HEAT97792** - Made change for 837 segment override when selecting ISA15. It was printing a bunch of extra delimiters (*). ABMUTL8
- **HEAT99278** - Made change to 5010 837 to send DMG segment in loop 2010BA. ABME5L3
- **HEAT100200** - Insurer was unbillable in claim editor because the claim editor was using the parent location instead of the visit location when it was checking the insurer status in the 3P Insurer file. ABMDLCK1
- **HEAT102837** - Made change when adding the default dental prefix on the UB-04. Confirm that code is an ADA code before adding the prefix. Reporting site had entry in CPT file, and the prefix was being added to it. ABMDF28Y
- **HEAT104117** - Made change 8010 837s to include hyphen in last name of patient if there is a hyphen in RPMS. ABME5NM1
- **HEAT104470** - Made change for claim editor error 218 missing MSP. User was able to approve claim without MSP when Medicare was secondary. ABMDE2X
- **HEAT104682** - Made change for FL override for 1500 (08/05). When trying to override the line item, it would only edit the first line and not any subsequent lines. ABMDF27X
- **HEAT105003** - Made change to claim export where it builds a list of line items. If the claim is flat rate and the visit type is 831 it was still trying to itemize from the surgical, medical, and radiology multiples. Removed the itemized part completely. ABMEHGRV, ABMERGRV
- **HEAT105864** - Added HCFA POS code 03 SCHOOL. ABMP2611
- **HEAT116046** - Added check to sequencing of DX codes in claim editor. Now it will force what is entered to be numeric, to correct a typo that was made when sequencing was done, where a tick mark was typed after the sequence number. ABMDEMLA

- **HEAT117086** - If HCPCS code T1015 is present on a claim and the active insurer has an insurer type of Medicaid, T1015 will be the first line item to print. This is for all 837 formats, 1500(08/05), UB-04, ADA-2006, and ADA-2012. ABMDESM, ABMEHGRV, ABMERGRV, ABMEHGR2, ABMDES4, ABMDF34, ABMDF34X, ABMDF29X
- New export mode ADA-2012 added. Also updated REPR option so it will default to this new export mode if a reprint is being done of a 5010 837D form. ABMDF34, ABMDF34A, ABMDF34B, ABMDF34X, ABMDFRDO
- Added new report for Visit Counts by VA Patient. It will list all VA patients with a visit in the requested date range and how many visits are in that range. The report is located at menu path ABMM-->ELTP--> RPEL-->VTRP. ABMRPVET
- Added VETERANS MEDICAL BENEFIT to Billing Entity for reports (ABMDRSL1). Will display on reports:
  - BRRP Brief (single-line) Claim Listing
  - 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
  - CCRP Cancelled Claims Report
  - CLRP Closed Claims Report
  - PCRP Pending Claims Status Report
  - SURP Summarized (multi-line) Claim Listing
  - AWPR Bills Awaiting Export Report (located at ABMM->PRTP->AWPR)
  - EXPR Print Approved Bills (located at ABMM->PRTP->EXPR)
- Updated LOOP option to include VETERANS MEDICAL BENEFIT PROGRAM. ABMDESL1
- Updated UFMS Cashiering Sessions so it will capture claims/bills with any of the insurer types in the new Insurer Type file. Also updated option UVCH View Cashiering Session to show them as well. DD change and ABMUCASH, ABMUCUTL, ABMUITIN, ABMUVCSH, ABMUXCLD
- Update option TPRP Tribal Payment Report to give the option Veterans Administration for insurer type. ABMTPYMT
- Updated option ESPR Bills Export Statistical Report to include allowance category VMBP for insurer type V Veterans Administration. ABMESTAT

- Added prompt to SITM Site Parameter Maintenance for VA STATION NUMBER. If this field is populated and the insurer type is Veterans Administration, box 23 on the HCFA 1500(08/05) or box 63 on the UB-04 will populate with the VA STATION NUMBER. ABMDTPAR, ABMDF27B,ABMDF28Z
- Added prompt to SITM Site Parameter Maintenance for VA CONTRACT NUMBER. If this field is populated and the insurer type is Veterans Administration, box 19 on the HCFA 1500(08/05) or box 80 on the UB-04 will populated with the VA CONTRACT NUMBER. ABMDTPAR, ABMDF27B, ABMDF28Z

Changes made for Meaningful Use:

- Existing report menu was changed to include CY 2011/2012.
- Added message to 2011/2012 reports. If they select 2013 as the Participation Year they will receive a note that they should use the CY2013 reports and then it will exit out of the option.
- Added prompt to report when AUTOMATED is selected, asking if they want the HIGHEST or FIRST 90-day window that is found. This is for both the PVP2 and the PVH2 options.
- For the Not Met report, output was changed to only report one date range per line. The one line now has a breakdown of the numerator, including paid Medicaid/SCHIP, zero paid Medicaid/SCHIP, and enrolled Medicaid/SCHIP.
- For the FEIR Facility EHR Incentive Report, added LOOKBACK DATE prompt and FACILITY or HOSPITAL report. The LOOKBACK DATE will allow the user to select any date prior to today, and it will calculate back one year for the start date of the report. If you select FACILITY, the output will be what it was before. If you select HOSPITAL, you will get a limited number of records from the facility report.
- Added two prompts to the PVP2 and the PVH2 report, D AUTOMATED 90-DAY PERIOD WITHIN THE LAST 12 MONTHS and E SPECIFIC 90-DAY PERIOD WITHIN THE LAST 12 MONTHS. D will use the attestation date look back through 12 months of data for the first/highest 90-day window. The report will also prompt for an end date, then calculate back 90 days.
- Updated checks for percentage to be 29.5 or greater for EPs, and 9.5 or greater for EHs. Sites are being allowed to round up on both reports.
- Added option MUPV to both MUS1 and MUS2 menus. Allows user to view what is in the 3P MU Parameters file both before and after setup is complete. ABMMUINQ
- Updated error 13 in the claim editor to display if the patient's sex is blank or UNKNOWN. ABMDE1X, ABMDE2X3

- Updated error 66 in claim editor to display if insured's sex is blank or UNKNOWN. ABMDE2XA
- Added option to output Patient List to Host File. This option will write an "^"-delimited file to the specified directory. It will include:
  - Visit Location
  - Full Patient Name
  - Chart Number
  - Policy Holder ID
  - Service Category
  - Clinic
  - Insurer Type
  - Billed to (Insurer)
  - Date of Service
  - Date Paid
  - Indicator (*) if claim was paid my Medicaid/SCHIP
  - Bill Number
  - Payment Amount
  - Primary POV
  - Eligibility flags for PRVT, MCR, MCD, RR and Needy Individual

2.0 Patch 11

2.1 Claim Editor

ABM > EDTP > EDCL

2.1.1 Page 2 - Insurers

Error 013 – Patient Sex Unspecified and Error 066 – Insured's Sex Unspecified have been added to alert the user when the patient or policy holders gender is set to unknown or the field is blank.

To correct error 13, the user will need to correct the sex field on page 1 of Patient Registration.

To correct error 66, the user will need to correct the sex field on page 4 of Patient Registration.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BABY,NEW  [HRN:221345]                          Claim Number: 31514
.............................. (INSURERS) ..............................

                          PAGE 2 - INSURER INFORMATION

To: FIRST HEALTH MEDICAID              Bill Type...: 131
    PO BOX 240729                      Proc. Code..: CPT4
    ANCHORAGE, AK  99524-0729          Export Mode.: 837P (HCFA) 5010
    (907)561-2171                      Flat Rate...: N/A
.....................................................................

             BILLING ENTITY            STATUS       POLICY HOLDER
   ============================  ==========  ==============================
[1]  ALASKA MEDICAID                 ACTIVE      BABY,NEW
---------------------------------------------------------------------------
Error:066 - INSURED'S SEX UNSPECIFIED
---------------------------------------------------------------------------

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

Figure 2-1: Page 2 of Claim Editor Displaying Error 66 – Insured's Sex Unspecified

2.1.2 Page 3 – Questions

2.1.2.1 Workmen's Compensation

The Case No. (External ID) field was modified on Page 3 to populate the REF segment in Loop 2010CA on the 837 or Box 1A on the CMS-1500 claim form. The Case Number External ID filed on Page 3 of the Claim Editor will be populated with the claim number that has been entered into the Workmen's Compensation entry in

Patient Registration Page 4. If the export mode is set to 837 5010 and if the Property/Casualty claim number is populated on Page 3B, the Property/Casualty claim number will display on the 837 file and will print in box 1A of the CMS-1500 claim form or box 50 of the UB-04 claim form.

> **Note**: The Case Number will display only if the Property and Casualty Claim Number and Patient Identifier/Number are left blank on page 3B.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BASS,BLINKY  [HRN:99115]                          Claim Number: 31469
.............................. (QUESTIONS) ..............................

 [1] Release of Information..: YES   From: 01/01/2013
 [2] Assignment of Benefits..: YES   From: 01/01/2013
 [3] Accident Related........: YES  EMPLOYMENT RELATED 01/20/2013
 [4] Employment Related......: YES
 [5] Emergency Room Required.: NO
 [6] Special Program.........: NO
 [7] Outside Lab Charges.....: NO  $0.00
 [8] Date of First Symptom...: 01/20/2013
 [9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17)  :
[12] Case No. (External ID)..: ACCIDENT0001
[13] Resubmission(Control) No:
```

Figure 2-2: Claim Editor Page 3 Questions Page Displaying Case No. (External ID)

> **Note**: The Patient Identifier will only print in box 1A of the CMS-1500 claim form or box 50 of the UB-04 claim form if the Property and Casualty Claim Number has been left blank on page 3B.

```
IHS REGISTRATION EDITOR  (page 4)                      INDIAN HEALTH HOSPITAL
================================================================================
BASS,BLINKY                (upd:JAN 25, 2013)          HRN:99115  DIRECT ONLY
================================================================================
WORKMAN'S COMPENSATION
--------------------------------------------------------------------------------
1. WC INJURY DATE: JAN 20, 2013          2.TYPE OF ACCIDENT: FALL ON SIDEWALK
3. DESCRIPTION OF INJURY: DISLOCATED ARM
EMPLOYER DATA---------------------------------------------------------------
4. EMPLOYER: ALLIED SECURITY
ATTORNEY DATA---------------------------------------------------------------
5. NAME OF PATIENT'S ATTORNEY:
INSURANCE COVERAGE----------------------------------------------------------
6. WORKMAN'S COMP ENTITY: WORKMEN'S COMP
7. GROUP NAME: ALLIED SECURITY                GROUP NUMBER: 25845-124155-1500
8. EFFECTIVE COVERAGE DATE: JAN 20, 2013    9.EXPIRATION DATE:
CLAIM INFORMATION-----------------------------------------------------------
10. CLAIM FILED: YES                           11. CLAIM STATUS: ACTIVE
12. CLAIM NUMBER: ACCIDENT0001              13. DATE LAST WORKED: JAN 20, 2013
14. DISABILITY START DATE: JAN 20, 2013    15. DISABILITY END DATE:
16. DATE AUTHORIZED RETURN TO WORK:
```

```
17. CONTACT INFO:
------------------------------------------------------------------------------
18. NOTES:
------------------------------------------------------------------------------
------------------------------------------------------------------------------
Last edited by: STOUT,CINDY on Jan 25, 2013
==============================================================================
CHANGE which item? (1-18) NONE// :
```

Figure 2-3: Page 4 of the Registration Editor displaying the Workmen's Compensation Claim Number

If the case number has been added into Patient Registration for Third Party Liability or Worker's Compensation the Patient Identifier/Number will be populated.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3B  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BASS,BLINKY  [HRN:99115]                        Claim Number: 31469
.............. (THIRD PARTY LIABILITY/WORKER'S COMP QUESTIONS) ..............

[1] Property and Casualty Claim Number: PROPERTY/CASUALTY NO
        Patient Identifier/Number: SY/585588558
[2] Date Last Worked: 01/20/2013
[3] Date Authorized to Return to Work: 03/15/2013

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

Figure 2-4: Page 3B of the Claim Editor displaying the Patient Identifier/Number Field

2.1.2.2 Supervising Provider

The Supervising Provider field was expanded to allow 30 characters for the name.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BABY,NEW  [HRN:221345]                          Claim Number: 31513
.............................. (QUESTIONS) ..............................

 [1] Release of Information..: YES   From: 01/01/2013
 [2] Assignment of Benefits..: YES   From: 01/01/2013
 [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

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

Desired FIELDS:  (1-22): 1-22// 16
[16] Supervising Prov.(FL19): FEATHERSTONEHAUGHFORD,FREDERIK
[16] Date Last Seen: 021513  (FEB 15, 2013)
[16] NPI: 1234567891
```

Figure 2-5: Page 3 – Questions of the Claim Editor displaying the Expanded Supervising Provider Field

2.1.3 Claim Codes from Page 3 – Questions

Various codes have been updated in Patch 11.

