Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 30
April 2020
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Preface

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

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

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

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

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

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1.0 Introduction

1.1 Summary of Changes

Patch 30 provides enhancements and minor corrections to Version 2.6 of the Third Party Billing application. This patch is not cumulative of prior released patches. Please refer to those patch addendums for additional information.

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

1.1.1 Patch 30

1. Change Request 8338 – HEAT 287500

A new cancel claim reason, EXCEEDS MAXIMUM VISITS ALLOWED, has been added to the 3P CANCEL CLAIM REASONS file. This new cancel claim reason is available in the Cancel Claim option as entry number 34 and will also display on the Cancelled Claims Report as appropriate.

2. Change Request 8717 – HEAT 277665

The following pages of the claim editor have been updated to allow for editing the Place of Service on individual charges: 8A (Medical), 8B (Surgical), 8E (Laboratory), 8F (Radiology), 8G (Anesthesia), and 8K (Ambulance). This change applies to claims that have a mode of export containing HCFA or CMS. For example, 837P (HCFA) 5010 and CMS-1500(02/12).

3. Change Request 8868 – HEAT 308002

The claim generator has been updated to use the diagnoses in the PRIMARY/SECONDARY field from Patient Care Component (PCC). When a diagnosis is labeled as primary in PCC, that diagnosis will be the primary diagnosis on the claim followed by any other diagnoses in the order they were entered on the visit. If the diagnoses on the PCC visit are changed, the Rebuild Items from PCC (RBCL) option can be used to update the diagnoses and their sequencing order on the claim in Third Party Billing.
4. Change Request 8870 – HEAT 308891

The UNITS field in the claim editor has been modified to allow up to three decimal places on pages 6A (Dental), 8A (Medical), 8B (Surgical), 8C (Revenue Code), 8F (Radiology), 8G (Anesthesia), 8H (Miscellaneous), 8J (Charge Master), and 8K (Ambulance). To accommodate this change, charge fields along with the total charges for each page have been expanded to display the additional digits without wrapping or overlapping into other fields. The Patient Statement option (REPT) has also been updated to allow the additional decimal places in the QTY column and to allow for six digits in the Amount column.

5. Change Request 8876/9866 – HEAT 305443/36809

Changes have been made to the 837 electronic claim format, SBR09 element for Loop 2320 (Other Subscriber) to report the correct relationship to the patient. Prior to patch 30, this segment would either be blank or report the incorrect relationship.

6. Change Request 8901 – HEAT 137034/178058/203070/236128

Changes have been made to report correct data when a patient has the same insurer twice. The 837 data will now report the correct policyholder, policy number, and payer responsibility. The Coordination of Benefits (COB) page in the claim editor will reflect accurate payment and adjustment amounts when billing a secondary insurer that has an electronic mode of export. The insurer status for the active insurer on a claim was also corrected to reflect Initiated so that, when the same insurer is being billed twice, only the active insurer will reflect Initiated.

7. Change Request 8939 – HEAT 310003

A new code was added to the 3P ERROR CODE file to alert users when a claim is missing an attending and/or rendering provider. The new code, 256 – ATTENDING AND/OR RENDERING PROVIDER MISSING, will display on page 4 of the claim editor.

8. Change Request 8975/9375 – HEAT 349007/471819/336550

The Test Forms Alignment (TSPR) option has been corrected to prevent the user from being kicked out with a programming error. The export modes included in this correction are the CMS-1500 (02/12), CMS-1500 (08/05), and the ADA-2012.
9. Change Request 9115 – HEAT 341586

The following insurer types have been mapped to the appropriate Claim Filing Indicator Code to ensure they are correctly populated in the SBR09 segment of an 837 file: 3P Liability, FPL 133 Percent, Guarantor, MCR Managed Care, MCR Part C, Non-Ben, State Exchange Plan, and Tribal Self Insured. Prior to patch 30, the SBR09 segment was not being populated when billing an insurer that had one of those insurer types specified.

