RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing System
(ABM)

Patch 11 Addendum

User Manual

Version 2.5 Patch 11
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1. Summary of Changes

Please review the following changes to the Third Party Billing System, Version 2.5, and add a copy of these changes to any printed documentation your site may be using for ABM 2.5. At the time of the next release of the Third Party Billing System, these changes will be integrated into future versions of the software and user manuals and will no longer be considered an addendum.

This addendum contains only those changes made in patches that are relevant to the user. For a list of all changes made in a patch, please refer to the patch notes for each of the respective patches.

1.1 Patch 11

Patch 11 provides corrections and enhancements to version 2.5 of the Third Party Billing System (ABM). It is inclusive of modifications implemented by previous patches (1 through 10).

Patch 11 contains the following modifications:

- Population and display of the National Provider Identifier (NPI) in the Claim Editor
- Addition of fields in the Insurer File to allow the user to select between NPI only or Legacy Number and NPI.
- Addition of error code in the claim editor to ensure that the NPI has been entered for the billing provider.
- Modification to the Claim Editor page 4 View option to display NPI number
- Modification to the Claim Editor page 3 to allow entry of REFERRING PHYS. NPI or LEGACY
- Modification to the Claim Editor page 3 to allow entry of SUPERVISING PROV. NPI
- Addition of a new error code in the claim editor for referring provider on page 3 if the export mode is 837 or one of the new formats
- Addition of a new error code in the claim editor for supervising provider on page 3 if the export mode is 837 or one of the new formats
- Modification of all 837 electronic export formats to allow for NPI display
- Modification of the 837P to print on new 1500 format
- Modification of the 837I to print on new UB format
- Modification of the 837D to print on new ADA format

- Addition of a new export mode: CMS-1500 (08/05) OMB No. 0938-0999 format (#27)
- Addition of a new export mode: UB-04 OMB No. 0938-0997 format (#28)
- Addition of a new export mode: ADA-2006 Dental Claim Form format (#29)
- Modification of the paper NCPDP format to allow for display of the NPI.
- Update to the current Value/Condition/Occurrence Codes for UB format
- Addition of a patient statement to print for Non-beneficiary patients.
- Correction to the UB92 paper export format to prevent the duplication of line items.
- Error <UNDEF>BODY+59^ABMDF12 was fixed when printing the ADA-94 paper claims.
- Correction to the Insurer File to allow for the addition of a future date in for a replacement insurer entry. This also corrected the claim editor to allow the correct replacement insurer to be displayed.
- Error <UNDEF>REMPL+16^ABMDE2X3 was corrected. This error occurred when an entry was deleted from the Employer File and the Claim Editor was trying to access the Employer information.
- Correction to claim editor to prevent the addition of HCPCS codes that have been inactivated for the service date the user is editing.
- Correction to the printing of the paper/electronic claim forms for the CLIA Number to print correctly. System wasn't checking the -90 modifier correctly to determine the CLIA number that needed to be printing.

1.2 Patch 10

Patch 10 provides corrections and enhancements to version 2.5 of the Third Party Billing System (ABM). It is inclusive of modifications implemented by previous patches (1 through 9).

Patch 10 contains the following modifications:

- A new Coordination of Benefit page (COB) has been added to the Claim Editor to enable electronic secondary insurer billing, using the HIPAA-compliant 837 format.
- Modifications were done to the LOOP option so a range of patients are selectable when LOOPING through claims.
- The insurer Railroad Retirement will now print on the UB92, FL50 as RAILROAD MEDICARE instead of RAILROAD RETIREMENT.

- A prompt was added under the Site Parameter to allow the removal of all PRV segments from an 837 file for a specified insurer.
- The Supervising Provider UPIN number for an 837 file will be pulled from Page 3 of the Claim Editor.
- When the insurer is North Carolina Medicaid; one-hour difference between admission hour and discharge hour for outpatient claims on 837 files was implemented.
- Addition of new prompts to Page 3 of the Claim Editor for Special Programs. These fields will populate on the 837P CRC segment.
- Addition of a new parameter to the Site Parameters menu to allow the user to indicate if the ISA08 segment of an 837 file will display as 'MA' for Medicare Part A or 'MB' for Medicare Part B. This is for sites that bill Part B with a visit type NOT equal to 999.
- A check was added to not populate the Service Facility (Loop 2310D) of an 837 file if the Place of Service code is 12 (home).
- Modification to the NEW-Add New Claim (Manual Entry) option to allow rebuilding of a claim in the EDCL-Edit Claim data mode.
- Error <SUBSCR>40+48^ ABME8NM1, which occurred while creating EMC file when claims with and without labs are in the same 837 batch, was corrected.
- Error <UNDEF>E+21^ABMDE6 was fixed to not occur when the user is making use of the delete command.
- Error <SUBSCR>LOOP+6^ABMECDSP, which occurred while running the CREM option, was corrected. (Error caused Viking claims export mode to be missing and these claims were skipped)
- Error <UNDEF>58+14^ABMDF51z was corrected for when the provider's UPIN was missing from the 3P Insurer file.
- Error <SUBSCR>BADDR+19^ABMDF25A was corrected to not error out if no secondary's information was present on an ADA-2002 format.
- Error <UNDEF>EXP+1^ABMDE2X5 was fixed to not occur when the claim generator runs at night.
- Error <SUBSCR>W34+3^ABMDE30 was amended to not occur when the 3P Reference Lab entry is deleted but is still being referenced on the claim.
- Error <UNDEF>DBFX+4^ABMDEFIP was fixed for Transworld transmissions.
- Error <READ>BY+5^ABMFOFS was corrected by setting "R" (READ) to default when loading a fee schedule through the FIFE option.
- Error <UNDEF>CONT+5^ABMDEMLB, which appeared on an error trap under the option of EDCL-Edit Claim Data, was fixed.

- Error <UNDEF>PRINT+13^ABMDRST1, which occurred when the system was prompted to run a report and the user entered a ^ (uphat) symbol at the VISIT/CLINIC prompt, was corrected.
- Error <UNDEF>SUBHDR^ABMDCCL3, which happened when running the Cancelled Claims Report and no data was available to print, was fixed.
- Error <UNDEF>E2+1ABMDE6 was fixed on Page 6 of the Claim Editor when user selects an edit command.
- Error <SUBSCR>BNODES+6^ABMDF3B was amended to not error out when an Outside Lab Charge is present but no Reference Lab CLIA number is available for both HCFA formats.
- Removed patient's address when insurer is Medi-Cal.
- Addition of the "Service To" prompt to the CPT pages of the Claim Editor.
- A system check was done for non-primary provider disciplines with an unbillable disciplines status to NOT change any information listed on the primary provider status. The Only time a change will occur is when the primary provider's discipline is unbillable.
- Modifications were made to the UB92, FL55 for Non Beneficiary billing so a printed dollar amount due from patient will appear instead of prior payment and estimated amounts due. An additional modification was also done to print a Patient's name and not a Non Beneficiary Patient name on FL50 of the UB92.
- The XCODE value from the Patient Relationship HIPAA codes will be used on the UB92, FL59.
- A fix was installed for FL4 on a UB92 to no longer wrap.
- Ensure all revenue codes display as 4 digits.
- Modification of FL79 and FL80 on the UB92 to reflect ICD9 coding.
- Addition of a new prompt under the EDIN-Add/Edit Insurer by visit type to accommodate for the printing of the RX number in FL44 of the UB92.
- Serve lines will print as separate lines on a UB92 when the Revenue code and/or the CPT codes are the same.
- A fix was done for FL47 and FL48 on a UB92 for covered days and non-covered days.
- The system check for FL38 on the UB92 was corrected so the address for the insurer Medicare and Medicaid will print.
- Alignment of all lines of the ADA-2002 moved to start on position 2 instead of position 1.
- Dollar amount fields on the ADA-2002 shortened to prevent wrapping to the next line.

- The ADA-2002 form, block 29 was extended to 15 characters.
- Page 9F (Remarks) was added to the ADA format in the Claim Editor. All information entered on this page will print on the notes field on the ADA form.
- The ADA-2002 forms for the insurer Delta Dental, Box 56 will print the treatment location's physical address.
- The alignment of Box 3 on the ADA-99 v2000 form was moved one line down and Boxes 64, 65 and 66 will print on form also.
- Alignment of the 1500 Y2K, FL5, FL24D, and FL24G moved one character to the left.
- Policy number will print on Block 1A, of a HCFA.
- A new parameter was added to the Insurer File by visit type for the insurer Medicaid so dashes in block 1A of the 1500B and the 1500 Y2K can be turned on and off.
- Coding fixed for Page 3 in the Claim Editor concerning the outside lab charges question was causing an error when printing the 1500Y2K; if the dollar amount is zero to not print.
- Policy Holder information will print on the 1500 Y2K, FL11a/11b.
- Addition of a new prompt to the Insurer file by visit type to select block 29a of the HCFA's to print or to not print on the claim.
- Addition of a new prompts under the Insurer File by visit type to allow the user to decide if CLIA numbers should print all the time and to select which CLIA number they prefer; the In house CLIA number or the Reference Lab Claim number on 1500 export modes.
- Page 2 of the Claim Editor was corrected to show the policy number for Private Insurance Carriers.
- A new manager report has been added to the Table Maintenance Menu.

  A Visit/Claim/Bill Tally Report (VCBT) will document visits, claims and bills totals within a date range.

- Addition of a new field on the Revenue Code Page (Page 8C) of the Claim Editor to allow the billing of a CPT code with the Revenue Code.
- The Assignment of Benefits and the Release of Information prompts on Page 3 of the Claim Editor will automatically populate from Patient Registration, Page 9 data.
- The Third Party billing package will pick up the Policy Holder name from question 8, the CARD NAME field in Patient Registration Private insurance page for all export modes, if the field is populated. If the field is not populated the system will default to Policy Holder name.

- New system checks were added to the claim generator to create two claims instead of one for two visits on the same day. The primary provider and primary diagnosis were added to the already existing checks of the encounter date, visit location, visit type, and clinic.
- Modification to the Merge Claim option-MRMG was fixed so most of the data from the original claims crosses over to the new claim that was created from the merge.
- Using the RBCL option to rebuild insurers on a claim was changed to not alter a complete status on existing insurer.
- Corrections were made on claims that printed on 2 pages. Wrapping adjusted on 2-line item description.
- The Health Record Number will now print correctly on the Cancelled Claims Report.
- Addition of a new prompt was added to the EDIN-Add/Edit Insurer option for Durable Medical Equipment for group name and group number by visit type. These populated fields will print on the 1500Y2K, FL11 or the UB92, FL61.
- The NDC number (National Drug Code) that is entered by the user on the claim will print on the 1500Y2K.
- Corrections were made to the NCPDP format concerning NAME, PLAN NAME, PATIENT/AUTHORIZED SIGNATURE, PRESCRIBER ID, and QUALIFIER.
- Page 4 of the Claim Editor, error 170 was updated to read the PAYER ASSIGNED PROVIDER NUMBER when the insurer type is Medicare.
- Addition of a new error message; number 219 was set up for Page 2 of the Claim Editor. If the active insurer type is Medicare and the Date of Birth is missing from page 4 of Patient registration, this error will be displayed.
- A new error message; number 217, was set up when a diagnosis code has been deleted, letting the user know corresponding diagnosis codes need to be re-sequenced.
- Error message number 134 (dental surface required) was removed.
- A new error message; number 123, was added to Page 8B of the Claim Editor when units are missing.
- A new error message will appear on Page 2 of the Claim Editor when there is no MSP in Patient Registration.
- Modification was done in the Claim Editor to display Page 8G (Anesthesia) when there is a Surgical CPT coding on a visit.
- A correction was made when cancellation of a claim was done and re-approval of the same claim was completed with a replacement insurer to not default back to previous active insurer.