2.1.3.1 Source of Admission

The source of Admission is a code that best describes the source of the patient's admission to the hospital. Nine new codes have been added and two codes have been deactivated from the Source of Admission list.

Active Codes:

Code	Description
1	Non-Health Care Facility Point of Origin
2	Clinic or Physician's Office
4	Transfer From A Hospital
5	Transfer From Skilled Nursing/Intermediate Care/Assisting Living Fac
6	Transfer From Another Facility
8	Court/Law Enforcement
9	Information Not Available
A	Transfer From A Critical Access Hospital
B	Transfer From Another Home Health Agency
D	Transfer From One Unit To Another, Same Hosp, Separate Claim To Payer
E	Transfer From Ambulatory Surgery Center
F	Transfer From Hospice Facility

Inactivated Codes:

Code	Description
3	HMO Referral
7	Emergency Room

The inactivated codes can be reactivated by using the UB-92 Codes Menu (UCTM) located in the Third Party billing Table Maintenance menu.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

```
Patient: PIPER,PETER  [HRN:6038]                          Claim Number: 31508
.............................. (QUESTIONS) ..............................

 [1] Release of Information..: YES   From: 04/14/2004
 [2] Assignment of Benefits..: YES   From: 04/14/2004
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.:
 [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.......:  1  EMERGENCY
[12] Source of Admission.....:
[13] Discharge Status..........:
[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// 12

[12] Admission Source: ??
   Choose from:

   1        NON-HEALTH CARE FACILITY POINT OF ORIGIN
   2        CLINIC OR PHYSICIAN'S OFFICE
   3        HMO REFERRAL
   4        TRANSFER FROM A HOSPITAL
   5        TRANSFER FROM SKILLED NURSING/INTERMEDIATE CARE/ASSISTING LIVING
            FAC
   6        TRANSFER FROM ANOTHER FACILITY
   8        COURT/LAW ENFORCEMENT
   9        INFORMATION NOT AVAILABLE
   A        Transfer from a Critical Access Hospital
   B        Transfer from Another Home Health Agency
   D        TRANSFER FROM ONE UNIT TO ANOTHER, SAME HOSP, SEPARATE CLAIM TO
            PAYER
   E        TRANSFER FROM AMBULATORY SURGERY CENTER
   F        TRANSFER FROM HOSPICE FACILITY
```

Figure 2-6: Page 3 of the Claim Editor Displaying the Source of Admission

2.1.3.2 Source of Admission for Newborn

The type of admission code shows the way in which the patient was admitted to the health care facility. Three new codes have been added and four codes that have been deactivated from the Source of Admission list for Newborns.

Active Codes:

Code	Description
05	Born Inside This Hospital
06	Born Outside This Hospital

Code	Description
09	Unknown

Inactive Codes:

Code	Description
01	Normal Birth
02	Premature Birth
03	Sick Baby
04	Extramural Birth

The inactivated codes can be reactivated by using the UB-92 Codes Menu (UCTM) located in the Third Party billing Table Maintenance menu.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 7  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: SMITH,NBM  [HRN:20933]                          Claim Number: 31987
.............................. (INPATIENT DATA) ..............................

[1] Admission Date...: 07-01-2013       [2] Admission Hour....: 18
[3] Admission Type...: 04 (NEWBORN)
[4] Admission Source.:
[5] Admitting Diag...: 999.9 (COMPLIC MED CARE NEC/NOS)

[6] Discharge Date...: 07-05-2013       [7] Discharge Hour....: 00
[8] Discharge Status.:
[9] Service From Date: 07-01-2013       [10] Service Thru Date: 07-05-2013
[11] Covered Days...: 4                 [12] Non-Cvd Days...:
[13] Prior Auth Number.....:
[14] Prof Comp Days..: 5
--------------------------------------------------------------------------------
WARNING:018 - ADMISSION SOURCE UNSPECIFIED
WARNING:021 - PATIENT (DISCHARGE) STATUS UNSPECIFIED
WARNING:146 - PSRO AUTHORIZATION NUMBER NOT SPECIFIED
--------------------------------------------------------------------------------

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

Desired FIELDS:  (1-14): 1-14// 4
[4] Admission/Newborn Code..: ??

   05        BORN INSIDE THIS HOSPITAL
   06        BORN OUTSIDE THIS HOSPITAL
   09        UNKNOWN
```

Figure 2-7: Page 7 of the Claim Editor Displaying the Newborn Admission Source Codes for Inpatient Data

2.1.3.3 Discharge Status

A patient discharge status code is a two-digit code that identifies where the patient is at the end of an inpatient encounter or at the end time of a billing cycle. Discharge status codes have been added and inactivated.

Active Codes:

Code	Description
01	Discharged To Home Or Self Care (Routine Discharge)
02	Discharged/transferred To A Short-Term General Hospital For Inpt Care
03	Discharged/transferred To Skilled Nursing Facility (SNF) With Medicare Certification in Anticipation Of Skilled Care
04	Discharged/transferred to a Facility that Provides Custodial or Supportive Care
05	Discharged/transferred to a Designated Cancer Center Or Children's Hospital
06	Discharged/transferred to Home Under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	Left Against Medical Advice Or Discontinued Care
09	Admitted as an Inpatient to this Hospital
20	Expired (Did Not Recover)
30	Still Patient
40	Expired at Home
41	Expired in a Medical Facility (e.g. hospital, SNF, ICF, or free standing hospice)
42	Expired - Place Unknown
43	Discharged/Transferred to a Federal Health Care Facility
50	Hospice – Home
51	Hospice - Medical Facility (Certified) Providing Hospice Level Of Care
61	Discharged/transferred to a Hospital-Based Medicare Approved Swing Bed
62	Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital
63	Discharged/transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64	Discharge/transferred to a Nursing facility Certified under Medicaid but not Certified under Medicare
65	Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
70	Discharged/transferred to another Type Of Health Care Institution not Defined Elsewhere in this Code List

Inactive Codes:

Code	Description
08	Discharged/Transferred To Home Under Care Of Home IV Provider
72	Discharged/Transferred/Referred To This Facility For Outpatient Svcs

Additional information may be found on:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0801.pdf

The inactivated codes can be reactivated by using the UB-92 Codes Menu (UCTM) located in the Third Party billing Table Maintenance menu.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BABY,NEW  [HRN:221345]                          Claim Number: 31512
.............................. (QUESTIONS) ..............................

 [1] Release of Information..: YES   From: 01/01/2013
 [2] Assignment of Benefits..: YES   From: 01/01/2013
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.:
 [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.......:  1  EMERGENCY
[12] Source of Admission.....:  2  CLINIC OR PHYSICIAN'S OFFICE
[13] Discharge Status..........:
[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// 13

[13]Discharge Status: ??

   Choose from:

   10 DISCHARGED TO MENTAL HEALTH FACILITY
   20 EXPIRED (DID NOT RECOVER)
   30 Still Patient
   40 Expired at home
   41 Expired in a medical facility
   42 Expired - Place Unknown
   43 Discharged/transferred to a Federal Health Care Facility
   50 Hospice - Home
   51 Hospice - Medical Facility (Certified) Providing Hospice Level of Care
   61 Discharged/transferred to a Hospital-Based Medicare Approved Swing Bed
   62 Discharged/transf to IRF incl Rehab Distinct Part Units of a Hospital
   62 DISCHARGED/TRANSFERRED TO ANOTHER REHAB FAC
   62 DISCHARGED/TRANSFERRED TO ANOTHER REHAB FAC
   63 Discharged/transf to a Medicare Certified Long Term Care Hosp (LTCH))
   64 Discharged/transf to a Nursing Fac Cert under Medicaid, not Medicaree
   65 Discharged/transf to a Psych Hosp or Psych Distinct Part Unit of Hosp
   66 Discharged/transf to a Critical Access Hospital (CAH)
   70 Discharged/transf to another Type of Health Care Inst not Defined
   01 Discharged to Home or Self Care (Routine Discharge)
   02 Discharged/transferred to a Short-Term General Hospital for Inpt Care
   03 Dischrgd/trans to SNF with Medicare Cert, Anticipation of Skilled Care
   04 Discharged/transf to Facility that Provides Custodial/Supportive Care
   05 Discharged/transf to a Designated Cancer Center or Children's Hospital
   06 Discharged/transf to Home Under Care of an Org Home Hlth Svc Org
   07 Left Against medical Advice or Discontinued Care
```

```
   09 Admitted as an inpatient to this hospital
```

Figure 2-8: Page 3 of the Claim Editor Showing Discharge Status

2.1.4 Page 4 – Provider Data

Error 244 will now display on page 4 when there is no provider listed on the page. Users will not be able to approve the claim until a provider has been added.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BABY,NEW  [HRN:221345]                          Claim Number: 31513
............................. (PROVIDER DATA) .............................
                 PROVIDER              NPI               DISCIPLINE
      ========================  ============  ==============================
--------------------------------------------------------------------------------
  ERROR:244 - No Providers on claim
--------------------------------------------------------------------------------

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

Figure 2-9: Page 4 of the Claim Editor Displaying Error #244 for No Providers on the Claim

2.1.5 Claim Editor CPT Pages: Pages 8A (Medical Services) – 8K (Ambulance Services)

The Place of Service code *'03-School'* has been added CPT and HCPCS pages in the claim editor. This includes Pages 8A to 8K.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BABY,NEW  [HRN:221345]                          Claim Number: 31512
Mode of Export: 837 PROF (HCFA)
............................ (MEDICAL SERVICES) ............................

     REVN                                                  UNIT       TOTAL
     CODE         CPT - MEDICAL SERVICES                  CHARGE QTY  CHARGE
     ==== ============================================  ====== === =======
[1]  CHARGE DATE: 03/07/2013
     **** 99213 OFFICE/OUTPATIENT VISIT EST             150.00  1     150.00
                                                                  ==========
                                                                     $150.00

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

[1]  99213

Select 1st MODIFIER:

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

SERVICE FROM DATE/TIME: MAR 7,2013//
SERVICE TO DATE/TIME: MAR 7,2013//
UNITS: 1//
```

```
PLACE OF SERVICE: 11// ??