10. Change Request 9263 – NO HEAT TICKET

Security keys have been added to two reports that contain the patient social security numbers. These reports are the Visits by Commissioned Officers and Dependents (VCRP) and the Summarized (multi-line) Claim Listing (SURP). The VCRP is locked with security key ABMDZ VCRP CO/DEP VISITS, and the SURP is locked with security key ABMDZ SURP SUMMARY CLM LIST. Users who had access to these reports prior to patch 30 will no longer have access unless they are assigned the appropriate security key(s).

11. Change Request 9457 – HEAT 352796

A correction was made to the Listing of Patient Eligibility Counts (PORP) report to ensure that Railroad Retirement will populate under the Medicare column of the report if the insurer type for Railroad Retirement is identified as Medicare FI in the insurer file.

12. Change Request 9872 – NO HEAT TICKET

A correction was made to the Charge Print Order Summary Screen in the claim editor to ensure that modifiers and anesthesia units display correctly. This correction is dependent on the following setup in the Insurer file: Insurer Type is set to Medicaid FI, Export Mode is set to 837I or UB-04, Visit Type is set to Itemized Billing, and the Display Print Order Screen is set to Yes.

13. Change Request 10215 – HEAT 392914

The default of 01-Discharged to Home has been removed from the Discharge Status field of the claim editor. The existing 3P ERROR CODE, 021 – PATIENT (DISCHARGE) STATUS UNSPECIFIED, has been changed from a warning to an error and will display when the Discharge Status field is blank for hospitalization and emergency room claims. A new 3P ERROR CODE, warning number 257, was added to alert users when a Discharge Status containing the word ‘expired’ is selected for claims that have an export mode of 837I or UB-04.
14. Change Request 10400 – HEAT 326962

A correction was made to the ‘Init Prosthesis Placed’ prompt on page 3 of the Claim Editor when billing a dental claim. This prompt now reads ‘Replace Prosthesis’ and only prompts the user for a Prior Placement Date if the prompt is answered with a Yes. This data populates in boxes 43 and 44 of the ADA-2012 and the ADA-2019 claim forms, if present on the claim.

15. Change Request 11053 – HEAT 470230

A correction was made to prevent a programming error in the claim editor when a claim contains a surgical CPT code that is missing the CPT CATEGORY. The Charge Summary page of the claim editor will automatically populate the Type of Service (TOS) with a 1 for these CPT codes.

16. Change Request 11171 – HEAT 479351

A new export mode was created in the 3P EXPORT MODE file for the ADA-2019 claim form. The Reprint Bill option was updated to allow for selecting the ADA-2019 when reprinting a claim that was approved with an export mode of 837D, and the Form Locator Override option was updated to allow for selecting the ADA-2019.
2.0 Patch 30

2.1 Claim Editor

2.1.1 Units and Charge Fields Expanded

The following claim editor pages have been updated to accommodate up to three decimals in the Units (QTY) field:

- 6 (Dental),
- 8A (Medical),
- 8B (Surgical),
- 8C (Revenue Code),
- 8F (Radiology),
- 8G (Anesthesia),
- 8H (Miscellaneous),
- 8J (Charge Master), and
- 8K (Ambulance).

To accommodate the additional decimal spaces, the Charge fields and Total Charge fields have been expanded to prevent wrapping onto the next line.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8K  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,DEMO  [HRN:12345]                         Claim Number: 987654
Mode of Export: 837I (UB) 5010
                                                     (AMBULANCE SERVICES)                      

<table>
<thead>
<tr>
<th>REVN CODE</th>
<th>HCPCS - AMBULANCE SERVICES</th>
<th>UNIT CHARGE</th>
<th>QTY</th>
<th>TOTAL CHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>540</td>
<td>A0021-RH-25-27 Outside state ambulance serv</td>
<td>500.00</td>
<td>1.585</td>
<td>792.50</td>
</tr>
</tbody>
</table>