- A fix was done so that when a replacement insurer was terminated and the user does not enter a term date, the system will default to a TODAY date.
- Medicare Part B question in the Site Parameter menu was corrected so 999 claims will not print if the site answers Yes to this prompt.
- A fix was installed for the insurer Medicare when eligibility end dates are populated to not cross over claims as billable. However, if the patient has more than one eligibility date, the system will not pick up the unbillable status.
- Provider taxonomy codes can be viewed on Page 4 of the Claim Editor. Error 190 fixed for Page 4 of the Claim Editor to check for Rendering Providers and not only the Operating and Attending Providers.
- The Cancel Claims Report subtotals and totals calculation corrected and alignment readjusted.
- A Medicare Part D report was added to the Third Party Billing package.
- Changes were made for Durable Medical Equipment billing to document what loop it is, so local Modifiers can be done. Without the local Modifiers, there is no affect on the national code.
- The lookup from the V CPT file was removed for Radiology billing and units will always default to one.
- Page 3 of the Claim Editor, question 13 for Prior authorization numbers was extended to 22 characters.
- A new patient status code was added to the Claim Editor;

  62-(Discharged/transferred to another rehabilitation facility)

- Modifications were done to the service category of “R” (Nursing home) so the “Service Date To” will default to the “Service Date From.”
- Payer Assigned Provider Number lookup for the insurer Medicare was corrected.
- Medications billed through the Point-of-Sales package that have been denied for reimbursement will now rollover to the Third Party Billing package.
- The PCRP - Pending Claims Status Report option for the Billing Entity exclusion parameter for Private Insurance was fixed.
- Active insurers will display on the Summary Page of the Claim Editor and the option to delete these active insurers will no longer be available. Page 2 of the Claim Editor will have the Pick option to alter active insurer.
- The Third Party Billing package will pick up the Workmen Compensation claim number from the Patient Registration package and will print on HCFA’s and UB92’s.
- ChargeMaster calls have been included. If you are running ChargeMaster, you will not have to add these calls back in after installation of this patch.

- Modification to the 3P Reference Lab Location vendor file. User will not have the ability to edit this file.
- Updates to the 3P Provider Taxonomy file consist of:

-376K00000x	Nurse's Aide
-163WS0200x	School
-390200000x	Student in an Organized Health Care Education/Training Program
-227900000x	Respiratory Therapist, Registered
-207R00000x	Internal Medicine
-183700000x	Pharmacy Technician
-207RI0008x	Hepatology
-207RG0100x	Gastroenterology
-207RE0101x	Endocrinology, Diabetes & Metabolism
-207RR0500x	Rheumatology
-207RH0003x	Hematology & Oncology
-207RP1001x	Pulmonary Disease
-207T00000x	Neurological Surgery

- New entries to the Cancel Claims reason table;

  -POS Plan limitation exceeded
  -POS refill too soon
  -Unbillable professional claim (Medicare B)
  -72 hour outpatient visit
  -Visit unrelated to accident/injury
  -Claim created for wrong patient

1.3 Patch 8

Patch 8 provides corrections and enhancements to version 2.5 of the Third Party Billing system (ABM). It is inclusive of modifications implemented by previous patches (1 through 7).

Patch 8 contains the following modifications:

- Addition of new dental billing format labeled ADA-2002
- Addition of a modified ADA-99 format to comply with certain payer requirements for alignment.
- Ability to enter a new Pending claim category into the claim editor.
- Addition of a Third Party Revenue Accounts Management and Internal Controls policy report entitled Pending Claims Status Report
- Modifications have been made to the claim editor to not allow visits with an uncoded diagnosis code (.9999) to generate a claim.

- Modifications have been made to the claim editor to not allow visits with a visit status other than Reviewed in the PCC RPMS Application to generate a claim.
- Addition of new claim editor screens and export mode modifications to allow for billing for Ambulance services.
- Modification to the Cancel Claims option that requires a user to enter a reason when cancelling claims.
- Addition of a Third Party Revenue Accounts Management and Internal Controls Policy Report entitled Cancelled Claims Report
- Addition of new CLIA Number fields to allow for proper CLIA number entry to be entered in the claim editor and on electronic claim formats.
- Ability to split claims for different payers by set up Replacement Insurers for or other types of billing rules.
- Addition of a Third Party Accounts Management and Internal Controls policy report entitled Table Maintenance Site Parameter Report
- Addition of 837 Corrections such as:
  - REF Segment – New Mexico Medicaid
  - Provider Number Fix for Satellite Facilities
  - Incorrect Amounts on 837 Export Modes
  - Correction to Accident Date and Time
- Inclusion of modifications to the accommodate the IHS Pharmacy-Automated Dispensing Interface System

1.4 Patch 6

Patch 6 provides corrections and enhancements to version 2.5 of the Third Party Billing system (ABM).It is inclusive of modifications implemented by previous patches (1 through 5).

Patch 6 contains the following modifications:

- Removed Type of Service auto-population from 837 (see Section 5.5).
- Correction to make Discharge Status default on page 3 of claim editor (see Section 5.6).
- Changed functionality of Referring Provider prompts on page 3 of claim editor. User now has option to populate either:
  - Person Class
  - Provider Class
  - Taxonomy Code

One of the three must be populated for 837. An error message will display if none of the above are populated or it is not linked to a provider taxonomy code (required for 837). (See Sections 5.1 and 5.2.)

- Fixed to remove QTY segment from Medicare 837 file if not inpatient (see Section 5.7).

1.5 Patch 5

Patch 5 provides corrections and enhancements to version 2.5 of the Third Party Billing system (ABM).It is inclusive of modifications implemented by previous patches (1 through 4).

Patch 5 contains the following modifications:

- The Health Record Number can be populated under the Parent Billing location (see Section 6.1).
- The entry of "Unknown" was removed from all 837 formats (837-I, 837-P, and 837-D) for Medicare Payers (see Section 6.2).
- Surgical Procedure Codes (ICD-9) will be removed from all 837 formats (see Section 6.3).
- The current 837 formats did not populate the 6th diagnosis piece on the 837. The ABM system has been programmed to ensure the 6th diagnosis piece has been populated (see Section 6.4).
- Trailing space in addresses was removed from all 837 formats only (see Section 6.5).
- If you elect to link more than four diagnosis codes and are billing using the 837 P, then the electronic batch will only transmit the first four diagnosis codes that were sequenced to the charge (see Section 6.6).
- An error displays on Page 3 of the claim editor to prevent approving a claim if the injury date is incomplete (see Section 6.7).
- You can no longer delete or cancel claims that have been billed (see Section 6.8).
- The system now prompts you to complete the Admission Source, Admission Type, and the Discharge Status when the mode of export is UB-92 (paper), UB-92 (NSF), or 837 Institutional. The system also has defaults for any field left blank (see Section 6.9).
- Two fields have been added when accessing the CPT pages (Pages 8A to 8H) that allow you to edit the Place of Service and Type of Service codes by line item (see Section 6.10).
- You can now enter the appropriate provider taxonomy for the Referring/Ordering provider (see Section 6.11).
- Medicare Provider Number will populate correctly on Page 4.

1.6 Patches 2-4

To see a list of changes included in patches 2-4 please refer to the patch notes file of the appropriate patch.

1.7 Patch 1

Patch 1 provides corrections and enhancements to version 2.5 of the Third Party Billing system (ABM). It contains the following modifications:

- Three new 837-compliant modes of export (see Section 7.1).
- A need for person class data on file for each provider (see Section 7.2).

2. Patch 11

2.1 National Provider Identifier (NPI) Updates

New functionality has been added to Third Party Billing system to capture the provider NPI. A new prompt has been added that enables the user to pick, by insurer, to send

- NPI or
- Legacy or
- Both

Based on how this prompt is answered, the display of the provider number on Page 4 of the Claim Editor will change, as well as what prints on the selected export mode.

Upon installation of this patch, you should have an idea of what your payers will be accepting on the claim forms. Facilities that bill electronically to a variety of payers need to investigate from each payer whether the NPI will be accepted. In most cases, you are required to submit the provider's NPI to that payer. Be sure to check with your payer to verify their billing requirements.

2.2 Setting up the Insurer File

A new field was added to the Insurer file to enable the user to determine what they will be sending to the payer. Every payer that is affected by NPI will need to be updated by entering a value into the NPI USAGE field.

The NPI USAGEs field can contain one of the following values:

- NPI ONLY -This allows the system to print/display the NPI on the claim forms. Payers that require the NPI to only be submitted will need to use this status.
- NPI & LEGACY - This allows the system to send both the NPI and Legacy number on the claim forms. Payers that allow the NPI and the Legacy number to be submitted will use this status.
- LEGACY ONLY - This allows the system to send the legacy number only. The Legacy number is the number that currently prints on the claim forms.

If the field is left blank, the system will continue to use the existing format of displaying/printing the provider numbers on the claim forms (also known as the LEGACY ONLY status).

For example:

```
EMC SUBMITTER ID: V00233//
EMC PASSWORD: IHS233//
EMC TEST INDICATOR:
USE PLAN NAME?: NO//
72 HOUR RULE:
NPI USAGE: ??

     Choose from:
       N        NPI ONLY
       B        NPI & LEGACY
       L        LEGACY ONLY
NPI USAGE:
GROUP NUMBER: 8HZ000//
PROVIDER PIN#
```

Figure 2-1: Example of prompts to add NPI information to Insurer file

2.2.1 Adding the NPI Number in RPMS

A new menu option has been added to the Table Maintenance option to allow entry of the provider NPI.

The option, labeled Add/Edit NPI Values for Providers, is located under the newly created Provider Menu.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                     Provider Menu                                      +
          |                  INDIAN HEALTH HOSPITAL                                |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    30-MAR-2007 3:42 PM

   PRTM   Inquire to Provider File
   PETM   Provider Number Edit
   NPI    Add/Edit NPI values for Providers

Select Provider Menu Option:
```

Figure 2-2: Provider Menu NPI option

When selected, the NPI option displays the “Select Provider” prompt. At this prompt, type the name of the provider for which you are entering the NPI. To be selected, the provider must be stored in the New Person File (File #200).

After selecting the name of the provider, the system prompts the user to enter the NPI. Once the user enters a valid number, the system will display a re-verification prompt. Enter the number again. Entering the number correctly alerts the user that the number was saved successfully.

For example:

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +           Add/Edit NPI values for Providers             +
          |                 INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    30-MAR-2007 3:44 PM

Select Provider: UNDER,ANESTASIA       ADU
This user doesn't have a Taxonomy Code indicating a need for an NPI.
Provider: UNDER,ANESTASIA   XXX-XX-   DOB:

Enter NPI (10 digits): 1234567810
Please re-enter NPI  : 1234567810

For provider UNDER,ANESTASIA the NPI 1234567810
was saved to VistA successfully.
```

Figure 2-3: Example of entering the NPI for a provider

Tips for Entering the NPI Number

The Indian Health Service has adopted the standard of entering the NPI from the Veterans Administration. As a result, logic has been associated to the entry of the NPI. It is helpful to keep the following points in mind when entering an NPI:

- An NPI can never be entered more than once. This prevents the duplication of NPI entries by provider. For example:

```
Select Provider: RADISSON,RONALD       RR
This user doesn't have a Taxonomy Code indicating a need for an NPI.
Provider: RADISSON,RONALD   XXX-XX-   DOB:
Enter NPI (10 digits): 1234567802
That NPI value is already associated with DOCTOR,TRUDEL
```

- The Provider Taxonomy code is required when submitting claims that contain a provider or institution NPI.