   Choose from:
   11        OFFICE
   12        PATIENT'S HOME
   21        INPATIENT HOSPITAL
   22        OUTPATIENT HOSPITAL
   23        EMERGENCY ROOM - HOSPITAL
   24        ABMULATORY SURGICAL CENTER
   25        BIRTHING CENTER
   26        MILITARY TREATMENT CENTER
   31        SKILLED NURSING FACILITY
   32        NURSING FACILITY
   33        CUSTODIAL CARE FACILITY
   34        HOSPICE
   41        AMBULANCE - LAND
   42        AMBULANCE - AIR OR WATER
   51        INPATIENT PSYCHIATRIC FACILITY
   52        PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
   53        COMMUNITY MENTAL HEALTH CENTER
   54        INTERMEDIATE CARE FACILITY/MENTAL RETARTED
   55        RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
   56        PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
   61        COMPREHENSIVE INPATIENT REHABILITATION FACILITY
   62        COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
   65        END STAGE RENAL DISEASE TREATMENT FACILITY
   71        STATE OR LOCAL PUBLIC HEALTH CLINIC
   72        RURAL HEALTH CLINIC
   81        INDEPENDENT LABORATORY
   99        OTHER UNLISTED FACILITY
   03        SCHOOL
   05        INDIAN HEALTH SERVICE FREE-STANDING FACILITY
   06        INDIAN HEALTH SERVICE PROVIDER-BASED FACILITY
   07        TRIBAL 638 FREE-STANDING FACILITY

PLACE OF SERVICE: 11// 03       SCHOOL

UNIT CHARGE: 150.00//

Select SERVICE LINE PROVIDER:
```

Figure 2-10:Claim Editor Page 8A – Medical Services Displaying Place of Service Codes

2.1.6 Page 8K – Ambulance Services

Modified the units prompt to now allow for tenths of a mile to be entered. The units for covered and non-covered mileage will also display on page 3.

Partial units must be entered as “n.n” where the “.n” is the tenth of the mile that can identify the unit.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8K  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BABY,NEW  [HRN:221345]                          Claim Number: 31514
Mode of Export: 837P (HCFA) 5010
.......................... (AMBULANCE SERVICES) ........................
```

```
     REVN                                                    UNIT       TOTAL
     CODE         HCPCS - AMBULANCE SERVICES                CHARGE QTY  CHARGE
     ==== ========================================  ====== === ========
[1]  CHARGE DATE: 03/30/2013
          A0425-TN Ground mileage                    8.00 75.4   603.20
[2]  CHARGE DATE: 03/30/2013
          A0888-TN Noncovered ambulance mileage      5.00 2.6     13.00
[3]  CHARGE DATE: 03/30/2013
          A0426-TN Als 1                             5.00 10      50.00
                                                                ==========
                                                                  $666.20

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

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

[3]  A0426

Select 1st MODIFIER: TN//        RURAL/OUT OF SERVICE AREA

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

SERVICE FROM DATE/TIME: MAR 30,2013//
SERVICE TO DATE/TIME: MAR 30,2013//
UNITS: 10// 10.5
HCFA POS: 41//
UNIT CHARGE: 5//

Select SERVICE LINE PROVIDER:
```

Figure 2-11: Claim Editor Ambulance Page (Page 8K) Displaying Modified Units

2.1.7 Page 9A – Occurrence Codes

Occurrence codes help define a specific event that may affect how a medical claim is processed by an insurance company. The Occurrence codes are broken down into accident codes, medical condition codes, insurance related codes and service related codes. Occurrence codes have been added and inactivated.

Active codes:

Code	Description
01	Accident/Medical Coverage
02	Auto Accident/No Fault Insurance Involved
03	Accident/Tort Liability
04	Accident/Employment Related
05	Accident/No Medical Or Liability Coverage
06	Crime Victim
09	Start of Infertility Treatment Cycle

Code	Description
10	Last Menstrual Period
11	Onset of Symptoms/Illness
12	Date of Onset For A Chronically Dependent Individual
16	Date of Last Therapy
17	Date Outpatient Occupational Therapy Plan Established/Last Reviewed
18	Date of Retirement (Patient)
19	Date of Retirement (Spouse)
20	Date Guarantee of Payment Began
21	Date Ur Notice Received
22	Date Active Care Ended
23	Payer Code
24	Date Insurance Denied
25	Date Benefits Terminated By Payor
26	Date SNF Bed Available
27	Date of Hospice Certification or Re-Certification
28	Date Comprehensive Outpatient Rehab Plan Established or Last Reviewed
29	Date Outpatient Physical Therapy Plan Established or Last Reviewed
30	Date Outpatient Speech Pathology Plan Established or Reviewed
31	Date Beneficiary Notified Of Intent To Bill Accommodations
32	Date Beneficiary Notified Of Intent To Bill Procedures Or Treatments
33	1st Date of Medicare Coordination Period For ESRD Beneficiaries Covered By EGHP
34	Date of Election of Extended Care Facilities
35	Date Treatment Started For Physical Therapy
36	Date of Inpatient Hospital Discharge For Covered Transplant Patients
37	Date of INPT Hospital Discharge For Non-Covered Transplant Patient
38	Date Treatment Started For Home IV Therapy
39	Date Discharged on a Continuous Course Of Iv Therapy
40	Scheduled Date of Admission
41	Date of First Test For Preadmission Testing
42	Date of Discharge
43	Scheduled Date of Cancelled Surgery
44	Date Treatment Started For Occupational Therapy
45	Date Treatment Started For Speech Therapy
46	Date Treatment Started For Cardiac Rehabilitation
47	Date Cost Outlier Status Begins

Code	Description
50	Assessment Date
51	Date of Last KT/V Reading
52	Medical Certification/Recertification Date
54	Physician Follow-Up Date
55	Date of Death
A1	Birthdate - Insured A
A2	Effective Date - Insured A Policy
A3	Benefits Exhausted-Payer A
A4	Split Bill Date
B1	Birthdate - Insured B
B2	Effective Date - Insured B Policy
B3	Benefits Exhausted
C1	Birthdate - Insured C
C2	Effective Date - Insured C Policy
C3	Benefits Exhausted

Inactive Codes:

Code	Description
E1	Birthdate-Insured D
E2	Effective Date-Insured D Policy
E3	Benefits Exhausted
F1	Birthdate - Insured E
F2	Effective Date - Insured E Policy
F3	Benefits Exhausted
G1	Birthdate - Insured F
G2	Effective Date - Insured F Policy
G3	Benefits Exhausted

The inactivated codes can be reactivated by using the UB-92 Codes Menu (UCTM) located in the Third Party billing Table Maintenance menu.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BABY,NEW  [HRN:221345]                          Claim Number: 31513
............................ (OCCURRENCE CODES) ............................

      OCCR
      CODE                 OCCURRENCE DESCRIPTION                   DATE
      ====    ================================================  ========

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

===============  ADD MODE - OCCURRENCE CODES  ===============
```

```
Select Occurrence Code: ??

   Choose from:
   10    LAST MENSTRUAL PERIOD
   11    ONSET OF SYMPTOMS/ILLNESS
   12    Date of Onset for a Chronically Dependent Individual
_____________________________________________________________________________

   C1    Birthdate - Insured C
   C2    Effective Date - Insured C Policy
   C3    Benefits Exhausted

Select Occurrence Code:
```

Figure 2-12: Claim Editor Page 9A Displaying Occurrence Codes

2.1.8 Page 9B - Occurrence Span Codes

Occurrence Span Codes define a specific event relating to the billing period. The event being reported is defined by a date range rather than by a single date.

Added Active codes:

Code	Description
79	Payer Code
80	Prior Same-SNF Stay Date for Payment Ban Purposes
81	Antepartum Days at Reduced Level of Care
M3	ICF Level of Care
M4	Residential Level of Care

The inactivated codes can be reactivated by using the UB-92 Codes Menu (UCTM) located in the Third Party billing Table Maintenance menu.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9B  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BABY,NEW  [HRN:221345]                          Claim Number: 31513
.......................... (OCCURRENCE SPAN CODES) ..........................

      SPAN
      CODE           OCCURRENCE SPAN DESCRIPTION          FROM       TO
      ====    ======================================  ========  ========


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

===============  ADD MODE - OCCURRENCE SPAN CODES  ===============

Select Occurrence Span: ??

   Choose from:
   70        QUALIFYING STAY DATES
   71        PRIOR STAY DATES
   72        FIRST/LAST VISIT
   73        BENEFIT ELIGIBILITY
```

```
   74        NON-COVERED LEVEL OF CARE/LEAVE OF ABSENCE DATES
   75        SNF LEVEL OF CARE
   76        PATIENT LIABILITY PERIOD
   77        Provider Liability Period
   78        SNF Prior Stay Dates
   79        Payer Code
   80        Prior Same-SNF Stay Date for Payment Ban Purposes
   81        Antepartum Days at Reduced Level of Care
   M0        QIO/UR APPROVED STAY DATES
   M1        Provider Liability - No Utilization
   M2        Inpatient Respite Dates
   M3        ICF Level of Care
   M4        Residential Level of Care

Select Occurrence Span: 70       QUALIFYING STAY DATES

   Occurence Span Code FROM DATE: 032813  (MAR 28, 2013)
   Occurence Span Code TO DATE: 033013
```

Figure 2-13: Claim Editor Page 9A Displaying Occurrence Span Codes

2.1.9 Page 9C - Condition Codes

Condition Codes indicate that a condition applies to the bill that affects processing and payment of the claim. Condition codes indicate whether coverage exists under another insurance, whether the injury or illness is related to employment, whether the bill is an outlier, or if medical necessity affects room assignment.

Active codes:

Code	Description
01	MILITARY SERVICE RELATED
02	CONDITION IS EMPLOYMENT RELATED
03	PATIENT COVERED BY INSURANCE NOT REFLECTED HERE
04	Information Only Bill
05	LIEN HAS BEEN FILED
06	ESRD Patient in 1st 30 Months of Entitlement Cov by Employer Grp Ins
07	TREATMENT OF NONTERMINAL CONDITION FOR HOSPICE PATIENT
08	Beneficiary wouldn't Provide Information Concerning Other Ins Coverage
09	Neither Patient Nor Spouse Is Employed
10	Patient/Spouse is Employed but NO Employee Group Health Plan Exists
11	Disabled Beneficiary but NO LGHP
17	PATIENT IS HOMELESS
18	MAIDEN NAME RETAINED
19	Child Retains Mother's Name
20	Beneficiary Requested Billing
21	Billing for Denial Notice

Code	Description
22	Patient on Multiple Drug Regimen
23	Home Caregiver Available
24	Home IV Patient Also Receiving HHA Services
25	Patient is Non-US Resident
26	VA Eligible Patient Chooses to Rec Svcs in a Medicare Certified Fac
27	Patient Ref to a Sole Community Hospital for a Diagnostic Lab Test
28	Patient and/or Spouse's EGHP is Secondary to Medicare
29	Disabled Beneficiary and/or Family Member's LGHP is 2nd to Medicare
30	Qualifying Clinical Trials
31	PATIENT IS STUDENT (FULL TIME-DAY)
32	PATIENT IS STUDENT (COOPERATIVE/WORK STUDY PROGRAM)
33	PATIENT IS STUDENT (FULL TIME-NIGHT)
34	PATIENT IS STUDENT (PART TIME)
36	GENERAL CARE PATIENT IN A SPECIAL UNIT
37	Ward Accommodation - Patient Request
38	Semi-Private Room Not Available
39	Private Room Medically Necessity
40	SAME DAY TRANSFER
41	Partial Hospitalization
42	Continuing Care Not Related to Inpatient Admission
43	Continuing Care Not Provided Within Prescribed Post-Discharge Window
44	Inpatient Admission Changed to Outpatient
45	Ambiguous Gender Category
46	Non-Availability Statement on File
47	Transfer from another Home Health Agency
48	Psychiatric Residential Tx Centers for Children & Adolescents (RTC)
49	Product Replacement within Product Lifecycle
50	Product Replacement for Known Recall of Product
51	Attestation of Unrelated Outpatient Nondiagnostic services
52	Out of Hospice Service Area
56	Medical Appropriateness
57	SNF Readmission
58	Terminated Medicare Advantage Enrollee
59	Non-primary ESRD Facility
60	Day Outlier
61	Cost Outlier

Code	Description
66	Provider Does not Wish Cost Outlier Payment
67	Beneficiary Elects not to use Life Time Reserve (LTR) Days
68	Beneficiary Elects to use Life Time Reserve (LTR) Days
69	IME/DGME/N&AH Payment only
70	Self-Administered Anemia Management Drug
71	Full Care in Unit
72	Self-Care in Unit
73	Self-Care Training
74	Home
75	Home - 100% Reimbursement
76	Back-up in Facility Dialysis
77	Provider Accepts Payment by a Primary Payer as Payment in Full
78	New Coverage not Implemented by Managed Care Plan
79	CORF Services Provided Offsite
80	Home Dialysis - Nursing Facility
A0	TRICARE EXTERNAL PARTNERSHIP PROGRAM
A1	EPSDT/CHAP
A2	PHYSICALLY HANDICAPPED CHILDREN'S PROGRAM
A3	SPECIAL FEDERAL FUNDING
A4	FAMILY PLANNING
A5	DISABILITY
A6	VACCINES/MEDICARE 100%
A9	SECOND OPINION SURGERY
AA	Abortion Performed due to Rape
AB	Abortion Performed due to Incest
AC	Abortion Performed-Serious Fetal Genetic Defect/Deformity/Abnormality
AD	Abortion Performed due to Life Endangering Physical Condition
AE	Abortion Performed-Physical Health of Mother not Life Endangering
AF	Abortion Performed-Emotional/psychological Health of the Mother
AG	Abortion Performed due to Social or Economic Reasons
AH	Elective Abortion
AI	Sterilization
AJ	Payer Responsible for Co-Payment
AK	Air Ambulance Required
AL	Specialized Treatment/bed Unavailable - Alternate Facility Transport
AM	Non-emergency Medically Necessary Stretcher Transport Required