CHARGE DATE: 02/22/2020

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

Figure 2-1: Example of Units (QTY) being populated with three decimal places

When a claim’s mode of export is 837 Institutional or 837 Professional, the Charge Summary screen displays the additional decimal places, if present on the claim. This does not apply to the 837 Dental as units do not display on the 837D Charge Summary screen.
### 837P (HCFA) 5010 Charge Summary

**Active Insurer:** NEW MEXICO BC/BS INC

* - Indicates time (minutes) instead of units

<table>
<thead>
<tr>
<th>Charge Date</th>
<th>POS</th>
<th>TOS</th>
<th>Description</th>
<th>Diag</th>
<th>Charge</th>
<th>Qty</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-12-19</td>
<td>12-12-19</td>
<td>22</td>
<td>12001</td>
<td>1,2</td>
<td>518.54</td>
<td>1.035</td>
</tr>
<tr>
<td>12-12-19</td>
<td>12-12-19</td>
<td>22</td>
<td>99215-25-27-57</td>
<td>1,2,4,5</td>
<td>761.13</td>
<td>1.589</td>
</tr>
<tr>
<td>12-12-19</td>
<td>12-12-19</td>
<td>22</td>
<td>74022-76</td>
<td>2</td>
<td>503.53</td>
<td>2.258</td>
</tr>
<tr>
<td>12-12-19</td>
<td>12-12-19</td>
<td>22</td>
<td>00140</td>
<td>2</td>
<td>100.00</td>
<td>60*</td>
</tr>
<tr>
<td>12-12-19</td>
<td>12-12-19</td>
<td>22</td>
<td>R&amp;B</td>
<td></td>
<td>39.73</td>
<td>1.589</td>
</tr>
<tr>
<td>12-12-19</td>
<td>12-12-19</td>
<td>22</td>
<td>J7030</td>
<td>4</td>
<td>106.56</td>
<td>3.33</td>
</tr>
</tbody>
</table>

**TOTAL CHARGE**

2,055.94

---

### 837I (UB) 5010 Charge Summary

**Active Insurer:** NEW MEXICO MEDICAID

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Units</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMBULANCE</td>
<td>0540</td>
<td></td>
<td>1,255.00</td>
</tr>
</tbody>
</table>

**TOTAL CHARGE**

1,255.00

---

Additional decimal places are populated in the 837D, 837I, and 837P if present on a claim’s charge(s).

---

### 837D Populated with Additional Decimal Places

---

### 837I Populated with Additional Decimal Places

---

**Figure 2-2:** Example of 837P (HCFA) 5010 Charge Summary page displaying additional decimal places

**Figure 2-3:** Example of 837I (HCFA) 5010 Charge Summary page displaying additional decimal places

---

**Figure 2-4:** Example of 837D populated with additional decimal places

**Figure 2-5:** Example of 837I populated with additional decimal places
Figure 2-6: Example of 837I populated with additional decimal places

The Patient Statement has been updated to allow additional decimal places to print in the QTY column. In addition, the Amount column has been expanded to accommodate a six-digit number.
2.1.2 Diagnosis Code Display

A modification was made to the Claim Generator that will now use the PRIMARY/SECONDARY field from the diagnosis file (V POV) within the PCC Visit. The field is usually populated for inpatient services. If no PRIMARY/SECONDARY entry has been added, the system will continue to use its current logic where the codes display in the claim editor based on entry into the visit file.

Figure 2-7: Example of units (QTY) being populated with three decimal places on the patient statement

<table>
<thead>
<tr>
<th>Your insurance has been billed (03/25/2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments or inquiries may be sent to:</td>
</tr>
<tr>
<td>2017 DEMO HOSPITAL</td>
</tr>
<tr>
<td>5300 HOMESTEAD NE</td>
</tr>
<tr>
<td>ALBUQUERQUE, NM  87110</td>
</tr>
<tr>
<td>5052481111</td>
</tr>
</tbody>
</table>

Figure 2-8: Display of Primary/Secondary indicator in the V POV file

2.1.3 New 3P ERROR Codes

Two new codes were added to the 3P ERROR CODE file.