  Because of this, users must ensure that the correct Provider Taxonomy code has been submitted with the provider's NPI application. Also, the user may have to verify the Provider Taxonomy code used, from the View Provider option on Page 4 of the Claim Editor.

- The National Provider Identifier check digit is calculated using the Luhn formula for computing the modulus 10 “double-add-double” check digit. This logic applies during the entry of the NPI.

  If the user enters an invalid NPI, the system will display the following response:

```
Enter NPI (10 digits): 1234567813
NPI values have a specific structure to validate them...
The Checksum for this entry is not valid
```

- A message will be displayed, if the NPI already exists. At this point, the user has the option of deleting or replacing the current value. For example:

```
Select Provider: UNDER,ANESTASIA       ADU
This user doesn't have a Taxonomy Code indicating a need for an NPI.
This provider already has an NPI value (1234567810) entered.

     Select one of the following:

          D         Delete
          R         Replace

Do you want to (D)elete or (R)eplace this NPI value?:
```

  Once the National Provider Identifier has been added, it is ready for use in the Claim Editor and on claim forms.

2.3 Claim Editor Changes

Modifications have been made to the Claim Editor for the use and display of the National Provider Identifier. Depending on the set up of the NPI Usage field in the insurer file, the user will see different provider screens.

2.3.1 Page 3, Questions - Referring Provider

The Questions Page (Page 3) in the Claim Editor has been modified to allow the user to enter the NPI of the **Referring Provider**, when billing for services where a Referring Provider is required.

The Referring Physician NPI prompt will be displayed only if the NPI Usage is set to NPI Only or NPI & Legacy. The system will continue to ask for the entry of the Provider Taxonomy code, which is required, as the payer uses the code to validate the NPI when receiving claim information.

The entry of the NPI uses the Luhn formula to prevent the user from entering an invalid number.

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

Desired FIELDS:  (1-22): 1-22// 11

[11] Name of Referring Physician: KILDARE,BRUCE
     Referring Physician NPI: 1234567802
     Referring Physician ID Qualifier: 1G  PRV UPIN NO
     Referring Physician I.D. No: E99999

     Select one of the following:

          1         Person Class
          2         Provider Class
          3         Taxonomy Code

Which would you like to enter?: 2  Provider Class
          Referring Physician Provider Class..: PHYSICIAN
     1   PHYSICIAN
     2   PHYSICIAN (CONTRACT)
     3   PHYSICIAN (TRIBAL)
     4   PHYSICIAN ASSISTANT
CHOOSE 1-4: 1
```

Figure 2-4: Example of Page 3 of the Claim Editor with addition of NPI

Entry of the Referring Provider has also been modified to allow entry of the Referring Physician Identification Qualifier. This qualifier is used to describe the type of Legacy number submitted on the claim. This is required for both the 837 and the new paper formats.

```
    Referring Physician ID Qualifier: ??

        WHAT ID NUMBER WILL YOU BE ENTERING FOR THE REFERRING PROVIDER

     Choose from:
       0B       STATE LIC NO
       1B       BLUE SHIELD PRV NO
       1C       MEDICARE PRV NO
       1D       MEDICAID PRV NO
       1G       PRV UPIN NO
       1H       CHAMPUS ID NO
       EI       EMPLOYER'S ID NO
       G2       PRV COMMERCIAL NO
       N5       PRV PLAN NETWORK ID
       SY       SSN
```

Figure 2-5: Example of Referring Physician ID Qualifier response

The Physician Identification Qualifier prompt will be displayed when the NPI Usage is set to NPI & Legacy or Legacy Only.

2.3.2 Page 3, Questions - Supervising Provider

The Questions Page (Page 3) in the Claim Editor has been modified to allow the user to enter the NPI of the **Supervising Provider**, when billing for services where a Supervising Provider is required.

The Supervising Physician NPI prompt will be displayed only if the NPI Usage is set to NPI Only or NPI & Legacy. The system will continue to ask for the entry of the Provider Taxonomy code, which is required, as the payer uses the code to validate the NPI when receiving claim information.

The entry of the NPI uses the Luhn formula to prevent the user from entering an invalid number.

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

Desired FIELDS:  (1-22): 1-22// 16
[16] Supervising Prov.(FL19): LAST,FIRST
[16] Date Last Seen: MAR 3,2007
[16] NPI: 1234556789
[16] I.D. Number (UPIN): E03919
```

Figure 2-6: Example of Supervising Physician NPI response

The system will display the NPI field, if the NPI Usage indicates NPI Only or NPI & Legacy. If the NPI Usage in the Insurer file is set to NPI only, the user enters only the NPI number.

2.3.3 Page 4 (Provider Data) Display if "NPI Only" Selected

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

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

              PROVIDER                 NPI              DISCIPLINE
     ==========================  ============  ======================
(attn)  ALEXIS,ALEXANDRA          8084020220    PHYSICIAN

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

Figure 2-7: Example of Page 4 (Provider Data) when NPI Only is selected

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

2.3.4 Page 4 (Provider Data) Display if "NPI & Legacy Number" Selected

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

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

           PROVIDER            NPI         NUMBER        DISCIPLINE
        ==================  ==========  ===========  =================
(attn)  ALEXIS,ALEXANDRA    8084020220   NM-001393    PHYSICIAN

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

Figure 2-8: Example of Page 4 (Provider Data) when NPI & Legacy Number is selected

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

2.3.5 Page 4 (Provider Data) Display if "Legacy Only" is selected

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

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

           PROVIDER              NUMBER           DISCIPLINE
        ======================  ============  ======================
(attn)  ALEXIS,ALEXANDRA          NM-001393     PHYSICIAN

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

Figure 2-9: Example of Page 4 (Provider Data) when Legacy Only is selected

This screen display is the same as the display prior to Patch 11, because the user has the option to submitting the legacy number to the payer, if the payer does not accept the NPI yet.

2.3.6 Addition of NPI Display in Page 1 View Option - Institution

The Page 1 View option has been modified to display the institution NPI. This field pulls its data from the Institution file. If the NPI is missing, the field will be blank. For example:

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JANE  [HRN:9999]                      Claim Number: 29845
..................... (IDENTIFIER - VIEW OPTION) .....................

Patient.: DEMO,JANE (9999)                 Sex.: F    DOB..: 09-14-1967
          3928 EVERGREEN TERRACE           Home Phone......:
          ALBUQUEQRUE, NM  87110           Marital Status..: UNKNOWN
-------------------------------------------------------------------------
Facility: INDIAN HEALTH HOSP               Tax Number..: 85-0105601
          INDIAN HEALTH HOSP               Phone.......: 505 248 4349
          PO BOX 34982                     NPI.........: 7745613100
          PASADENA, CA  91110-0655
-------------------------------------------------------------------------
WARNING:071 - EMPLOYMENT INFORMATION UNSPECIFIED
-------------------------------------------------------------------------
 Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired):
```

Figure 2-10: Example of Page 1 (Identifier View Option) with NPI display

2.3.7 Addition of NPI Display in the Page 4 View Option - Provider

The Page 1 View option has been modified to display the provider NPI. This field pulls its data from the New Person file (File #200). If the NPI is missing, the field will be blank.

The Provider View option is accessible by typing “V” to View the page.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                  Claim Number: 29732
..................... (PROVIDER VIEW OPTION) .....................

Attn Prov..: ALEXIS,ALEXANDRA              Phone #....:
Discipline.: PHYSICIAN                     MCR/MCD #..: NM-001393
Affilliation: IHS                          DEA #......:
NPI.........: 8084020220                   Provider Taxonomy:208D00000X
Oper Prov..: NURSE,BETTY                   Phone #....:
Discipline.: REGISTERED NURSE              MCR/MCD #..: AZ-1234
Afilliation: IHS                           DEA #......:
NPI.........:                              Provider Taxonomy:163W00000X
------------------------------------------------------------------------
             ***** Provider Information Entered Through PCC *****
PRI        PROVIDER                                DISCIPLINE
=== ================================   ============================
 P  ALEXIS,ALEXANDRA                    PHYSICIAN
------------------------------------------------------------------------
WARNING:170 - MEDICARE/MEDICAID PROVIDER NUMBER UNSPECIFIED FOR
PROVIDER(S)
  ERROR:220 - NPI UNSPECIFIED IN NEW PERSON FILE FOR PROVIDER
------------------------------------------------------------------------
 Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired):
```

Figure 2-11: Example of Page 4 (Provider View Option) with NPI display

2.3.8 UB Code Additions/Updates

The UB-04 manual updates various codes that are needed for billing for different services. Codes that have been updated fall into the following categories:

- Value Codes
- Occurrence Codes
- Condition Codes

There were some code descriptions that were modified and some codes that were inactivated. Please refer to your UB-04 manual, which is also available on the www.nubc.org website.

2.4 Error Checking in the Claim Editor

New Error and Warning messages have been added to the Claim Editor to inform the user know if National Provider Identifier entries are missing. The way the system displays the Error or Warning message depends on the NPI Usage field located in the Insurer File.

2.4.1 Error 220 - NPI Unspecified for Rendering/Ordering Provider

Error 220 displays on Pages 8A to 8K, depending on where the Provider entry is located, when the user is billing for services for a Rendering or Ordering Provider, and the Provider's NPI is missing.

This error is also displayed, if the NPI usage is set to NPI & Legacy or NPI Only and the user is billing using the 837 Professional, 837 Dental, or the CMS-1500.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                  Claim Number: 29716
Mode of Export: 837 PROF (HCFA)
......................... (MEDICAL SERVICES) .......................

     REVN                                              UNIT       TOTAL
     CODE        CPT - MEDICAL SERVICES              CHARGE QTY  CHARGE
     ==== ========================================  ====== === =======
[1]  CHARGE DATE: 09/04/2006@11:00-09/04/2006 (DOE,J E-R)
     0510 99282 EMERGENCY DEPT VISIT                  84.00  1    84.00
[2]  CHARGE DATE: 09/04/2006@11:00
     0730 93000 ELECTROCARDIOGRAM, COMPLETE           66.00  1    66.00
                                                               ========
                                                                $150.00
-------------------------------------------------------------------------
  ERROR:220 - NPI UNSPECIFIED IN NEW PERSON FILE FOR PROVIDER (1)
-------------------------------------------------------------------------
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Figure 2-12: Example of Error 220 display

2.4.2 Warning 221 - NPI Unspecified in New Person File for This Provider

Warning 221 has been added to notify the user that an NPI has not been entered for the Provider. This Warning displays on the Provider Page (Page 4) in the Claim Editor. This warning displays when the NPI Usage is set to NPI & Legacy and advises the user that an NPI must be entered prior to approving the claim.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JANE  [HRN:9999]                      Claim Number: 29845
.......................... (PROVIDER DATA) ............................