Code	Description
AN	Preadmission Screening not Required
B0	Medicare Coordinated Care Demonstration Claim
B1	Beneficiary is Ineligible for Demonstration Program
B2	Critical Access Hospital Ambulance Attestation
B3	Pregnancy Indicator
B4	Admission Unrelated to Discharge on Same Day
BP	Gulf Oil Spill of 2010
C1	APPROVED AS BILLED
C2	AUTOMATIC APPROVAL AS BILLED BASED ON FOCUSED REVIEW
C3	PARTIAL APPROVAL
C4	ADMISSION/SERVICES DENIED
C5	POSTPAYMENT REVIEW APPLICABLE
C6	ADMISSION PREAUTHORIZATION
C7	EXTENDED AUTHORIZATION
D0	CHANGES TO SERVICE DATES
D1	CHANGES TO CHARGES
D2	CHANGES IN REVENUE CODES/HCPCS/HIPPS RATE CODES
D3	SECOND OR SUBSEQUENT INTERIM PPS BILL
D4	CHANGE IN CLINICAL CODES (ICD) FOR DIAGNOSIS AND/OR PROCEDURE
D5	CANCEL TO CORRECT INSURED'S ID OR PROVIDER ID
D6	CANCEL ONLY TO REPAY A DUPLICATE OR OIG OVERPAYMENT
D7	CHANGE TO MAKE MEDICARE THE SECONDARY PAYER
D8	CHANGE TO MAKE MEDICARE THE PRIMARY PAYER
D9	ANY OTHER CHANGE
DR	Disaster Related
E0	CHANGE IN PATIENT STATUS
G0	DISTINCT MEDICAL VISIT
H0	Delayed Filing-Statement of Intent Submitted
H2	Discharge by a Hospice Provider for Cause
H3	Reoccurrence of GI Bleed Comorbid Category
H4	Reoccurrence of Pneumonia Comorbid Category
H5	Reoccurrence of Pericarditis Comorbid Category
P1	Do Not Resuscitate Order (DNR)
P7	Direct Inpatient Admission from Emergency Room
W0	United Mine Workers of America (UMWA) Demonstration Indicator
W2	Duplicate of Original Bill

Code	Description
W3	Level I Appeal
W4	Level II Appeal
W5	Level III Appeal

Inactive codes:

Code	Description
55	SNF Bed Not Available
A7	INDUCED ABORTION DANGER TO LIFE
A8	INDUCED ABORTION VICTIM RAPE/INCEST

The inactivated codes can be reactivated by using the UB-92 Codes Menu (UCTM) located in the Third Party billing Table Maintenance menu.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9C  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BABY,NEW  [HRN:221345]                          Claim Number: 31513
............................. (CONDITION CODES) .............................

      COND
      CODE                 CONDITION CODE DESCRIPTION
      ====    ============================================================


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

===============  ADD MODE - CONDITION CODES  ===============

Select Condition Code: ??

   Choose from:
   01     MILITARY SERVICE RELATED
   02     CONDITION IS EMPLOYMENT RELATED
   03     PATIENT COVERED BY INSURANCE NOT REFLECTED HERE
_____________________________________________________________________________

   W3     Level I Appeal
   W4     Level II Appeal
   W5     Level III Appeal

Select Condition Code:
```

Figure 2-14: Claim Editor Page 9C Displaying Condition Codes

2.1.10 Page 9D – Value Codes

Value Codes help identify data and financial elements about other insurances to the insurance company that is being billed.

Active Codes:

Code	Description
01	MOST COMMON SEMI-PRIVATE RATE
02	NO SEMI-PRIVATE ROOMS
04	Professional Component Charges which are Combined Billed
05	PROFESSIONAL COMPONENT INCLUDED IN CHARGES AND ALSO BILLED SEPERATE
06	BLOOD DEDUCTIBLE
08	MEDICARE LIFETIME RESERVED AMOUNT IN THE 1ST CALENDAR YEAR
09	MEDICARE COINSURANCE AMOUNT (1ST CALENDAR YEAR)
10	LIFETIME RESERVE AMOUNT (2ND YEAR)
11	COINSURANCE AMOUNT (2ND YEAR)
12	WORKING AGED BENEFICIARY/SPOUSE W/ EMPL GROUP HLTH PLAN
13	ESRD PATIENT W/ EMPL GROUP HLTH PLAN
14	AUTO, NO FAULT OR LIABILITY
15	WORKER'S COMPENSATION INCLUDING BLACK LUNG
16	VA, PHS, OR OTHER FEDERAL AGENCY
21	CATASTROPHIC
22	SURPLUS
23	RECURRING MONTHLY INCOME
24	MEDICAID RATE CODE
25	Offset to the Patient-Payment Amount - Prescription Drugs
26	Offset to the Patient-Payment Amount - Hearing and Ear Services
27	Offset to the Patient-Payment Amount - Vision and Eye Services
28	Offset to the Patient-Payment Amount - Dental Services
29	Offset to the Patient-Payment Amount - Chiropractic Services
30	PREADMISSION TESTING
31	PATIENT LIABILITY AMOUNT
32	Multiple patient ambulance transport
33	Offset to the Patient-Payment Amount - Podiatric Services
34	Offset to the Patient-Payment Amount - Other Medical Service
35	Offset to the Patient-Payment Amount - Health Insurance Premiums
37	Units of Blood Furnished
38	Blood Deductible
39	Units of Blood Replaced
40	NEW COVERAGE NOT IMPLEMENTED BY HMO
41	Black Lung

Code	Description
42	VA
43	Disabled Beneficiary Under Age 65 with LGHP
44	Amt Prov Agreed to Accept fr 1st Payer, Amt < Chrgs Higher than Pymnt
45	Accident Hour
46	Number of Grace Days
47	Any Liability
48	Hemoglobin Reading
49	Hematocrit Reading
50	Physical Therapy Visit
51	Occupational Therapy Visit
52	Speech Therapy Visit
53	Cardiac Rehab Visits
54	Newborn Birth Weight in Grams
55	Eligibility Threshold for Charity Care
56	Skilled Nurse - Home Visit Hours (HHA only)
57	Home Health Aide - Home Visit Hours (HHA only)
58	Arterial Blood Gas (PO2/PA2)
59	Oxygen Saturation
60	HHA Branch
61	Location Where Service is Furnished (HHA and Hospice)
66	Medicaid Spend Down Amount
67	Peritoneal Dialysis
68	EPO-Drug
69	State Charity Care Percent
80	COVERED/NON-COVERED DAYS
81	NON-COVERED DAYS
82	CO-INSURANCE DAYS
83	LIFETIME RESERVE DAYS
A0	Special ZIP Code Reporting
A1	Deductible Payer A
A2	Coinsurance Payer A
A3	Estimated Responsibility Payer A
A4	Covered Self-Administrable Drugs - Emergency
A5	Covered Self-Administrable Drugs - Not Self-Administrable
A6	Covered Self-Administrable Drugs - Diagnostic Study and Other
A7	Co-payment Payer A

Code	Description
A8	Patient Weight
A9	Patient Height
AA	Regulatory Surcharges/Assessments/Allow/Hlth Cre Related Taxes Payer A
AB	Other Assessments or Allowance (e.g., Medical Education) Payer A
B1	Deductible Payer B
B2	Coinsurance Payer B
B3	Estimated Responsibility Payer B
B7	Co-Payment Payer B
BA	Regulatory Surcharges/Assessments/Allow/Hlth Cre Related Taxes Payer B
BB	Other Assessments or Allowance (e.g., Medical Education) Payer B
C1	Deductible Payer C
C2	Coinsurance Payer C
C3	Estimated Responsibility Payer C
C7	Co-Payment Payer C
CA	Regulatory Surcharges/Assessments/Allow/Hlth Cre Related Taxes Payer C
CB	Other Assessments or Allowance (e.g., Medical Education) Payer C
D3	Patient Estimated Responsibility
D4	Clinical Trial Number Assigned by NLM/NIH
D5	Last Kt/V Reading
FC	Patient Paid Amount
FD	Credit Received from the Manufacturer for a Replaced Medical Device
G8	Facility where Inpatient Hospice Service is Delivered
Y1	Part A Demonstration Payment
Y2	Part B Demonstration Payment
Y3	Part B Coinsurance
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims

Inactive codes:

Code	Description
07	MEDICARE PART A CASH DEDUCTIBLE INACTIVE FLAG
73	Drug DeductibleINACTIVE FLAG
74	Drug Coinsurance INACTIVE FLAG
E1	Deductible Payer D INACTIVE FLAG
E2	Coinsurance Payer D INACTIVE FLAG
E3	Estimated Responsibility Payer D INACTIVE FLAG
F1	Deductible Payer E INACTIVE FLAG

Code	Description
F2	Coinsurance Payer E INACTIVE FLAG
F3	Estimated Responsibility Payer E INACTIVE FLAG
G1	Deductible Payer F INACTIVE FLAG
G2	Coinsurance Payer F INACTIVE FLAG
G3	Estimated Responsibility Payer F INACTIVE FLAG

The inactivated codes can be reactivated by using the UB-92 Codes Menu (UCTM) located in the Third Party billing Table Maintenance menu.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BABY,NEW  [HRN:221345]                          Claim Number: 31513
.............................. (VALUE CODES) ..............................

      VALU
      CODE              VALUE CODE DESCRIPTION                    AMOUNT
      ====    ================================================  ========


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


===============  ADD MODE - VALUE CODES  ===============

Select Value Code: ??

   Choose from:
   10     LIFETIME RESERVE AMOUNT (2ND YEAR)
   11     COINSURANCE AMOUNT (2ND YEAR)
   12     WORKING AGED BENEFICIARY/SPOUSE W/ EMPL GROUP HLTH PLAN
   13     ESRD PATIENT W/ EMPL GROUP HLTH PLAN

   Y1     Part A Demonstration Payment
   Y2     Part B Demonstration Payment
   Y3     Part B Coinsurance
   Y4     Conventional Provider Payment Amount for Non-Demonstration Claims

Select Value Code:
```

Figure 2-15: Claim Editor Page 9D Displaying Value Codes

2.2 Eligibility Menu

ABM > ELTP

The following section explains changes made to the Eligibility Menu in Third Party Billing.

2.2.1 Visit Counts by Veterans

ABM > ELTP > RPEL > VTRP

The Visit Counts by Veterans report shall print the number of visits each veteran patient has in the requested date range. To initiate the report, the user will select a starting and ending date. The user will be able to print this report to a printer or to the screen. The Veterans on page 6 of Patient Registration will need to be set to YES for the patient to display on this report. All visits that have been billed will be totaled on the right hand side of the page.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
           +                Visit Counts by Veterans                  +
           |                 INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: STOUT,CINDY                         2-MAY-2013 2:33 PM

 ============ Entry of VISIT DATE Range =============

Enter STARTING VISIT DATE for the Report:  010113  (JAN 01, 2013)

Enter ENDING DATE for the Report:  t  (MAY 02, 2013)

Output DEVICE: HOME//

=============================================================================
VET LISTING of VISITS                        MAY 2,2013@14:33:48   Page 1
For VISIT DATES: 01/01/2013 thru 05/02/2013
Billing Location: INDIAN HOSP
=============================================================================
PATIENT NAME                       HRN     DOB        SSN       VISIT CNT
=============================================================================
DEMO,JOHN                           123567  01/01/1950 22222XXXX     3
DEMO,WILL                           322512  06/06/1937 52705XXXX     7
DEMO,EDWARD                         123456  08/02/2006 50085XXXX     3
OLDAGE,MAN                          990901  09/10/1936 55555XXXX     11
SMITH,BAIT CAT                      203336  08/21/1999 55560XXXX     1

(REPORT COMPLETE):
```

Figure 2-16: Report of Visit Counts by Veterans in the Eligibility Reports Option

For now, the report will print patients that are deceased and Non-Indian (Non-Beneficiary) veterans.

2.3 Claim/Bill Management Menu

ABM > MGTP

2.3.1 Cancel Claim

ABM > MGTP > CLMG

The Cancel Claim option has been modified to require the user to enter in a cancellation reason. If the cancellation reason has not been entered in the user will receive a message that the claim was not cancelled and the claim will not be deleted out of the Third Party Billing package. To view the cancellation reason the user can type two question marks (**??**) at the Cancellation Reason prompt.

2.4 Export Modes

2.4.1 New Dental Export: Mode ADA-2012

The new ADA-2012 Dental export mode has been added to the insurer file menu. Users will be able to export and reprint bills to the ADA-2012 form. To set the mode of export to ADA-2012, select the Insurer File menu. Enter the Insurance Name and press enter until you are at the Visit Type prompt. Type the Visit Type "**DENTAL**" and press the Enter key until you are at the Mode of Export prompt. Type **ADA-2012** to add the entry.