- **Code 256** will alert users that a claim is missing an attending and/or rendering provider. Code 256 will display the following: ATTENDING AND/OR RENDERING PROVIDER MISSING. By default, this code will be reflected as an error upon patch installation but may be changed to a warning, if desired.

This code will display on page 4 of the claim editor when the claim is missing an attending and/or rendering provider.
**Code 257** was added to the 3P ERROR CODE file to alert users when a Discharge Status has been selected that contains the word ‘expired’ for claims that have an export mode of 837I or UB-04. Code 257 will display the following: Discharge Status contains ‘Expire’. By default, this code will be reflected as a warning upon patch installation but may be changed to an error, if desired.

---

**2.1.4 Default Removed from Discharge Status**

The default of 01 Discharged to Home has been removed from the Discharge Status field on page 3 of the claim editor. This field will now be blank and must be populated by the user, as appropriate.

If the Discharge Status is not populated for claims that have a bill type of 11#, or a Service Category of Hospitalization or In Hospital, or a clinic of Emergency Room, the following 3P ERROR CODE will display on page 3 of the claim editor: ERROR 021 – PATIENT DISCHARGE STATUS UNSPECIFIED. Prior to patch 30, this 3P ERROR CODE was a warning and was only displayed on page 7 of the claim editor.
### Questions

1. Release of Information..: YES
2. Assignment of Benefits..: YES
3. Accident Related.......: NO
4. Employment Related.......: NO
5. Emergency Room Required.: NO
6. Special Program.......: NO
7. Blood Furnished.(pints).: NO
8. Referring Phys. (FL17): 
9. Case No. (External ID)...:
10. PRO Approval Number...:
11. Type of Admission.......: 2 URGENT
12. Source of Admission.......: 2 CLINIC OR PHYSICIAN'S OFFICE
13. Discharge Status.......:
14. Admitting Diagnosis.......: E11.9 Type 2 diabetes mellitus without complications
15. Prior Authorization #....:
16. Delayed Reason Code.....:

---

**ERROR:021 - PATIENT (DISCHARGE) STATUS UNSPECIFIED**

---

To assist users with determining which Discharge Status to select, the View option has been updated on page 3 of the claim editor to display specific information from the PCC visit, if it exists in PCC.

For inpatient claims, the user will see the V HOSPITALIZATION file. This file contains the DISCHARGE TYPE, if populated on the visit in PCC.

#### Desired ACTION (Edit/Next/View/Jump/Back/Quit): V

```
---------------------------
V HOSPITALIZATION
---------------------------
DATE OF DISCHARGE: DEC 13, 2019@10:00  PATIENT NAME: DEMO,PATIENT
VISIT: DEC 10, 2019@10:00  ADMITTING SERVICE: GENERAL MEDICINE
DISCHARGE SERVICE: GENERAL MEDICINE  DISCHARGE TYPE: REGULAR DISCHARGE
ADMISSION TYPE: REFERRED FROM IHS CLINIC
ADMITTING DX: R46.1  DATE/TIME ENTERED: DEC 19, 2019@13:52:12
ENTERED BY: USER,SUPER
DATE/TIME LAST MODIFIED: DEC 19, 2019@13:52:46
LAST MODIFIED BY: USER,SUPER  ADMISSION TYPE-UB92: EMERGENCY
ADMISSION SOURCE-UB92: PHYSICIAN REFERRAL
DISCHARGE STATUS-UB92: 01  DISCHARGE SNOMED CT: 306689006
LENGTH OF STAY (c): 3  DISCH SNOMED PREFERRED TERM (c): Discharge to home
```

---

For emergency medicine claims, users will see the V EMERGENCY VISIT RECORD file. This file contains the DISPOSITION OF CARE, if populated on the visit in PCC.
2.2 ADA-2019

A new export mode has been created for the ADA-2019. The ADA-2019 form allows for a gender specification of U for unknown in boxes 7, 14, and 22. This information is pulled from pages 1 and 4 in the Patient Registration application.