               PROVIDER           NPI        NUMBER       DISCIPLINE
        ==================== ==========  ===========  ================
(attn)  GLASSES,EYE                      NM-93280983  OPTOMETRIST
------------------------------------------------------------------------
WARNING:221 - NPI UNSPECIFIED IN NEW PERSON FILE FOR PROVIDER
------------------------------------------------------------------------

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

Figure 2-13: Example of Warning 221 display

Note: Not adding the NPI may result in a rejected batch file.

2.4.3 Error 222 - NPI Usage Says NPI But Export Mode Doesn't support It

Error 222 displays on the Identifiers Page (Page 1) of the Claim Editor when the user selects an export mode that does not allow the submission of the NPI. This includes the UB92, HCFA-1500B, HCFA-1500, Y2K and older forms.

This error also displays if the NPI Usage field is set to NPI & Legacy or NPI Only and advises the user to select a form that support the usage of the NPI or change the NPI Usage prompt to Legacy Only.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JANE  [HRN:9999]                      Claim Number: 29845
......................... (CLAIM IDENTIFIERS) ........................

                 [1] Clinic.............: OPTOMETRY
                 [2] Visit Type.........: OPTOMETRY
                 [3] Bill Type..........: 131
                 [4] Billing From Date..: 02/28/2007
                 [5] Billing Thru Date..: 02/28/2007
                 [6] Super Bill #.......:
                 [7] Mode of Export.....: HCFA-1500B
                 [8] Visit Location.....: INDIAN HEALTH HOSPITAL
------------------------------------------------------------------------
WARNING:071 - EMPLOYMENT INFORMATION UNSPECIFIED
  ERROR:222 - NPI USAGE SAYS NPI BUT EXPORT MODE DOESN'T SUPPORT IT
------------------------------------------------------------------------
Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//
```

Figure 2-14: Example of Error 222 display

> **Note:** Failure to correct this error will not allow the claim to be approved.

2.4.4 Error 223 - NPI Unspecified for Referring Provider

Error 223 displays on the Questions Page (Page 3) of the Claim Editor when the user is billing for services for a referring provider and the Referring Provider's NPI has not been entered.

This error also displays if the NPI usage is set to NPI & Legacy or NPI Only and the user is billing using the 837 Professional, 837 Dental, or the CMS-1500.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JANE  [HRN:9999]                     Claim Number: 29845
........................... (QUESTIONS) ............................

 [1] Release of Information..: YES   From: 02/28/2007
 [2] Assignment of Benefits..: YES   From: 02/28/2007
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.: NO
 [6] Outside Lab Charges.....: NO  $0.00
 [7] Date of First Symptom...:
 [8] Date of Similar Symptom.:
 [9] Referring Phys. (FL17)  : BROTHERS,JOYCE    ID/NPI: /
[10] Resubmission(Control) No:
[11] PRO Approval Number.....:
[12] Source of Admission.....:  1  PHYSICIAN REFERRAL
[13] Supervising Prov.(FL19).:     ID/NPI: /
       Date Last Seen:
[14] Reference Lab CLIA#.....: 12T1234567  THE REFERENCE LAB INC.
[15] In-House CLIA#..........: 12A3456789
-------------------------------------------------------------------------
  ERROR:223 - NPI UNSPECIFIED FOR REFERRING PROVIDER
-------------------------------------------------------------------------
Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//
```

Figure 2-15: Example of Error 223 display

Note: Failure to enter the NPI may result in returned or rejected.

2.4.5 Error 224 - NPI Unspecified for Supervising Provider

Error 224 displays on the Questions Page (Page 3) of the Claim Editor when the user is billing for services for a Supervising Provider and the Supervising Providers NPI is missing.

This error also displays if the NPI usage is set to NPI & Legacy or NPI Only and the user is billing using the 837 Professional, 837 Dental, or the CMS-1500.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JANE  [HRN:9999]                      Claim Number: 29845
.............................. (QUESTIONS) ............................

 [1] Release of Information..: YES   From: 02/28/2007
 [2] Assignment of Benefits..: YES   From: 02/28/2007
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.: NO
 [6] Special Program.........: NO
 [7] Outside Lab Charges.....: NO  $0.00
 [8] Date of First Symptom...:
 [9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17)  : KILDARE,BRUCE  ID/NPI: E99999/1234567802
[12] Case No. (External ID)..:
[13] Resubmission(Control) No:
[14] PRO Approval Number.....:
[15] HCFA-1500B Block 19.....:
[16] Supervising Prov.(FL19).: LAST,FIRST    ID/NPI: e03919/
      Date Last Seen: 03/03/2007
[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
-------------------------------------------------------------------------
  ERROR:224 -  NPI UNSPECIFIED FOR SUPERVISING PROVIDER
-------------------------------------------------------------------------
Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//
```

Figure 2-16: Example of Error 224 display

> **Note:** Failure to enter the NPI may result in returned or rejected claim files.

2.5 Export Mode Changes

The following lists the changes that have been made to current export modes and summarizes the forms that have been added. For the new export modes, please refer to the claim form instructions for the correct population of the form.

2.5.1 837 Export Modes

All three 837 export modes (837I, 837P, and 837D) have been modified to allow billing for the National Provider Identifier based on the response in the NPI Usage field.

- NM segments providing information regarding location identifiers or provider identifiers will be affected. For example, NM108 contains an identifier of "XX" to indicate the NPI will be sent. NM109 contains the NPI.
- REF segments will be utilized to submit the Tax Identifier information. REF01 contains an identifier of "EI" to indicate the Tax Identification Number is submitted. REF02 will contain the Tax Identification Number. This data is contained in Loops 2010AA and 2010AB.
- REF segments (excluding 2010AA and 2010AB it will depend upon the NPI Usage field entry. The current Legacy number is submitted if the NPI Usage is set to NPI & Legacy.

2.5.2 CMS-1500 (08-05)

Entry 27 was created in the 3P Export Mode file and named CMS-1500 (08/05), OMB No. 0938-0999. This new export mode will print the National Provider Identifier as well as the usual required information for a CMS claim. For now, only one format of the CMS-1500 has been developed, since the previous version of the HCFA-1500 contained two versions: one for the 2-digit year and one for the 4-digit year.

Reprints of these formats should all be changed to use the new NPI formats based on the response to the NPI USAGE prompt.

```
Mode of Export..:

   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
   51           UB-92 Medi-Cal     UB-92 Medi-Cal version
```

Figure 2-17: Example of Entry 27 in 3P Export Mode file

Using this export mode requires the user to order this claim form. Instructions to complete this form can be found at http://www.nucc.org.

2.5.3 UB-04

Entry 28 was created in the 3P Export Mode file and is labeled UB-04, OMB No. 0938-0997. This format prints the NPI, as well as the usual required info for a UB claim.

```
Mode of Export..:

   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
   51           UB-92 Medi-Cal     UB-92 Medi-Cal version
```

Figure 2-18: Example of Entry 28 in the 3P Export Mode file

Using this export mode requires the user to order this claim form. Instructions to complete this form can be found at www.nubc.org.

2.5.4 ADA-2006

Entry 29 has been created in the 3P Export Mode file and is labeled ADA-2006. This format prints the NPI, as well as the usual required information for an ADA claim.

```
Mode of Export..:

   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
   51           UB-92 Medi-Cal     UB-92 Medi-Cal version
```

Figure 2-19: Example of Entry 29 in the 3P Export Mode file

Using this export mode requires the user to order this claim form. Instructions to complete this form can be found in the current CDT manual.

2.5.5 NCPDP

Entry 24 has been modified to allow the NPI to populate Form Locator 5 and Form Locator 15, if NPI has been specified in the Insurer File. The current NCPCP form is still valid for this export mode.

2.6 Manual Entry of Resubmission Number

A new menu option has been added to the Third Party Billing system to allow the entry of a resubmission number. This new menu is located under the Print Bills Menu.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                    Print Bills Menu                     +
          |                 INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    2-APR-2007 10:55 AM

   AWPR   Bills Awaiting Export Report
   EXPR   Print Approved Bills
   WSPR   Print Worksheet (Itemized CPT Data)
   MLPR   Print Mailing Address Labels
   REPR   Reprint Bill
   RESB   Enter Resubmission Number
   REPT   Print Patient Statement
   TRPR   Transmittal Listing
   TSPR   Test Forms Alignment

Select Print Bills Menu Option: RESB <Enter> Enter Resubmission Number
```

Figure 2-20: Example of the Resubmission Number (RESB) option on the Print Bills Menu

This option allows for the manual entry of the resubmission number. This is used when the payer has returned a claim, and the billing clerk needs to resubmit after corrections have been made. The user also has the option to reprint the bill right as soon as the resubmission number has been entered.

Prior to patch 1, the user would have to write the number manually on the claim form.

To use this option, consider the following:

- The system will display the Bill Type field. This allows the Bill Type to be updated to correctly reflect a resubmitted bill. Normally, the third digit of the bill type indicates the submission status of the claim.
- Resubmission (Control) Number is the number that has been assigned to the claim for processing by the payer. This is also known as the Internal Control Number (ICN). The user can enter a number up to 29 characters.
- Resubmission (Control) Note is a field that allows the user to enter a message as to why they are resubmitting a claim. The entry of a message is mandatory and is stored into the bill file for historical reference. The user can enter up to 80 characters into this free-text field.

- The user has the option to review the information they entered. The system will display the user's information and the data entered. They can choose to make corrections if needed.
- If the information entered is correct, the user can reprint the bill at that time.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
        +               Enter Resubmission Number                                +
        |                 INDIAN HEALTH HOSPITAL                                 |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: LUJAN,ADRIAN M                      2-APR-2007 10:55 AM

Select BILL or PATIENT:    29733A     DEMO,JOHN          MEDICARE
Bill 29733A? Y// YES
Bill type: 131// 135
Resubmission (Control) Number: // 9999999999
Resubmission (Control) note: // Resubitting with correct provider ID

     Bill# 29733A   04/03/2006PROFESSIONAL COMPONENTEMERGENCY
MEDICINEINDIAN HOSP

     837 PROF (HCFA)BILLED          MEDICARE                1,211.36

     Bill Type: 135                    User: LUJAN,ADRIAN M
     Resubmission Number: 9999999999   Date: 04/02/2007
     Notes: Resubmitting with correct provider ID

Correct? Y// yes  YES

Reprint bill? Y// ES

     (NOTE: HCFA-1500 (08/05) forms need to be loaded in the printer.)

Output DEVICE: HOME//
```

Figure 2-21: Example of Enter Resubmission Number (RESB) option screen

The date entered is used to populate the CMS-1500 Version 2006 and the UB-04 version. The Bill Type and Resubmission number prompts are audited and track the user who edited this information.