```
Visit                      Mode of     Mult  Fee    ------- Flat Rate --------
Type - Description          Export     Form Sched   Start      Stop       Rate
================================================================================
 998   DENTAL              ADA-2006      NO

Select VISIT TYPE..: 998  DENTAL

...OK? Yes//   (Yes)

Billable (Y/N/E)....: YES//
Reporting purposes only:
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before)..:
Procedure Coding....:
Fee Schedule........:
Add Zero Fees?...:
Multiple Forms?.....:
Payer Assigned Provider Number.....:
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.......:
Mode of Export......: ADA-2006// ??

   Choose from:

   27           CMS-1500 (08/05)     OMB No. 0938-0999
   28           UB-04     OMB No. 0938-0997
```

```
   29           ADA-2006     ADA-2006 Dental Claim Form
   31           837I (UB) 5010     837 5010 INSTITUTIONAL
   32           837P (HCFA) 5010     837 5010 PROFESSIONAL
   33           837D (ADA) 5010     837 5010 DENTAL
   34           ADA-2012     ADA Claim Form dated 2012
   51           UB-92 Medi-Cal     UB-92 Medi-Cal version

Mode of Export......: ADA-2006// 34  ADA-2012     ADA Claim Form dated 2012
```

Figure 2-17: Adding the ADA-2012 into the Insurer file in Table Maintenance

Reprinting a bill approved to the 837 Dental Version 5010 export mode will allow the user to view the ADA-2012 as an option to reprint.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
           +                     Reprint Bill                        +
           |                 INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: LUJAN,ADRIAN M                     11-JUL-2013 2:15 PM

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:    31963A
                 Visit: 06-02-2013 DENTAL        DENTAL            INDIAN HOSP
                    Bill: NM BC/BS DENTAL CLASSIC        837D (ADA) 5010    430.
00


Select 2nd BILL to Re-Print:

     Select one of the following:

          25        ADA-2002
          29        ADA-2006
          34        ADA-2012

**Use the following export mode: : ADA-2012//
```

Figure 2-18: Display of ADA-2012 Export Mode Using the Reprint Bill Option

See Appendix A: for a sample of the ADA-2012 claim form.

2.4.2 Modifications to ADA-2006: Claim Form Block 48 - New Parameter Physical or Mailing Address

A new parameter was added to allow the option to print the Physical Address or Mailing Address for the facility in block 48 of the ADA-2006 claim form.

> **Note**: The address that prints in block 48 is linked to the address that is in the Location File Menu in Third Party Table Maintenance.

```
Visit                     Mode of     Mult  Fee    ------- Flat Rate --------
Type - Description         Export     Form Sched   Start      Stop       Rate
================================================================================
 998   DENTAL             ADA-2006      NO

Select VISIT TYPE..: 998  DENTAL
         ...OK? Yes//   (Yes)

Billable (Y/N/E)....: YES//
Reporting purposes only:
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before)..:
Procedure Coding....: ADA//
Fee Schedule........:
Add Zero Fees?...:
Multiple Forms?.....:
Payer Assigned Provider Number.....:
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.......:
Mode of Export......:
Block 48..........: ??

     Choose from:

       P        PHYSICAL
       M        MAILING

Block 48..........: M  MAILING
```

Figure 2-19: Display of the Visit Type Section of the Insurer File in Table Maintenance

2.4.3 UB-04 Modifications: Block 44

A new parameter has been added to give users the option to leave block 44 (HCPCS/RATE//HIPPS CODE) of the UB-04 claim form blank.

```
Visit                     Mode of     Mult  Fee    ------- Flat Rate --------
Type - Description         Export     Form Sched   Start      Stop       Rate
================================================================================
 131   OUTPATIENT         837I (UB) 5010NO      01/01/2013             316.00
 997   PHARMACY            NCPDP-P      NO
 998   DENTAL              ** Replace with: DELTA DENTAL OF NEW MEXICO INC **
 999   PROFESSIONAL COMP  837 PROF (HCFA)N/A
```

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

Billable (Y/N/E)....: YES//
Reporting purposes only:
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before)..:
Procedure Coding....: CPT//
Fee Schedule........:
Add Zero Fees?...:
Multiple Forms?.....: NO//
Payer Assigned Provider Number.....:
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.......: NO//
Mode of Export......: 837I (UB) 5010//
Relationship Code?:
Itemized UB?.....: YES//
UB-04 Form Locater 38:
ICD PX on Claim?: YES//
Print meds on 2 lines?:
UB-04 Block 44 Blank?: ??

     Choose from:

       Y        YES
       N        NO

UB-04 Block 44 Blank?: Y  YES
```

Figure 2-20: Display of the Visit Type Section of the Insurer File in Table Maintenance

2.5 Site Parameters

2.5.1 Claim form requirements

ABM > TMTP > SITM

The VA Station Number and the Contract Number will need to print on each paper claim form. New fields have been added to the site parameters to automatically populate the VA Station Number and the Contract Number on the paper claim format.

The VA Station Number is a three-digit number and identifies the VA Medical Center associated to the Indian Health or Tribal Health facility where the patient was seen at.

The Contract Number is the number that the VA assigns to the Indian Health or Tribal Health facility once the Implementation Agreement has been signed. This number will be used to identify the IHS and VA facility and must be sent on the claim.

```
EMC File Preference.............: HOST FILE//
DEFAULT EMC PATH................: c:\pub//
Facility to Receive Payments....: INDIAN HEALTH HOSPITAL
```

```
         //
Printable Name of Payment Site..: INDIAN HEALTH HOSPITAL
           Replace
Current Default Fee Schedule....: 35//
Create Bills for all Patients...: IP//
Always Display Beneficiary Patient: YES//
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)...: IHH//
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-2006//
VA STATION NUMBER: 638//
VA CONTRACT NUMBER: VA-638-IHS-0001//
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)....: 180//
UNCODED DX LAG TIME (DAYS): 180//
USE A/R PARENT SATELLITE SET-UP?: NO//
USE NPI OF:
MEDICARE PART B?...........:
MAMMOGRAPHY CERTIFICATION: 10101010//
ISA08 VALUE:
DEFAULT DENTAL CODE PREFIX......: D//
STATEMENT HEADER PRINT:
PRINT STATEMENT DATE: YES//
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.......: 9//

Select CLAIM PAGE(s) TO BE SKIPPED:
PAGE 9 REMARKS:
Send Payment to Provider (see Block 1)

  Edit? NO//
```

Figure 2-21:Site Parameter Edit Displaying the VA Contract Number and VA Station Number

2.6 Cashiering Options Modifications

ABM > UCSH

The following section outlines changes to the Cashiering Sessions Option.

2.6.1 Cashiering Sign In/Sign Out

ABM > UCSH > CIO

The UFMS Cashiering Sessions option has been updated to capture claims and/or bills where the Active Insurer has been assigned for new Insurer Types.

The following screen capture shows how the new Insurer Types are listed when signing out of Cashiering mode.

> **Note**: The new Insurer Type must be mapped at both the IHS Integration Engine (HUB) and the financial system (UFMS). Approving claims to these new Insurer Types without prior setup will result in errors at the HUB or UFMS. Contact Finance for further guidance.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
          +              Cashiering Sign In/Sign Out                +
          |                 INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: STOUT,CINDY                          5-APR-2013 10:11 AM

YOU ARE SIGNING *OUT* FOR BILLING

Will now check for any "missing" claims/bills...

No "missing" bills found

          Billing Activity      COUNT        TOTAL

     FPL 133 PRECENT
          - Cancelled Claims     1
          - Approved Bills       2      $    600.00
          - Cancelled Bills      1      $    450.00
     MCR PART C
          - Cancelled Claims     1
          - Approved Bills       2      $    201.00
          - Cancelled Bills      1      $    150.00
     MCR MANAGED CARE
          - Cancelled Claims     1
          - Approved Bills       2      $    600.00
          - Cancelled Bills      1      $    300.00
     STATE EXCHANGE PLAN
          - Cancelled Claims     1
          - Approved Bills       2      $    300.00
          - Cancelled Bills      1      $    150.00
     TRIBAL SELF INSURED
```

```
          - Cancelled Claims     1
          - Approved Bills       2      $    300.00
          - Cancelled Bills      1      $    150.00
     VETERANS ADMINISTRATION
          - Cancelled Claims     1
          - Approved Bills       2      $    300.00
          - Cancelled Bills      1      $    150.00
-------------------------------------------------------------------------------
  TOTAL CANCELLED CLAIMS:        6
  TOTAL CANCELLED BILLS:         6      $  1,350.00
  TOTAL APPROVED:                12     $  2,301.00
  TOTAL EXCLUDED:                0      $      0.00

 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

     Done...
        the session 3130405.1001 will be sent to your manager for processing.

     Signing out of session 3130405.1001

View detail? YES

Enter DEVICE: HOME//
```

Figure 2-22: Display of the Cashiering Sign-Out Option

2.6.2 View Cashiering Sessions

ABM > UCSH > UVCH

The View Cashiering Session option was updated to show all new insurer types. Users will be able to select an open session

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
           +               View Cashiering Session                   +
           |                INDIAN HEALTH HOSPITAL                   |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: STOUT,CINDY                        26-APR-2013 4:35 PM

The following SESSIONS are currently OPEN =>

   (*)  Indicates no activity in session.

      SESSION ID   CASHIER                     DATE OPENED
-------------------------------------------------------------------------------
1.  3130417.09585  SMITH,CHERYL                04/17/2013@09:58
2.  3130417.154106 STOUT,CINDY                 04/17/2013@15:41
3.  3130418.132322 RENDER,SHONDA               04/18/2013@13:23
4.  3130424.140937 POS CLAIMS                  04/24/2013@14:09


Select Session Number to View: :  (1-4): 2
```

Figure 2-23: Display of View Cashiering Option when Selecting a Session to Close

Viewing one Session ID will display the activity of the user by Insurer Type.

```
Session detail for Session ID: 3130417.154106   Date opened: 04/17/2013@15:41
Cashier: STOUT,CINDY
-------------------------------------------------------------------------------
     MEDICAID FI
               - Cancelled Claims       0
               - Approved Bills         5          $  1,082.00
               - Cancelled Bills        3          $    450.00
     FPL 133 PRECENT
               - Cancelled Claims       0
               - Approved Bills         1          $     65.00
               - Cancelled Bills        0          $      0.00
     MCR PART C
               - Cancelled Claims       0
               - Approved Bills         1          $     65.00
               - Cancelled Bills        0          $      0.00
     MCR MANAGED CARE
               - Cancelled Claims       0
               - Approved Bills         1          $     65.00
               - Cancelled Bills        0          $      0.00
     PRIVATE
               - Cancelled Claims       2
               - Approved Bills         5          $  1,374.00
               - Cancelled Bills        0          $      0.00
     MEDICARE FI
               - Cancelled Claims       0
               - Approved Bills         2          $    423.00
               - Cancelled Bills        0          $      0.00
     STATE EXCHANGE PLAN
               - Cancelled Claims       0
               - Approved Bills         1          $     65.00
               - Cancelled Bills        0          $      0.00
     TRIBAL SELF INSURED
               - Cancelled Claims       0
               - Approved Bills         1          $     65.00
               - Cancelled Bills        0          $      0.00
     VETERANS ADMINISTRATION
               - Cancelled Claims       0
               - Approved Bills         1          $     65.00
               - Cancelled Bills        0          $      0.00
     WORKMEN'S COMP
               - Cancelled Claims       0
               - Approved Bills         4          $    357.00
               - Cancelled Bills        0          $      0.00
```

Figure 2-24: Closing the Session and Viewing the Bill Activity Sorted by Insurer Type

The detail of the cashiering session will display a list of bills by Insurer Type. The new Insurer Type will be listed along with the bills approved to that Type.