The Reprint Bill option has been updated to allow for selecting the ADA-2019 when reprinting a claim that was approved with an export mode of 837D.
3 UNPAID BILLS

Select Desired Option: 1 SELECTIVE BILL(S)

Select 1st BILL to Re-Print: 12345A
Visit: 12-01-2019 DENTAL DENTAL 2017 DEMO
Bill: GEHA 837D (ADA) 5010 171.00

Select 2nd BILL to Re-Print:
Select one of the following:
29 ADA-2006
34 ADA-2012
36 ADA-2019

**Use the following export mode: ADA-2019//

Figure 2-15: ADA-2019 added to the Reprint Bill option

The Form Locator Override option in the Table Maintenance Menu was also updated to allow for selecting the ADA-2019.

Select INSURER NAME: DELTA DENTAL OF NEW MEXICO INC NEW MEXICO 87110 ...
...OK? Yes// (Yes)

Select 3P EXPORT MODE FORMAT: ??

Choose from:
3 HCFA-1500B New Version Dated 12-90
14 HCFA-1500 Y2K HCFA 1500 Y2K version
27 CMS-1500 (08/05) OMB No. 0938-0999
34 ADA-2012 ADA Claim Form dated 2012
35 CMS-1500 (02/12) OMB No. 0938-1197
36 ADA-2019 ADA Claim Form dated 2019, J-430

Select 3P EXPORT MODE FORMAT: 36 ADA-2019 ADA Claim Form dated 2019, J-430

Select one of the following:
16 PLAN/GROUP NUMBER
38 PLACE OF SERVICE
48 BILLING DENTIST OR DENTAL ENTITY ADDRESS
49 BILLING DENTIST NPI
50 BILLING DENTIST LICENSE NUMBER
51 SSN/TIN
52 PHONE NUMBER or ADD'L PROVIDER ID
53 TREATING DENTIST/LOCATION
54 NPI
55 TREATING DENTIST LICENSE NUMBER
56 TREATING DENTIST ADDRESS or PROVIDER SPECIALTY CODE
57 PHONE NUMBER
58 ADD'L PROVIDER ID
Select Form Locator:

Figure 2-16: ADA-2019 added to the Form Locator Override option
## Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>3P</td>
<td>Third Party</td>
</tr>
<tr>
<td>ADA</td>
<td>American Dental Association</td>
</tr>
<tr>
<td>CHS</td>
<td>Contract Health Services</td>
</tr>
<tr>
<td>COB</td>
<td>Coordination of Benefits</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>EDCL</td>
<td>Edit Claim Data</td>
</tr>
<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
</tr>
<tr>
<td>HCFA</td>
<td>Healthcare Financing Administration</td>
</tr>
<tr>
<td>IHS</td>
<td>Indian Health Service</td>
</tr>
<tr>
<td>MCR</td>
<td>Medicare</td>
</tr>
<tr>
<td>PCC</td>
<td>Patient Care Component</td>
</tr>
<tr>
<td>PORP</td>
<td>Listing of Patient Eligibility Counts Report</td>
</tr>
<tr>
<td>POV</td>
<td>Purpose of Visit</td>
</tr>
<tr>
<td>RBCL</td>
<td>Rebuild Items from PCC</td>
</tr>
<tr>
<td>REPR</td>
<td>Reprint Bill</td>
</tr>
<tr>
<td>RPMS</td>
<td>Resource and Patient Management System</td>
</tr>
<tr>
<td>SBR</td>
<td>Data Within an Electronic Claim File</td>
</tr>
<tr>
<td>SURP</td>
<td>Summarized (multi-line) Claim Listing</td>
</tr>
<tr>
<td>TOS</td>
<td>Type of Service</td>
</tr>
<tr>
<td>TSPR</td>
<td>Test Forms Alignment</td>
</tr>
<tr>
<td>UB</td>
<td>Uniform Billing</td>
</tr>
<tr>
<td>VCRP</td>
<td>Visits by Commissioned Officers and Dependents</td>
</tr>
</tbody>
</table>
Contact Information

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