```
                          *** BILL FILE INQUIRY ***

===============================================================================
BILL NUMBER: 29733A                       BILL TYPE: 135
  VISIT LOCATION: INDIAN HEALTH HOSPITAL
  BILL STATUS: BILLED                     PATIENT: DEMO,JOHN
  EXPORT MODE: 837 PROF (HCFA)            VISIT TYPE: PROFESSIONAL COMPONENT
  ACTIVE INSURER: MEDICARE                PROCEDURE CODING METHOD: CPT
  CLINIC: EMERGENCY MEDICINE              APPROVING OFFICIAL: LUJAN,ADRIAN M
  DATE/TIME APPROVED: APR 02, 2007@09:28:48
  EXPORT STATUS: AWAITING TRANSFER TO AR
  EXPORT NUMBER: APR 02, 2007@09:28:55    BILL AMOUNT: 1211.36
  INSURER TYPE: MEDICARE                  GROSS AMOUNT: 1211.36
  *UNCOLLECTED BALANCE: 1211.36           ORIGINAL BILL AMOUNT: 0
  RESUBMISSION (CONTROL) NUMBER: 9999999999
  RESUBMISSION (CONTROL) NOTE: Resubmitting with correct provider ID
```

Figure 2-22: Example of Bill File Inquiry with Resubmission Control Number and Note

2.7 Patient Statement

A new menu option, Print Patient Statement, has been added to the Print Bills Menu option in Third Party Billing. This option allows the user to print an itemized statement for a patient. This statement can be used to notify the patient of the services that were provided for each bill approved.

The prompts that allow the statements to print are driven by the patient's eligibility status. The menu automatically screens out Beneficiary patients but the user can select to print a beneficiary statement. The user will be able to print a statement one at a time, by approving official, or by approval date.

Note that the statement is only to be used to inform the patient or insurer of services performed for a specific service date. Payments or adjustments posted to the Accounts Receivable application do not reflect on this statement. Please refer to the Statement section of the Accounts Receivable manual for additional information on printing the statement from that package.

DEPARTMENT OF HEALTH & HUMAN SERVICES
INDIAN HEALTH SERVICE

INDIAN HOSP

STATEMENT OF SERVICES

DATE : 04/02/2007 PATIENT,PAUL
CHART #: 3948 329 WYOMING BLVD
REF # : 21204A ALBUQUERQUE, NM 87112

|PATIENT NAME: PATIENT,PAUL |SERVICE DATE: 06/18/2002 |PAGE: 001
|VISIT TYPE: OUTPATIENT |ATTENDING PHYSICIAN: WILLIAMS,WETZEL D

SERVICE DATE	SERVICE CODE	DESCRIPTION	QTY	AMOUNT
06/18/02	99202	OFFICE/OUTPATIENT VISIT, NEW	1	91.00
		TOTAL CHARGES		91.00

Your coverage on file is:
NO COVERAGE FOUND

|Summary of services rendered

Payments or inquiries may be sent to: INDIAN HEALTH HOSP
PO BOX 34982
PASADENA, CA 91110-0655

505 248 4349

Figure 2-23: Example of Patient Statement

2.7.1 Setting-up the Header

The statement was designed with the following header:

```
                    DEPARTMENT OF HEALTH & HUMAN SERVICES
                            INDIAN HEALTH SERVICE
```

The user may edit the header to more accurately reflect the name of the billing facility or the location where services were rendered. To do so, the user will need to access the Site Parameters menu.

```
USE A/R PARENT SATELLITE SET-UP?:
MEDICARE PART B?.....: NO//
DEFAULT DENTAL CODE PREFIX.:
STATEMENT HEADER PRINT     :
```

The user can enter up to 80-characters of free-text data. Once the header has been edited, it is ready for use.

2.7.2 Printing a Statement

The inclusion parameters for printing a statement are similar to how the Reprint Print Bills option works. The user may elect to print bills one by one or by statements within an approval date. The user can also sort the statements by approving official.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                              |
          +                Print Patient Statement                                     +
          |                 INDIAN HEALTH HOSPITAL                                     |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                      2-APR-2007 1:24 PM

Re-Print Statements for:

     Select one of the following:

          1         SELECTIVE STATEMENT(S)
          2         ALL STATEMENTS WITHIN APPROVED DATE RANGE
          3         APPROVING OFFICIAL

Select Desired Option:
```

Figure 2-24: Example of Re-Print Statements options

The default print option is to print Non-Beneficiary (Non-Indian Patients). A patient is considered Non-Beneficiary, if any insurer on the claim is a Non-Beneficiary (Indian Patient) entry. On the other hand, a patient is considered Beneficiary, if the CHS Eligibility status that has been approved on the bill is Ineligible or if any insurer on the claim is a Beneficiary (Indian Patient) entry.

2.7.3 Printing Selective Statements

Statements may be printed individually. The difference between printing individually and printing in a batch is that by printing individually, the user has the option of adding a message that the patient can view. For example, the message could advise the patient of a payment amount due or to contact the Business Office.

When the user types in the bill number, a prompt appears after the bills have been entered. The user has the option to enter a free-text message up to 80 characters.

```
Select Desired Option: 1  SELECTIVE STATEMENT(S)

Select 1st BILL to Re-Print:    21204A
          Visit: 06-18-2002 OUTPATIENT    URGENT CARE      INDIAN HOSP
           Bill: NON-BENEFICIARY PATIENT       HCFA-1500 Y2K   91.00

This message will print on bottom of statement:

Summary of services rendered
Would you like to edit it?? N// YES <Enter>
Summary of services rendered: This is your first notice. Please remit
payment promptly.

Select 2nd BILL to Re-Print:

               (NOTE: Plain Paper needs to be loaded in the printer.)
```

Figure 2-25: Example of Adding a free text message to the statement

When printed, the bottom of the form will appear similar to the following:

```
Your coverage on file is:
          NO COVERAGE FOUND

 ------------------------------------------------------------------
 |This is your first notice. Please remit payment promptly          |
 ------------------------------------------------------------------

 Payments or inquiries may be sent to:  INDIAN HEALTH HOSP
```

If the user selects a bill for a Beneficiary (Indian) Patient, the system will display the following message. The user still has the option of printing the statement.

```
YOU HAVE SELECTED A STATEMENT FOR AN INDIAN BENEFICIARY.
DO YOU WISH TO CONTINUE PRINTING? N//
```

2.7.4 Printing All Statements within an Approved Date Range

The user may elect to print a batch of statements within an approval date range. To do this, the user selections option number 2 from the menu. They can enter the range of approval dates to print the statements.

```
Select Desired Option: 2 <Enter>  ALL STATEMENTS WITHIN APPROVED DATE RANGE

Enter STARTING APPROVAL DATE for the Report:  04/02/2007// <Enter>  (APR 02,
2007)

Enter ENDING APPROVAL DATE for the Report:  04/02/2007// <Enter>  (APR 02,
2007)

               (NOTE: Plain Paper needs to be loaded in the printer.)

Output DEVICE: HOME//
```

Figure 2-26: Example of prompts for printing All Statements within Approved Date Range option

The user does not have the choice of adding a patient message, if they select to print statements using this option. The option will only print statements where any insurer on the bill is a Non-Beneficiary (Non-Indian) patient.

2.7.5 Approving Official

Use this option to apply Approving Official as an inclusion parameter. This will allow printing the statements by the approving official.

3. Patch 10

3.1 New Coordination of Benefit Page

A new Coordination of Benefit Page (COB) has been added to the claim editor in order to bill secondary insurers when using the export mode for Electronic Data Interchange of the HIPAA 837 format.

> **Note:** ABM Version 2.5 Patch 10 includes a Standard Adjustment Reason Code List (see Appendix C: HIPAA Standard Adjustment Codes Mapped to RPMS).

3.1.1 Accessing the Coordination of Benefit Page

To use the Coordination of Benefit (COB) page,

- One of the insurers must have a Status of Complete, indicating that the insurer's payment was received, posted, and rolled back from the Accounts Receivable system.
- The Mode of Export must an 837 format.

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

When the biller is ready to bill the claim to the secondary payer, entering the letter "A" to Approve the claim, displays a Summary Charge screen. For example:

```
 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MATTHEWS, XXXXX  [HRN: XXXXX]                    Claim Number: XXXXX
.............................. (CLAIM SUMMARY) ..............................

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

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

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

Active Insurer: NEW MEXICO MEDICAID

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

Figure 3-1: Example of the Claim Editor Summary screen

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

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

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

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

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

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

Figure 3-2: Example of Coordination of Benefit (COB) screen

The COB page displays Account Receivable transactions, as follows:

- The left hand column displays Account Receivable Adjustment Categories.
- The right hand column displays the claim's Original Bill Amount and Current Charges. The Current bill Amount displays the sum or the Deductible and Co-insurance total amount from the primary insurer, and the Non-Covered Amount.
- The lower half of the COB page displays billable insurers and claim status codes.

3.1.2 Using the Coordination of Benefit Page

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

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

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

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

Begin by selecting one of the numbered Adjustment transactions and responding to the "Amount," "Adjustment Category," and "Adjustment Type" prompts. At the "Standard Reason" prompt, refer to the Standard Adjustment Reason Codes List to select the appropriate HIPAA code for this Adjustment transaction.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MATTHEWS, XXXXX  [HRN: XXXXX                    Claim Number:  XXXXX
.....................(PRIOR PAYMENTS/ADJUSTMENTS).....................

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

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

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

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

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

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

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

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

Entering a Standard Adjustment Reason Code

When entering a Standard Adjustment Reason Code for an adjustment transaction, the system asks if this amount should be billed to the secondary insurer, which requires a Yes or No response.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MATTHEWS,XXXX  [HRN: XXXXX]                    Claim Number:  XXXXX
..................... (PRIOR PAYMENTS/ADJUSTMENTS) .......................

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

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

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

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

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

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

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

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

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

For example:

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MATTHEWS, XXXX  [HRN: XXXXX]                    Claim Number:  XXXX
..................... (PRIOR PAYMENTS/ADJUSTMENTS) .....................

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

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

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

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

Figure 3-5: Example of using the COB page (3 of 3)

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

- Current Bill Amount is correct, and
- Standard Adjustment Reason Codes are accurate.

If the biller is satisfied with changes applied, typing ‘Q’ (Quit) or pressing Enter displays the prompt to approve the claim for billing to the secondary insurer. Answering Yes creates the bill. For example:

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

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

Transferring Data....

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

DRG Reimbursements Billed to Secondary Insurance

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

When the biller is ready to bill the claim to the secondary payer, entering the letter "A" to Approve the claim, displays a Summary Charge screen. For example:

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MATTHEWS, XXXXX  [HRN: XXXX]                    Claim Number:  XXXX
.............................. (CLAIM SUMMARY) ..............................

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

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

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

Active Insurer: MEDICARE

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

Figure 3-6: COB example of DRG reimbursement billed to Secondary (1 of 4)

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

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MATTHEWS,EMILY  [HRN:45614]                     Claim Number: 29904
..................... (PRIOR PAYMENTS/ADJUSTMENTS).....................

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

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

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

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

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

Figure 3-7: COB example of DRG reimbursement billed to Secondary (2 of 4)

At the “Desired Action” prompt,

- Type E (Edit) and press Enter.
- Select the insurer who has a Completed claim status.

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

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

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

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

Figure 3-8: COB example of DRG reimbursement billed to Secondary (3 of 4)

When entering a Standard Adjustment Reason Code for an adjustment transaction, the system asks if this amount should be billed to the secondary insurer, which requires a Yes or No response.

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

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MATTHEWS,XXXXX  [HRN: XXXXX]                    Claim Number: XXXXX
..................... (PRIOR PAYMENTS/ADJUSTMENTS).....................

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

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

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

[3] INSURER: NEW MEXICO MEDICAID        PRIORITY ORDER: 3   STATUS: PENDING
------------------------------------------------------------------------------

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

Figure 3-9: COB example of DRG reimbursement billed to Secondary (4 of 4)

If the biller is satisfied with changes applied, typing ‘Q’ (Quit) or pressing Enter displays the prompt to approve the claim for billing to the secondary insurer. Answering Yes creates the bill.

3.2 Modification to Anesthesia Calculation in the Claim Editor

Calculating the Anesthesia charges has been modified in Patch 10. The system will only ask for the Base Charge, Start Date/Time, Stop Date/Time, and Service Line provider, along with the standard questions relating to the export mode you are billing for.

The question for Time Charge was removed.

Page 8G - Anesthesia Services of the Claim Editor will now display the minutes that are reported. The reported minutes will also appear on the HCFA-1500 in Form Locator 24G.

Note: Base units and conversion factors were not added to Page 8G, since the Third Party Payer will be calculating the allowance amount based on their fee schedule. In addition, the time is reported as minutes, since most payers require the total minutes to be submitted.

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

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

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

Figure 3-10: Page 8G - Anesthesia Services, modification of the calculation of anesthesia charges

3.3 Addition of Alpha Selection to Claim Editor Loop

New functionality has been added to the Claim Editor LOOP option to allow the billing staff to edit claims alphabetically by the patient's last name. For example, users may select claims with patient names beginning with the letter A and end with the letter K. Additional screening of the patient name is allowed; for example, the letter "G," which should be entered as GAA through GZZ. The option requires an entry of at least three characters at designated prompts.

3.3.1 Accessing the Claims

To begin the edit of claims through the LOOP process by an alpha search, select the LOOP option on the Add/Edit Claim Menu and then Exclusion Parameter number 8, Range of Patients.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                       |
          +                  Add/Edit Claim Menu                                +
          |                 INDIAN HEALTH HOSPITAL                              |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    23-OCT-2006 10:44 AM

   CG1P   Claim Generator, One Patient
   EDCL   Edit Claim Data
   LOOP   Claim Editor Loop
   NEW    Add New Claim (Manual Entry)
   RBCL   Rebuild Items from PCC

Select Add/Edit Claim Menu Option: LOOP  Claim Editor Loop
```