```
View detail? YES

Enter DEVICE: HOME//   Virtual


                       UFMS VIEW CASHIERING SESSION DETAIL           Page: 1
SESSION ID: 3130417.154106
BILLER: STOUT,C
```

```
(*) Indicates bills that will be excluded from export

LOC  BILL#      HRN     PATIENT                APPROVE DT    DOS       BILL AMT
-------------------------------------------------------------------------------

MEDICAID FI
  -APPROVED BILLS - 5     $  1,082.00
IHH  31508B   6038    PIPER,PETER            04/18/2013 04/02/2013     150.00
IHH  31508C   6038    PIPER,PETER            04/18/2013 04/02/2013     150.00
IHH  31508D   6038    PIPER,PETER            04/18/2013 04/02/2013     150.00
IHH  31649A   6051    RACOON,ROCKY           04/23/2013 04/16/2013     316.00
IHH  31651A   6051    RACOON,ROCKY           04/23/2013 04/20/2013     316.00
  -CANCELLED BILLS - 3   $    450.00
IHH  31508A   6038    PIPER,PETER            04/08/2013 04/02/2013     150.00
IHH  31508B   6038    PIPER,PETER            04/18/2013 04/02/2013     150.00
IHH  31508C   6038    PIPER,PETER            04/18/2013 04/02/2013     150.00
FPL 133 PRECENT
  -APPROVED BILLS - 1     $     65.00
IHH  31677A   456     BEGAY,LINDA            04/26/2013 04/13/2013      65.00

MCR PART C
  -APPROVED BILLS - 1     $     65.00
IHH  31675A   19167   CHEVAZ,MICHAEL JOHN    04/26/2013 04/15/2013      65.00

MCR MANAGED CARE
  -APPROVED BILLS - 1     $     65.00
IHH  31676A   13949   BALYDYTTU,KARA LEE     04/26/2013 04/13/2013      65.00
PRIVATE
  -CANCELLED CLAIMS - 2
IHH 31497   123567  DEMO,JOHN                04/24/2013 03/25/2013
IHH 31496   123567  DEMO,JOHN                04/24/2013 03/25/2013
  -APPROVED BILLS - 5     $  1,374.00
IHH  31623A   20723   SMYTH,GENEVIEVE        04/17/2013 04/16/2013     310.00
IHH  31636A   5205    WITCH,HAZEL            04/18/2013 04/03/2013     739.00
IHH  31637A   112345  MANN,SHORT             04/19/2013 04/01/2013     150.00
IHH  31638A   6074    MARKER,MARY            04/19/2013 04/15/2013     100.00
IHH  31632B   99109   HILL,JOE               04/19/2013 04/01/2013      75.00

MEDICARE FI
  -APPROVED BILLS - 2     $    423.00
IHH  31633A   99109   HILL,JOE               04/18/2013 04/01/2013     273.00
IHH  31632A   99109   HILL,JOE               04/19/2013 04/01/2013     150.00

STATE EXCHANGE PLAN
  -APPROVED BILLS - 1     $     65.00
IHH  31678A   33090   CHYQOYTU,ALBERT J      04/26/2013 04/13/2013      65.00

TRIBAL SELF INSURED
  -APPROVED BILLS - 1     $     65.00
IHH  31679A   35431   DELA,ABRAM             04/26/2013 04/16/2013      65.00

VETERANS ADMINISTRATION
  -APPROVED BILLS - 1     $     65.00
IHH  31680A   3225    GESHWEZRE,WILBURN RUFU 04/26/2013 04/13/2013      65.00

WORKMEN'S COMP
  -APPROVED BILLS - 4     $    357.00
IHH  31626A   5205    WITCH,HAZEL            04/17/2013 04/01/2013     162.00
IHH  31672A   6146    RAVEL,DEBORAH LADD     04/26/2013 04/15/2013      65.00
IHH  31673A   6146    RAVEL,DEBORAH LADD     04/26/2013 04/15/2013      65.00
```

```
IHH  31674A   6146    RAVEL,DEBORAH LADD     04/26/2013 04/15/2013      65.00


E N D   O F   R E P O R T
```

Figure 2-25: Viewing the Detail Report when Closing a Cashiering Session

2.7 Meaningful Use Stage 2

On September 4 2012, CMS published a final rule that specifies the Stage 2 criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to continue to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. All providers must achieve meaningful use under the Stage 1 criteria before moving to Stage 2.

Additional guidance may be found on the CMS.gov website: http://cms.hhs.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

Some of the highlights of these changes will be found in the Third Party Billing Meaningful Use Reports based on the following:

- CMS finalized an adjustment in the Medicaid Patient Volume calculation. For a provider to be eligible for the Medicaid EHR Incentives, he/she must meet the individual state's requirements for calculating the Medicaid volume threshold.
  - Under the Stage 2 Final Rule, this calculation is expanded to include Title XXI-funded Medicaid expansion encounters, but not separate Children's Health Insurance Programs (CHIPs).
- The Final Rule for Stage 1 Meaningful Use sets the general threshold per provider at 30 percent. Pediatricians still qualify with a reduced threshold, as low as 20 percent, although the incentive will be reduced by one-third. Pediatricians that meet the 30 percent volume threshold would be eligible for the full incentive. Additionally, providers performing more than 50 percent of their services to a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC) are afforded special considerations in the calculation. Under Stage 1 the EP would use a 90-day date range for the previous calendar year.
  - Under the Stage 2 Rule, the look back period to make this calculation has been changed to the 12 months preceding attestation and is no longer tied to a calendar year.

2.7.1 Meaningful Use Stage 2 Menu

Modifications have been made to Third Party Billing to fulfill the Stage 2 of the Meaningful Use reporting requirements. This includes adding a new menu to the Meaningful Use Reports option to allow Stage 2 reports to run. This is identified by the PARTICIPATION CY 2013+ PATIENT VOLUME REPORTS option.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
           +                 MEANINGFUL USE REPORTS                  +
           |                 INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: LUJAN,ADRIAN M                    11-JUL-2013 1:35 PM


   CEMU   PATIENT COUNTS & % BY ELIGIBILITY
   FEIR   Facility EHR Incentive Report
   MUS1   PARTICIPATION CY 2011/2012 PATIENT VOLUME REPORTS ...
   MUS2   PARTICIPATION CY 2013+ PATIENT VOLUME REPORTS ...

Select MEANINGFUL USE REPORTS Option:
```

Figure 2-26: Meaningful Use Reports Option Displaying New Menu Option

In addition to the newly added menu, the old menu labeled MUPV - PATIENT VOLUME REPORTS has been renamed to MUS1 – PARTICIPATION CY 2011/2012 PATEINT VOLUME REPORTS. All logic and menu items found in the old PATIENT VOLUME REPORTS option has been transferred to the PARTICIPATION CY 2011/2012 PATIENT VOLUME REPORTS for those sites that need to provide proof of attestation for the prior year.

2.7.2 Facility EHR Incentive Report

ABM > RPTP > MURP > FEIR

A LOOKBACK DATE prompt and FACILITY or HOSPITAL report have been added to the EHR Incentive Report. The LOOKBACK DATE will allow the user to select any date prior to today, and will calculate back one year for the start date of the report. If the user selects FACILITY, the output will be what it was before. If HOSPITAL is selected, the report will display a limited number of records from the facility report.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
           +             Facility EHR Incentive Report               +
           |                 INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: SMITH,CHERYL                      19-JUN-2013 9:24 AM

This report will calculate the number of Covered Inpatient days for Medicare,
Medicaid, and Private Insurance.  Outpatient All-Inclusive Rate (AIR) bills are
counted.  A report can be selected to view the bills used in the calculations.




     Select one of the following:

          F         FISCAL YEAR
          D         DATE RANGE
          L         LOOKBACK DATE
```

```
Run report by FISCAL YEAR, DATE RANGE, or LOOKBACK DATE: FISCAL YEAR// LOOKBACK DATE

Enter ENDING Date:  123112  (DEC 31, 2012)

     Select one of the following:

          F         FACILITY EHR INCENTIVE REPORT (COST REPORT)
          H         HOSPITAL CALCULATION MU INCENTIVE REPORT

Select the type of report to run: HOSPITAL CALCULATION MU INCENTIVE REPORT


     Select one of the following:

          S         SUMMARY
          D         DETAIL
          B         BOTH

SUMMARY, DETAIL, or BOTH: SUMMARY// BOTH

There will be two outputs, one for SUMMARY and one for DETAIL.
The first one should be a terminal or a printer.
The second forces an HFS file because it could be a large file



Output DEVICE: HOME//   Virtual
```

Figure 2-27: Selection Criteria for the Facility EHR Incentive Report

The Lookback criteria in the Report will only print the Inpatient Data (IP) by category. References to Outpatient Charges, both Itemized and All Inclusive, as well as Inpatient Newborn Charges and Inpatient Charges have been removed. Running the report by Fiscal Year or Date Range will print the removed categories.

```
==========================================================================
HOSPITAL CALCULATION MU INCENTIVE REPORT        JUN 19,2013@09:24:57   Page 1
Lookback Date Range: 01/01/2012 to 12/31/2012
Billing Location: INDIAN HOSP
==========================================================================
                                                              # Discharges
--------------------------------------------------------------------------
                           -- M E D I C A R E --
    # Paid MEDICARE IP Discharges                                     125
    # Paid MEDICARE IP Newborn Discharges                               0
    # Paid MEDICARE IP Bed Days                                       619
    # Paid MEDICARE IP Newborn Bed Days                                 0

                           -- M E D I C A I D --
    # Paid MEDICAID IP Discharges                                     159
    # Paid MEDICAID IP Newborn Discharges                              59
    # Paid MEDICAID IP Bed Days                                       524
    # Paid MEDICAID IP Newborn Bed Days                               163

                   -- P R I V A T E  I N S U R A N C E --
    # Paid PRIVATE IP Discharges                                        7
    # Paid PRIVATE IP Newborn Discharges                                1
    # Paid PRIVATE IP Bed Days                                         26
```

```
    # Paid PRIVATE IP Newborn Bed Days                                    2

                        -- K I D S C A R E / C H I P --
    # Paid KIDSCARE/CHIP IP Discharges                                   56
    # Paid KIDSCARE/CHIP IP Newborn Discharges                           12
    # Paid KIDSCARE/CHIP IP Bed Days                                    224
    # Paid KIDSCARE/CHIP IP Newborn Bed Days                             87

                                -- O T H E R --
    # Paid OTHER IP Discharges                                           3
    # Paid OTHER IP Newborn Discharges                                   2
    # Paid OTHER IP Bed Days                                             6
    # Paid OTHER IP Newborn Bed Days                                     4


(SUMMARY REPORT COMPLETE):

Enter RETURN to continue or '^' to exit:

(REPORT COMPLETE):
```

Figure 2-28: Printout of the Facility EHR Incentive Report by Summary

After the Summary Report is printed, the printing criteria for the Detailed Report will display. The report will be sent to the Host File. This report can be imported into Excel as a delimited file to view.

```
Will now write detail to file


Enter Path: c:\pub//
Enter File Name: FEIR061913

Creating file...DONE
```

Figure 2-29: Running the Detailed Facility EHR Incentive Report to the Host File

2.7.3 Meaningful Use Participation Patient Volume Reports

ABM > RPTP > MURP

Several changes have been made to the patient volume reports. The existing report menu has been changed to include CY 2011/2012 reports. A new report option for meaningful use stage 2 has also been added.

2.7.4 Participation CY 2011/2012 Patient Volume Reports

ABM > RPTP > MURP > MUS1

A message has been added to the 2011/2012 reports. If the user selects 2013 as the Participation year, they will receive a note that they should use the CY2013 reports and then it will exit out of the option.