Figure 3-11: Add/Edit Claim Menu LOOP option

The billing clerk will notice the RANGE OF PATIENTS parameter.

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

     Select one of the following:

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

Select ONE or MORE of the above EXCLUSION PARAMETERS: 8
```

Figure 3-12: Claim Looping Exclusion Parameters

The following example uses the LOOP option to edit claims for the patients whose last name begins with the letter "G". The two prompts require three (3) characters. At the "Start with Patient Name" prompt, you would enter GAA, and at the "Go to Patient Name" prompt, you would enter GZZ. The system will begin displaying patient's claims that are marked Flagged as Billable and In Edit mode, whose last name begins with the letter "G". The user can now begin the editing of claims.

```
 Select RANGE OF PATIENTS to display:

Start with Patient Name: GAA

Go to Patient Name: GAA// GZZ

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

   - Range of Patients..: GAA thru GZZ

     Select one of the following:

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

Select ONE or MORE of the above EXCLUSION PARAMETERS:

LOOPING through CLAIMS with a Status of IN EDIT MODE....

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

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

Figure 3-13: Example of selecting Range of Patient Exclusion Parameters

After the system has completed Claim Error checks and Eligibility for Potential Coverage checks, it displays the first claim that falls within the specified exclusion parameters. For this example, it would be the first claim in alphabetic order for patients whose last name begins with the letter "G."

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 0~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: GARCIA,XXXXXX  [HRN:XXXXX]                 Claim Number:  XXXX
......................... (CLAIM SUMMARY)............................

_______ Pg-1 (Claim Identifiers) ____________________ Pg-4 (Providers)_________
Location..:  NOT-A-REAL-FACILITY        | Attn: HANKS,W F
Clinic....: GENERAL                     |
Visit Type: OUTPATIENT                  |
Bill From: 02-19-2006 Thru: 02-19-2006  |__________ Pg-5A (Diagnosis)________
                                        | 1) DYSMENORRHEA
________ Pg-2 (Billing Entity) _________|
PHP                             ACTIVE  |________ Pg-8 (CPT Procedures)______
NON-BENEFICIARY PATIENT         PENDING | 1) OFFICE/OUTPATIENT VISIT,
MEDICARE                        PENDING |
                                        |
___________ Pg-3 (Questions) ____________|
Release Info: NO    Assign Benef: NO    |
____________________________________________|_____________________________

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

Figure 3-14: Example of accessing claims using the Range of Patients Exclusion Parameters

3.4 Visit/Claim/Bill Tally Report

A new Manager Report option has been add to the Table Maintenance submenu. This report is designed to count totals for visits, claims, and bills by a date range. The goal is to create a report that will identify which clinics are generating services more than others in order to accommodate budgets.

The new report is located in the submenu labeled Manager Reports of the Table Maintenance Menu option.

```
   FETM   Fee Schedule Menu ...
   CPTM   CPT File Menu ...
   PRTM   Inquire to Provider File
   LOTM   Location File Menu ...
   INTM   Insurer File Menu ...
   COTM   Coverage Type File Menu ...
   SITM   Site Parameter Maintenance
   ERTM   Error Codes Menu ...
   GRTM   Group Insurance Plans Menu ...
   RVTM   Revenue Codes Menu ...
   UCTM   UB-92 Codes Menu ...
   EMTM   Employer File Menu ...
   DRTM   Drug File Menu ...
   VITM   Visit Type Maintenance
   CMTM   Charge Master Add/Edit
   DMTM   Dental Remap Table Maintenance
   FLTM   Form Locator Override
   PETM   Provider Number Edit
   RLTM   Add/Edit Reference Lab Locations
   SSTM   Initialize New Facility
   TMRP   Manager Reports

Select Table Maintenance Menu Option: TMRP
```

Figure 3-15: Table Maintenance Menu with new Report option, TMRP - Manager Reports

A search can be done by selecting one or more of the exclusion parameters LOCATION, DATE RANGE, or CLINIC. The system default for Location and Clinics is ALL.

In the following example, exclusion parameters are set for the DATE RANGE, and the default ALL is used for LOCATION and CLINIC.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
        +             Visit/Claim/Bill Tally Report               +
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+

EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
=========================================================================
   - Visit Location.....: ALL
   - Clinics...:ALL

     Select one of the following:

          1         LOCATION
          2         DATE RANGE
          3         CLINIC

Select ONE or MORE of the above EXCLUSION PARAMETERS: 2  DATE RANGE

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

Enter STARTING DATE for the Report:  080106  (AUG 01, 2006)

Enter ENDING DATE for the Report:  090106  (SEP 01, 2006)

EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
=========================================================================
   - Visit Location.....: ALL
   - Date Range....:08/01/2006  to: 09/01/2006
   - Clinics...:ALL
```

Figure 3-16: Example of setting exclusion parameters for the Visit/Claim/Bill Tally Report

After the desired exclusion parameters have been selected for the report, the system returns to the Exclusion Parameters Menu, at which time the user should respond to all remaining prompts. The DEVICE will default to Host file server (HFS) and should not be sent to a printer. The system will automatically assign a file name in the format of FACILITY and DATE with a .txt extension.

```
Select one of the following:

          1         LOCATION
          2         DATE RANGE
          3         CLINIC

Select ONE or MORE of the above EXCLUSION PARAMETERS:
DEVICE: HFS//   Virtual    HOST FILE TO USE:
c:\inetpub\ftproot\pub\NOT-A-REAL-FACILITY3061004.txt
  ADDRESS/PARAMETERS: "NWS"//

Requested Start Time: NOW//  (OCT 04, 2006@14:33:24)
Task # 17356 queued.
File to be created:c:\inetpub\ftproot\pub\NOT-A-REAL-
FACILITY3061004.txt
Enter RETURN to continue or '^' to exit:
```

Figure 3-17: Example of setting general report options for the Visit/Claim/Bill Tally Report

3.4.1 Using TaskMan to Check Report Status

The Visit/Claim/Bill Tally Report was designed to print to a host file. The report is a queued task and is assigned a task number. It is important to write down the task number, so you can check the report status in TaskMan.

The report status can be checked in RPMS under the Users Toolbox (TBOX) by entering TASKMAN USER at the “Select User’s Toolbox Option” prompt.

```
Select Add/Edit Claim Menu Option: TBOX  User's Toolbox

          Change my Division
          Clear Electronic signature code
          Display User Characteristics
          Edit User Characteristics
          Electronic Signature code Edit
          Menu Templates ...
          Spooler Menu ...
          Switch UCI
          TaskMan User
          User Help

Select User's Toolbox Option: TASKMAN USER
```

Figure 3-18: Accessing TaskMan

At the "Select TASK" prompt, enter the task number. The system displays a TaskMan User Option menu. At the "Select Action (*Task #*)" prompt, type D to display the report status. The system will display the name of the task and the status of the report. A status of "Completed Today at <*time*>" indicates that the task has completed and is ready to be retrieved.

```
Select TASK: 3061004  TALLED REPORT OF PCC/TPB/AR

               Taskman User Option

                    Display status.
                    Stop task.
                    Edit task.
                    Print task.
                    List own tasks.
                    Select another task.

               Select Action (Task # 2312): D  Display status.

2312: COMPUTE^ABMTALLY, TALLED REPORT OF PCC/TPB/AR.  No device.
IHS,IHS. From Today at 15:46,  By you.  Completed Today at 15:47.
```

Figure 3-19: Example of TaskMan report status

3.4.2 Importing the Report to Excel

In order to read the Visit/Claim/Bill Tally Report, it must be imported to Microsoft Excel and opened in a Worksheet.

To import the report to Excel:

1. Open Microsoft Excel, and click **File** > **Open**.

2. On the **Open** dialog box,

   - For **Look in**, display the dropdown list, and select the folder location of the TaskMan report.
   - For **Files of type**, display the dropdown list, and select **Text Files (*.prn; *.txt; *.csv)** to display the report file (.txt).
   - Select the requested report file, for example, NOT-NOT-A-REAL-FACILITY3061004.txt, and click **Open**.

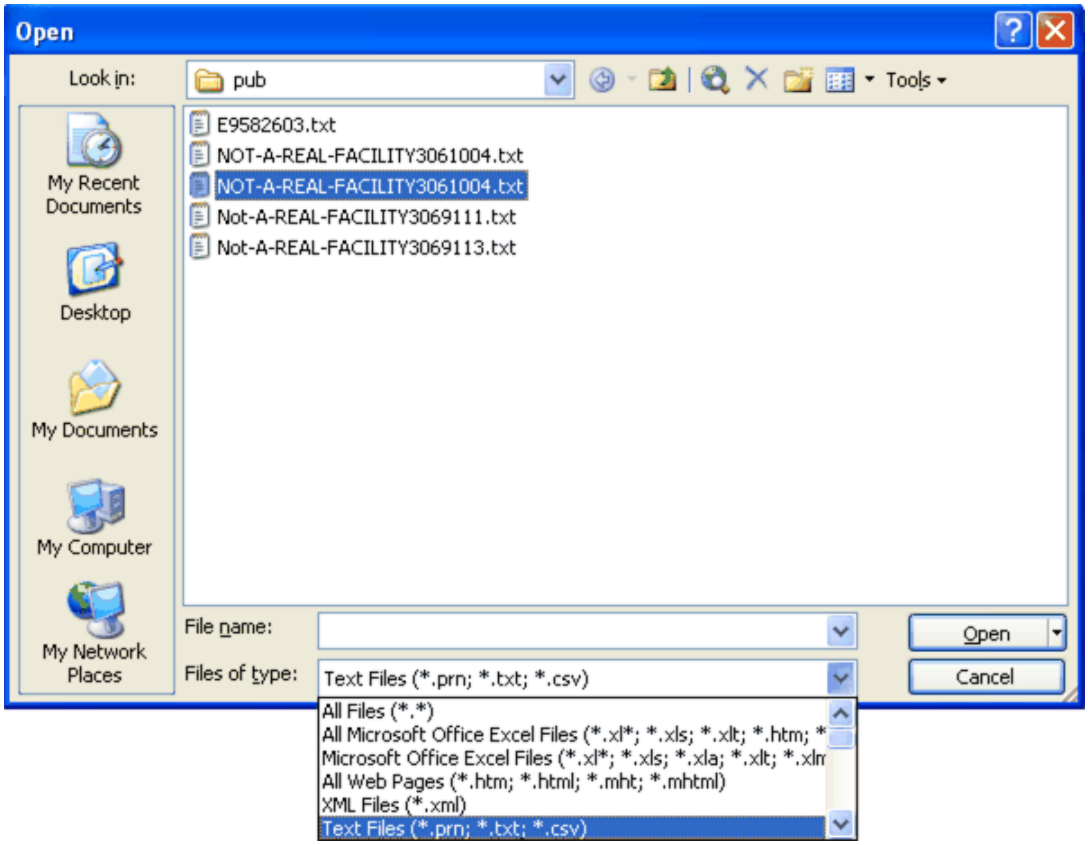


Figure 3-20: Example of Importing a Report to Excel (1 of 4)

The **Text Import Wizard – Step 1 of 3** dialog box appears.

3. For Step 1, choose the **Delimited** file type and click **Next**. For example:

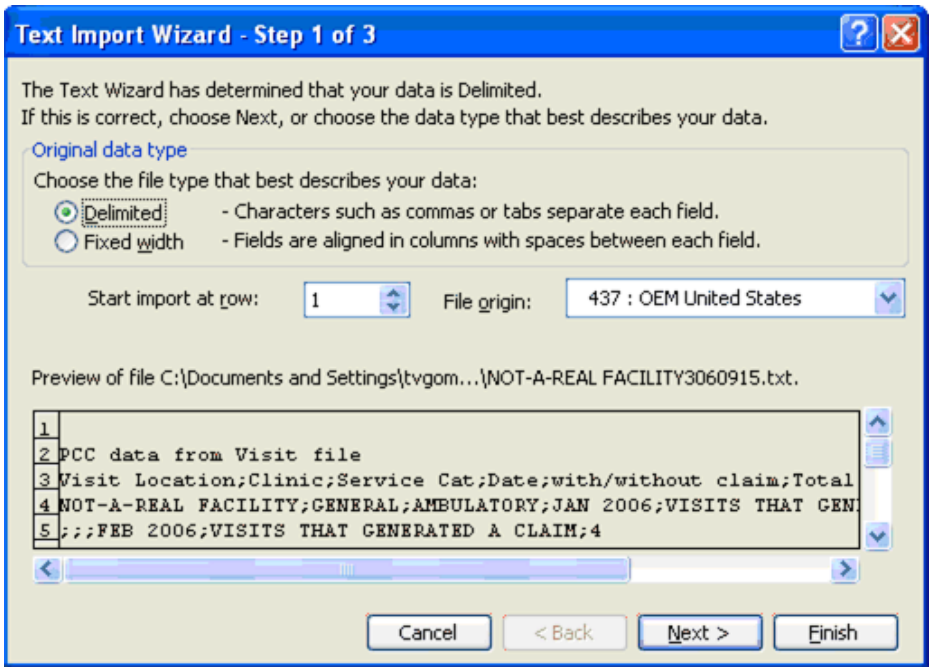


Figure 3-21: Example of Importing a Report to Excel (2 of 4)

4. For Step 2, select the **Tab** and **Semicolon** delimiters and click **Next**. For example:

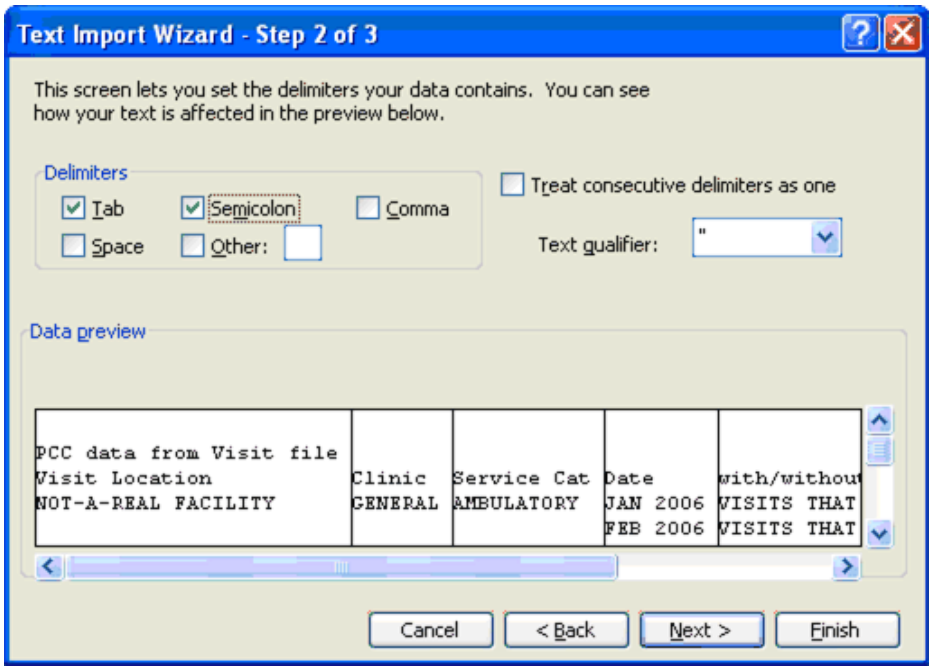
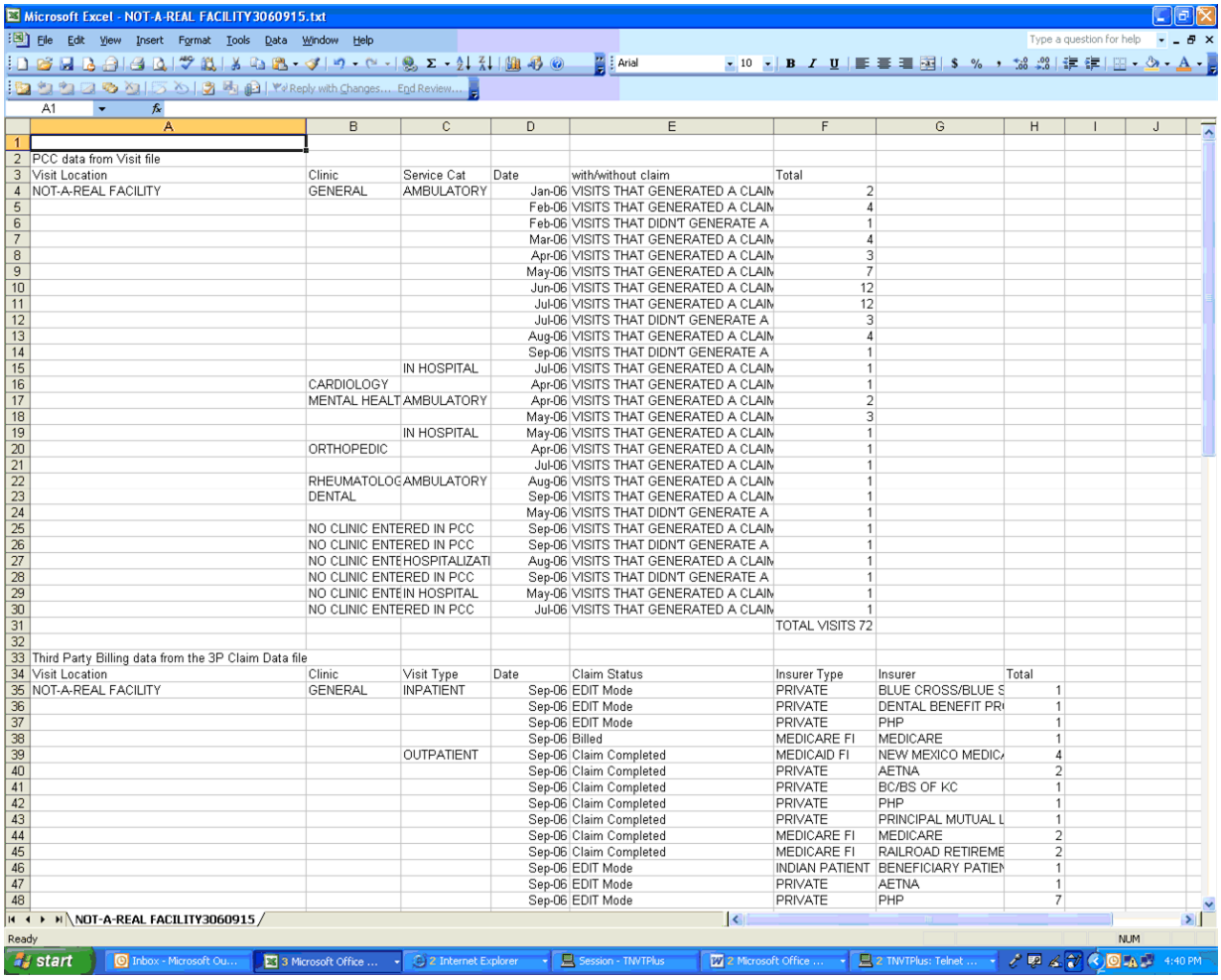


Figure 3-22: Example of Importing a Report to Excel 3 of 4)

5. For Step 3, click **Finish**.

The report appears in the Excel spreadsheet. To review all of the data, adjust the Excel columns.



Microsoft Excel - NOT-A-REAL FACILITY3060915.txt

	A	B	C	D	E	F	G	H
2	PCC data from Visit file							
3	Visit Location	Clinic	Service Cat	Date	with/without claim	Total		
4	NOT-A-REAL FACILITY	GENERAL	AMBULATORY	Jan-06	VISITS THAT GENERATED A CLAIM	2		
5				Feb-06	VISITS THAT GENERATED A CLAIM	4		
6				Feb-06	VISITS THAT DIDN'T GENERATE A	1		
7				Mar-06	VISITS THAT GENERATED A CLAIM	4		
8				Apr-06	VISITS THAT GENERATED A CLAIM	3		
9				May-06	VISITS THAT GENERATED A CLAIM	7		
10				Jun-06	VISITS THAT GENERATED A CLAIM	12		
11				Jul-06	VISITS THAT GENERATED A CLAIM	12		
12				Jul-06	VISITS THAT DIDN'T GENERATE A	3		
13				Aug-06	VISITS THAT GENERATED A CLAIM	4		
14				Sep-06	VISITS THAT DIDN'T GENERATE A	1		
15			IN HOSPITAL	Jul-06	VISITS THAT GENERATED A CLAIM	1		
16		CARDIOLOGY		Apr-06	VISITS THAT GENERATED A CLAIM	1		
17		MENTAL HEALT	AMBULATORY	Apr-06	VISITS THAT GENERATED A CLAIM	2		
18				May-06	VISITS THAT GENERATED A CLAIM	3		
19			IN HOSPITAL	May-06	VISITS THAT GENERATED A CLAIM	1		
20		ORTHOPEDIC		Apr-06	VISITS THAT GENERATED A CLAIM	1		
21				Jul-06	VISITS THAT GENERATED A CLAIM	1		
22		RHEUMATOLOG	AMBULATORY	Aug-06	VISITS THAT GENERATED A CLAIM	1		
23		DENTAL		Sep-06	VISITS THAT GENERATED A CLAIM	1		
24				May-06	VISITS THAT DIDN'T GENERATE A	1		
25		NO CLINIC ENTERED IN PCC		Sep-06	VISITS THAT GENERATED A CLAIM	1		
26		NO CLINIC ENTERED IN PCC		Sep-06	VISITS THAT DIDN'T GENERATE A	1		
27		NO CLINIC ENTE	HOSPITALIZATI	Aug-06	VISITS THAT GENERATED A CLAIM	1		
28		NO CLINIC ENTERED IN PCC		Sep-06	VISITS THAT DIDN'T GENERATE A	1		
29		NO CLINIC ENTE	IN HOSPITAL	May-06	VISITS THAT GENERATED A CLAIM	1		
30		NO CLINIC ENTERED IN PCC		Jul-06	VISITS THAT GENERATED A CLAIM	1		
31						TOTAL VISITS 72		
32								
33	Third Party Billing data from the 3P Claim Data file							
34	Visit Location	Clinic	Visit Type	Date	Claim Status	Insurer Type	Insurer	Total
35	NOT-A-REAL FACILITY	GENERAL	INPATIENT	Sep-06	EDIT Mode	PRIVATE	BLUE CROSS/BLUE S	1
36				Sep-06	EDIT Mode	PRIVATE	DENTAL BENEFIT PR	1
37				Sep-06	EDIT Mode	PRIVATE	PHP	1
38				Sep-06	Billed	MEDICARE FI	MEDICARE	1
39			OUTPATIENT	Sep-06	Claim Completed	MEDICAID FI	NEW MEXICO MEDIC	4
40				Sep-06	Claim Completed	PRIVATE	AETNA	2
41				Sep-06	Claim Completed	PRIVATE	BC/BS OF KC	1
42				Sep-06	Claim Completed	PRIVATE	PHP	1
43				Sep-06	Claim Completed	PRIVATE	PRINCIPAL MUTUAL L	1
44				Sep-06	Claim Completed	MEDICARE FI	MEDICARE	2
45				Sep-06	Claim Completed	MEDICARE FI	RAILROAD RETIREME	2
46				Sep-06	EDIT Mode	INDIAN PATIENT	BENEFICIARY PATIEN	1
47				Sep-06	EDIT Mode	PRIVATE	AETNA	1
48				Sep-06	EDIT Mode	PRIVATE	PHP	7

Figure 3-23: Example of Importing a Report to Excel (4 of 4)

3.5 Generating Two Claims

There may be instances when the patient has more than one encounter for the day. Prior to Patch 10, the claim generator generated one claim per patient visit, as long as the visits contained the same Visit Date, Visit Locations, Visit Type (from the Service Category), or Clinic Code.

Additional checks were added to the claim generator. In addition to checking the current criteria, the system will now check the Primary Providers and the Primary Diagnosis code for each visit, to determine if a new claim needs to be generated separately from the primary claim.

The following logic may help to clarify this:

IF:
- VISIT DATE are equal
- Visit Locations are equal
- Visit Type are equal
- Clinics are Equal
- Primary Provider are Equal
- Primary DX are Equal

Make 1 claim from Both Visits

IF:
- VISIT DATE are equal
- Visit Locations are equal
- Visit Type are equal
- Clinics are Equal
- Primary Provider **are not** Equal
- Primary DX are Equal

Make 2 claims from each of the two visits

IF:
- VISIT DATE are equal
- Visit Locations are equal
- Visit Type are equal
- Clinics are Equal
- Primary Provider **are** Equal
- Primary DX **are not** Equal

Make 2 claims from each of the two visits

IF:
- VISIT DATE are equal
- Visit Locations are equal
- Visit Type are equal
- Clinics are Equal
- Primary Provider **are not** Equal
- Primary DX **are not** Equal

Make 2 claims from each of the two visits

3.6 837 Export Mode Changes

3.6.1 Removal of the PRV Segment for certain insurers

> **Note:** The PRV Segment contains the HIPAA Provider or Location taxonomy codes. *Do not remove* the segment unless directed to do so by the insurer.

If certain insurers require that the PRV segments not be sent on any of the 837 formats, the user can elect to add the insurer to the new Site Parameters prompt, to remove the PRV Segment from the 837 files.