```
Enter the Participation year for this report: 2013

     **NOTE** For CY 2013+, you should use report options within menu
               MUS2 PARTICIPATION CY 2013+ PATIENT VOLUME REPORTS
```

Figure 2-30: Message Alerting the User to Run the Report that Best Reflects the Year of the Report

2.7.5 MUS2 Parameter Set-Up

ABM > RPTP > MURP > MUS2 > MUP2

Although an option has been placed into the 2013+ Patient Volume Reports, the set up done previously in the Stage 1 reports will be carried over to the Stage 2 reports.

The report parameters have to be set up in MUS2 (just like with Stage 1) prior to generating the patient volume reports. This includes designating a facility as an FQHC, RHC, or Tribal Clinic and adding additional Eligible Professionals (EP) for a state.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
           +     PARTICIPATION CY 2013+ PATIENT VOLUME REPORTS       +
           |                  INDIAN HEALTH HOSPITAL                 |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: SMITH,CHERYL                       10-JUN-2013 7:37 AM


   MUP2   Report Parameters
   PVP2   Patient Volume Report for Eligible Professionals
   EP2    EP Class - List of Eligible Professionals
   PVH2   Patient Volume Report for Eligible Hospitals
   DEF2   EP Reports Definitions List
   MUPV   View Report Parameters

Select PARTICIPATION CY 2013+ PATIENT VOLUME REPORTS Option: MUP2  Report Parameters

           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
           +                  Report Parameters                      +
           |                  INDIAN HEALTH HOSPITAL                 |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
User: SMITH,CHERYL                       10-JUN-2013 7:38 AM

You are setting up the Report Parameters.  Once completed, you will not be able to
edit.
Continue? N// YES
Do you wish to designate a Facility as an FQHC, RHC or Tribal clinic? NO

Some states consider Optometrists, Podiatrists, etc., as Physicians.

The next prompt will allow the identification of these provider classes as
EP types to generate volume reports.

Please note: Defaults have been provided so there are already entries in this
file that don't need to be entered again.
Are there additional EP types for your state? NO
```

```
Press RETURN to continue...
```

Figure 2-31: Setting Up Report Parameters for the Meaningful Use Reports

Once the parameters have been setup, the user must contact OIT to make changes. If setup has been previously completed, the option will display the current setup for the reports. Again, the Stage 1 set up will be moved to the Stage 2 reports so sites that are comfortable with their parameters need not set up anything more.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
           +     PARTICIPATION CY 2013+ PATIENT VOLUME REPORTS       +
           |                  INDIAN HEALTH HOSPITAL                 |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: SMITH,CHERYL                       29-APR-2013 8:52 AM


   MUP2   Report Parameters
   PVP2   Patient Volume Report for Eligible Professionals
   EP2    EP Class - List of Eligible Professionals
   PVH2   Patient Volume Report for Eligible Hospitals
   DEF2   EP Reports Definitions List
   MUPV   View Report Parameters

Select PARTICIPATION CY 2013+ PATIENT VOLUME REPORTS Option: MUP2  Report Parameters


           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
           +                   Report Parameters                     +
           |                  INDIAN HEALTH HOSPITAL                 |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
User: SMITH,CHERYL                       29-APR-2013 8:52 AM

Setup has already been done.  Contact OIT if changes need to be made

Will display current setup next...

Enter RETURN to Continue:

                       *** 3P MU PARMETER FILE INQUIRY ***

===============================================================================
PATIENT VOLUME: PATIENT VOLUME          SETUP COMPLETE: YES
PROVIDER CLASS: MD  00
PROVIDER CLASS: PHYSICIAN ASSISTANT  11 *At a PA Led FQHC/RHC only
PROVIDER CLASS: PEDIATRIC NURSE PRACTITIONER  16
PROVIDER CLASS: NURSE MIDWIFE  17
PROVIDER CLASS: CONTRACT PHYSICIAN  18
PROVIDER CLASS: NURSE PRACTITIONER  21
PROVIDER CLASS: CONTRACT OB/GYN  41
PROVIDER CLASS: TRIBAL PHYSICIAN  44
PROVIDER CLASS: OSTEOPATHIC MEDICINE  45
PROVIDER CLASS: CONTRACT PSYCHIATRIST  49
PROVIDER CLASS: DENTIST  52
PROVIDER CLASS: NEPHROLOGIST  64
PROVIDER CLASS: EMERGENCY ROOM PHYSICIAN  68
PROVIDER CLASS: CARDIOLOGIST  70
```

```
PROVIDER CLASS: INTERNAL MEDICINE  71
PROVIDER CLASS: OB/GYN  72
PROVIDER CLASS: ORTHOPEDIST  73
PROVIDER CLASS: OTOLARYNGOL  74
PROVIDER CLASS: PEDIATRICIAN  75
PROVIDER CLASS: RADIOLOGIST  76
PROVIDER CLASS: SURGEON  77
PROVIDER CLASS: UROLOGIST  78
PROVIDER CLASS: OPHTHALMOLOGIST  79
PROVIDER CLASS: FAMILY PRACTICE  80
PROVIDER CLASS: PSYCHIATRIST  81
PROVIDER CLASS: ANESTHESIOLOGIST  82
PROVIDER CLASS: PATHOLOGIST  83
PROVIDER CLASS: NEUROLOGIST  85
PROVIDER CLASS: DERMATOLOGIST  86
PROVIDER CLASS: SPORTS MEDICINE PHYSICIAN  A1
PROVIDER CLASS: HEPATOLOGIST  A9
PROVIDER CLASS: GASTROENTEROLOGIST  B1
PROVIDER CLASS: ENDOCRINOLOGIST  B2
PROVIDER CLASS: RHEUMATOLOGIST  B3
PROVIDER CLASS: ONCOLOGIST-HEMATOLOGIST  B4
PROVIDER CLASS: PULMONOLOGIST  B5
PROVIDER CLASS: NEUROSURGEON  B6
PROVIDER CLASS: OPTOMETRIST  08
================================================================================

Press RETURN to continue...
```

Figure 2-32: Display of the Meaningful Use Report Parameters after Setup Complete

2.7.6 MU Site Parameters

ABM > RPT > MURP > MUS2 > MUPV

An option to view the MU report parameters has been added to MUS2 menu. This allows the user to view what is in the 3p MU parameters file both before and after setup is complete. Regardless of which option the setup is completed at (MUS1 or MUS2), the system will reference the same setup.

```
                      *** 3P MU PARMETER FILE INQUIRY ***
================================================================================
PATIENT VOLUME: PATIENT VOLUME          SETUP COMPLETE: YES
PROVIDER CLASS: MD  00
PROVIDER CLASS: PHYSICIAN ASSISTANT  11 *At a PA Led FQHC/RHC only
PROVIDER CLASS: PEDIATRIC NURSE PRACTITIONER  16
PROVIDER CLASS: NURSE MIDWIFE  17
PROVIDER CLASS: CONTRACT PHYSICIAN  18
PROVIDER CLASS: NURSE PRACTITIONER  21
PROVIDER CLASS: CONTRACT OB/GYN  41
PROVIDER CLASS: TRIBAL PHYSICIAN  44
PROVIDER CLASS: OSTEOPATHIC MEDICINE  45
PROVIDER CLASS: CONTRACT PSYCHIATRIST  49
PROVIDER CLASS: DENTIST  52
PROVIDER CLASS: NEPHROLOGIST  64
PROVIDER CLASS: EMERGENCY ROOM PHYSICIAN  68
PROVIDER CLASS: CARDIOLOGIST  70
PROVIDER CLASS: INTERNAL MEDICINE  71
```

```
PROVIDER CLASS: OB/GYN  72
PROVIDER CLASS: ORTHOPEDIST  73
PROVIDER CLASS: OTOLARYNGOL  74
PROVIDER CLASS: PEDIATRICIAN  75
PROVIDER CLASS: RADIOLOGIST  76
PROVIDER CLASS: SURGEON  77
PROVIDER CLASS: UROLOGIST  78
PROVIDER CLASS: OPHTHALMOLOGIST  79
PROVIDER CLASS: FAMILY PRACTICE  80
PROVIDER CLASS: PSYCHIATRIST  81
PROVIDER CLASS: ANESTHESIOLOGIST  82
PROVIDER CLASS: PATHOLOGIST  83
PROVIDER CLASS: NEUROLOGIST  85
PROVIDER CLASS: DERMATOLOGIST  86
PROVIDER CLASS: SPORTS MEDICINE PHYSICIAN  A1
PROVIDER CLASS: HEPATOLOGIST  A9
PROVIDER CLASS: GASTROENTEROLOGIST  B1
PROVIDER CLASS: ENDOCRINOLOGIST  B2
PROVIDER CLASS: RHEUMATOLOGIST  B3
PROVIDER CLASS: ONCOLOGIST-HEMATOLOGIST  B4
PROVIDER CLASS: PULMONOLOGIST  B5
PROVIDER CLASS: NEUROSURGEON  B6
PROVIDER CLASS: OPTOMETRIST  08
====================================================================
```

Figure 2-33: Meaningful Use Parameter File Inquiry

2.7.7 Patient Volume Reports

ABM > RPTP > MURP>– MUS2

Patient Volume Reports for Eligible Professionals and a Patient Volume Report for Eligible Hospitals have been added to the Participation CY2013+ Patient Volume Report menu. The reports are similar to the reports for CY2011/2012 but additional options have been added to these reports.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p11          |
           +     PARTICIPATION CY 2013+ PATIENT VOLUME REPORTS       +
           |                 INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: SMITH,CHERYL                       30-APR-2013 1:00 PM


   MUP2   Report Parameters
   PVP2   Patient Volume Report for Eligible Professionals
   EP2    EP Class - List of Eligible Professionals
   PVH2   Patient Volume Report for Eligible Hospitals
   DEF2   EP Reports Definitions List
   MUPV   View Report Parameters

Select PARTICIPATION CY 2013+ PATIENT VOLUME REPORTS Option:
```

Figure 2-34: 2013+ Patient Volume Reports Menu

2.7.7.1 Report Selection Criteria

The PVP2 and the PVH2 reports have two additional reporting periods to select from:

- D – AUTOMATED 90-DAY PERIOD WITHIN THE LAST 12 MONTHS
  - D will use the attestation date and will look back through 12 months of data for the first/highest 90-day window.
- E – SPECIFIC 90-DAY PERIOD WITHIN THE LAST 12 MONTHS.
  - E will prompt you for an end date, then will calculate back 90 days and report.

```
    Select one of the following:

          A         Automated 90-Day Report
          B         Specific 90-Day Report Period
          C         User specified Report Period
          D         Automated 90-Day Period within the last 12 months
          E         Specific 90-Day Period within the last 12 months

Enter selection: Automated 90-Day Report
```

Figure 2-35: Display of the Meaningful Use Report Parameters

A prompt has also been added to the reports when AUTOMATED is selected, asking if the user wants the HIGHEST or FIRST 90-day window that is found. This is for both the PVP2 and PVH2 options.

```
     Select one of the following:

          F         First 90-day period found
          H         Highest 90-day period found


Enter selection: F//
```

Figure 2-36: Display of the First 90-Day or Highest 90-Day Period Sort Parameter

SCHIP plans included in the Medicaid Expansion program can now be included in the patient volume reports. The reports will automatically include SCHIP Insurance Type 'K' billed as either Medicaid or Private Insurance. The user will now have the option to add additional SCHIP payers, remove SCHIP payers, or not to include any SCHIP entries in the report. Pressing the Enter key will allow the listed SCHIP plans to be included on the report.

```
EP calculations can include any SCHIP visits that are part of a Medicaid
expansion program.  Visits for stand-alone SCHIP programs cannot be included
in the calculation.  The following list of insurers will be included unless
otherwise specified.
A breakdown of categories will be provided.

Report will include the following insurers that hold the SCHIP Insurer Type:
     1. KIDSCARE
     2. MSCHIP
     3. BLUECHIP
```

```
     Select one of the following:

          A         Add Additional SCHIP Payers
          R         Remove SCHIP Payers from List
          N         Do NOT count any SCHIP entries in the report

Would you like to Add or Remove (A/R/N): Add Additional SCHIP Payers
Select Insurer: BCBS OF NEW MEXICO
( BLUE/BLUECHIP/BLUECROSS/BLUESHIELD CROSS/CROSSBONES/CROSSE MEXICO NEW SHIELD )

The following matches were found:

  1: NEW MEXICO BC/BS INC            - P.O. BOX 27630                 Domain: NM
                                       ALBUQUERQUE, NM 87125-7630
  2: BCBS OF NEW MEXICO              - POST OFFICE BOX 27630
                                       ALBUQUERQUE, NM 87125-7630

Select 1-2: 1
  <ADDED>
```

Figure 2-37: Report Parameters Display Allowing for the Inclusion of SCHIP Insurers

2.7.8 Modified Patient List

ABM > RPTP > MURP > MUS2 > PVP2

The Patient List format provides detailed information for each patient encounter. A new option has been added when printing the patient list to print a delimited report to a host file. This option will write an "^"-delimited file to the specified directory and includes:

- Visit Location
- Full Patient Name
- Chart Number
- Policy Holder ID
- Service Category
- Clinic
- Insurer Type
- Billed to (Insurer)
- Date of Service
- Date Paid
- Indicator (*) if claim was paid my Medicaid/SCHIP
- Bill Number
- Payment Amount
- Primary POV

- Eligibility flags for PRVT, MCR, MCD, RR and Needy Individual

2.7.9 Not Met Report

ABM > RPTP > MURP > MUS2 > PVH2

The output has changed for the Not Met report to only report one date range per line. The one line will now have a breakdown of the numerator, including paid Medicaid/SCHIP, Zero-paid Medicaid/SCHIP, and enrolled Medicaid/SCHIP.

```
                SUMMARY OF PATIENT VOLUME REPORT TO BE GENERATED


Report Name: Patient Volume Report for Eligible Hospitals
The date ranges for this report are:
   Participation Year: 2014
   Qualification Year: 2013
Reporting Period: Automated First 90-day

Report Method Type: Hospital/ER

SCHIP insurers included:
     KIDSCARE
     MSCHIP
     BLUECHIP

Facility(s):
   INDIAN HEALTH CENTER
   INDIAN HEALTH HOSPITAL
   MERCY MEDICAL CENTER HOSPITAL
   HOME
   AMBULANCE

     Select one of the following:

          P         Print Report
          R         Return to Selection Criteria -Erases ALL previous selections

<P> to Print or <R> to Reselect: Print Report


Output DEVICE: HOME//   Virtual

VISITS....
BILLS...
ENROLLED...

          IHS Meaningful Use Patient Volume Report - Hospital          Page 1
                      Minimum Patient Volume NOT Achieved
                       Report Run Date:  05/01/2013@14:21
                       Report Generated by: SMITH,CHERYL

Participation Federal fiscal year: 2014
Qualification Federal fiscal year: 2013
First Reporting Period Identified: 10/01/2012 thru 12/29/2012

SCHIP insurers included:
     KIDSCARE
```

```
     MSCHIP
     BLUECHIP

Hospital used in this report: INDIAN HEALTH CENTER


The Patient Volume Threshold (10% for Hospitals) was not met for the MU
Qualification year.  Details for the volumes that were achieved are provided
for your information.

Highest Patient Volume Met: 0
First Day Highest Patient Volume Achieved: 10/01/2012

Patient Volume for the Qualification Year was calculated using the Medicaid
calculation method for the hospital and includes ER encounters

Total Patient Encounters of First Highest Patient Volume Period: 0
Total Hospital Encounters of First Highest Patient Volume Period: 0



          IHS Meaningful Use Patient Volume Report - Hospital          Page 2
                      Minimum Patient Volume NOT Achieved
                       Report Run Date:  05/01/2013@14:21
                       Report Generated by: SMITH,CHERYL

=====================================================================
HOSPITAL PATIENT VOLUME - QUALIFICATION YEAR 2013
Report Period  Rate  Denom-   Numer-  Mcd   Mcd     Mcd   Schip Schip    Schip
                     inator   ator   Paid ZeroPd Enrolled  Paid ZeroPd Enrolled
=============================================================================
21 OCT-18 JAN      0%     0      0      0     0        0      0     0          0
22 OCT-19 JAN      0%     0      0      0     0        0      0     0          0
23 OCT-20 JAN      0%     0      0      0     0        0      0     0          0
24 OCT-21 JAN      0%     0      0      0     0        0      0     0          0
25 OCT-22 JAN      0%     0      0      0     0        0      0     0          0
26 OCT-23 JAN      0%     0      0      0     0        0      0     0          0
27 OCT-24 JAN      0%     0      0      0     0        0      0     0          0
28 OCT-25 JAN      0%     0      0      0     0        0      0     0          0
29 OCT-26 JAN      0%     0      0      0     0        0      0     0          0
30 OCT-27 JAN      0%     0      0      0     0        0      0     0          0
```

Figure 2-38: Display of the Patient Volume Report

2.7.10 Report Calculations

Eligible professionals can use a “needy individual” definition for paid and zero paid, Medicaid enrolled, and CHIP encounters to use for the Patient Volume report. FQHC/RHC/Tribal facilities may also add the uncompensated care and sliding fee to their patient volume.

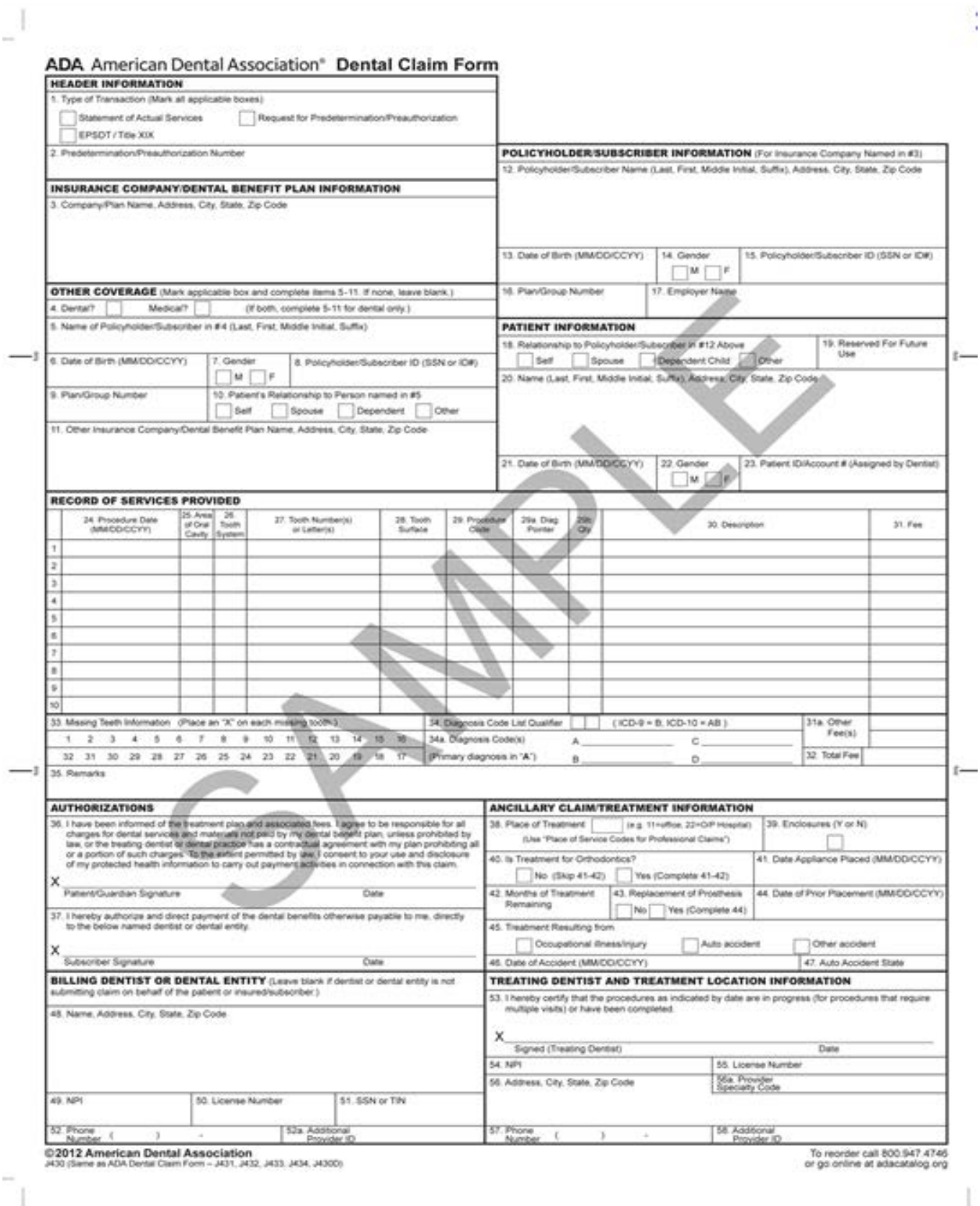
Please check with your state to confirm other types of “needy” encounters which are authorized to be included in the final volume counts for your site.

Sites are also being allowed to round up on the Patient Volume Reports. Checks have been updated for the percentages to be 29.5 or greater for EP’s and 9.5 or greater for EH’s.

The formula for calculating the numerator and denominator is listed below:

$$\frac{\text{Medicaid Paid + Medicaid Zero Pay + Medicaid Enrolled + SCHIP Paid + SCHIP Zero Pay + SCHIP Enrolled + Uncompensated}}{\text{Total Encounters}}$$

Appendix A: ADA-2012 Sample Claim Form



ADA American Dental Association® **Dental Claim Form**

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ ☐ (ICD-9 = B, ICD-10 = AB)
34a. Diagnosis Code(s) A ____ C ____ (Primary diagnosis in "A.") B ____ D ____
31a. Other Fee(s)
32. Total Fee
35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X ____ Patient/Guardian Signature ____ Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X ____ Subscriber Signature ____ Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ____ (e.g. 11=office, 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
49. NPI | 50. License Number | 51. SSN or TIN
52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X ____ Signed (Treating Dentist) ____ Date
54. NPI | 55. License Number
56. Address, City, State, Zip Code | 56a. Provider Specialty Code
57. Phone Number ( ) - | 58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J4300)

To reorder call 800.947.4746 or go online at adacatalog.org

Appendix B: Modified Patient List

Visit Location	Patient	Chart#	Policy Holder ID	Serv Cat	Clinic	Provider	Ins Type	BilledTo	Date Of Service	Date Paid	Medicaid/ SchipPaid	Bill#	Payment	Primary POV	PRVT	MCR	MCD	CHIP	RR	Needy Indiv.
INDIAN HOSP	DEMO, ANN	34783	585114949	AMBULATORY	GENERAL	1497849186		NEW MEXICO MEDICAID	06/28/2011 @13:02	2/29/2012		30939A-IH-34783	0	915.7	N	N	Y	N	N	N
INDIAN HOSP	DEMO, JOHN	123567	A231456789	AMBULATORY	RESPIRATORY CARE	1497849186		NOT BILLED	04/11/2011 @14:00						Y	N	Y	N	N	N

Acronym List

ADA	American Dental Association
A/R or AR	Accounts Receivable
CAH	Critical Access Hospital
CHIPs	Children's Health Insurance Programs
CPT	Current Procedural Terminology
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EP	Eligible Provider
ERA	Electronic Remittance Advice
FQHC	Federally Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System
ICD	International Classification of Disease
IHS	Indian Health Service
MCD	Medicaid
MCR	Medicare
MU	Meaningful Use
NPI	National Provider Identifier
OIT	Office of Information Technology
POS	Place of Service (CMS-1500 code)
POS	Point of Sale (Pharmacy)

POV	Purpose of Visit
RHC	Rural Health Clinic
RPMS	Resource and Patient Management System
RR	Railroad Retirement
SCHIP	State Children's Health Insurance Program
TDN	Treasury Deposit Number

Contact Information

If you have 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