```
Select CLAIM PAGE(s) TO BE SKIPPED: SUPPLIES//
PAGE 9 REMARKS:
  1>
Select INSURERS W/O 837 PRV SEGMENT: WASHINGTON MEDICAID(MEDICAID WASHINGTON)
.
WASHINGTON MEDICAID                  - PO BOX 9248
                                       OLYMPIA, WA 98507-9248
 OK? Y//

Select INSURERS W/O 837 PRV SEGMENT:
```

Figure 3-24: Removing PRV segment for 837 formats example

3.7 Addition of the SERVICE TO Prompt in the Claim Editor

An additional prompt was added to the CPT pages of the Claim Editor. The field allows the user to report an end date/time, if it is different than the begin date/time of service. This may be useful for billing for services such as Post-Op Care or Physical Therapy.

The following example displays page 8A - Medical Services of the Claim Editor. The Date of Service for this example is January 25, 2006.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: BANDERAS,ANTONIO  [HRN:45613]                   Claim Number: 29888
Mode of Export: HCFA-1500 Y2K
.............................. (MEDICAL SERVICES)............................

    REVN                                                    UNIT       TOTAL
    CODE         CPT - MEDICAL SERVICES                    CHARGE QTY  CHARGE
    ==== ============================================  ====== === =======
[1]  CHARGE DATE: 01/25/2006
     0510 99214 OFFICE/OUTPATIENT VISIT, EST              90.00  1    90.00
[2]  CHARGE DATE: 01/25/2006 (COBERLY,ROBERT W-R)
     **** 99215 OFFICE/OUTPATIENT VISIT, EST             174.00  1   174.00
                                                                   ========
                                                                    $264.00

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// E
Sequence Number to EDIT:  (1-2): 1

[1]  99214

Select 1st MODIFIER:

                     DIAGNOSES
       Seq   ICD9
       Num   Code              Diagnosis Description
       ===  ======   ========================================
        1   291.0    DELIRIUM TREMENS

SERVICE FROM DATE/TIME: JAN 25,2006// 012406  (JAN 25, 2006)
SERVICE TO DATE/TIME: JAN 26,2006//
UNITS: 1//

PLACE OF SERVICE: 21//
TYPE OF SERVICE: 1//
```

Figure 3-25: Example of SERVICE TO prompt addition to CPT pages in the Claim Editor

The Service From/To Date/Time prompts were used to change the date of services to indicate Post Op care from January 25, 2006 to January 26, 2006. As a result, the claim will print with date of services of January 25, 2006 to January 26, 2006.

3.8 Use of CARD NAME When Exporting

Patch 1 of the RPMS Patient Registration system allowed the user to enter the name of the policyholder, if the name was different than the name of the registered policyholder.

To enable the use of CARD NAME, Patch 10 modified the export modes to print the Card Name, if it exists on Page 4. If there is no Card Name entry, then the system prints the Policy Holder Name.

3.9 Claim Editor, Page 8C - Revenue Code: New CPT Field

A new field was added on Page 8C - Revenue Code of the Claim Editor to allow the Billing clerk to add a CPT code to the Revenue Code they are billing for.

In cases where the revenue code reflects the facility charge, for example, Room & Board or Emergency Room charges, the user can add the code which will be reflected on the 837-I or the UB92. The system will add the CPT code on the claim form as it is being printed.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8C  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                          Claim Number: 29715
Mode of Export: 837 INST (UB)
.............................. (REVENUE CODE) ............................

                                                                        TOTAL
     REVENUE CODE                      CPT    CHARGE    DAYS   UNITS     CHARGE
     ============================      ===    ======    ====   =====    =======

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A
Select REVENUE CODES: 450       EMERG ROOM     GENERAL CLASSIFICATION
UNITS: 1
UNIT CHARGE: 700//
CPT CODE: 99282    EMERGENCY DEPT VISIT
       EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A
       PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS:
         ...OK? Yes//   (Yes)

DATE/TIME: SEP 04, 2006

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8C  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                          Claim Number: 29715
Mode of Export: 837 INST (UB)
.............................. (REVENUE CODE) ............................

                                                                        TOTAL
     REVENUE CODE                      CPT    CHARGE    DAYS   UNITS     CHARGE
     ============================      ===    ======    ====   =====    =======
[1]  CHARGE DATE: 09/04/2006
     0450 EMERG ROOM                 99282   700.00      0       1      700.00
                                                        ====            =======
                                                          0            $700.00

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

Figure 3-26: Page 8C - Revenue Code, new CPT code field

3.10 Claim Editor: Special Program Referrals Question

On Page 3 - Questions, new fields were added to question 6, Special Program referrals. **Referral Reason** is used only to report the type of referral, if EPSDT is indicated. Completing this section is required to submit a successful 837 Professional file, since these fields get populated in Loop 2300, CRC01-CRC04.

To use the Special Program Referral option, your Mode of Export must be set to 837 P on Page 1 of the Claim Editor.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JAMES  [HRN:45613]                          Claim
Number: 29586
.............................. (QUESTIONS)
..............................

 [1] Release of Information..: YES   From: 06/09/2006
 [2] Assignment of Benefits..: YES   From: 06/09/2006
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.:
 [6] Special Program.........: YES
 [7] Outside Lab Charges.....:
```

Figure 3-27: Claim Editor, Page 3 - Questions

To enter a referral reason, type E (Edit) at the Desired ACTION prompt and select Question 6 on Page 3. The system asks if the visit is related to a Special Program. The default response is YES, since the visit is for a Special Program.

```
[6] Was visit related to a SPECIAL PROGRAM? Y// YES

Select SPECIAL PROGRAM: ??

   Choose from:
   80        NON-THERAPUTIC STERILIZATION
   01        EPSDT/CHAP
   02        PHYSICALLY HANDICAPPED CHILDREN'S PROGRAM
   03        SPECIAL FEDERAL FUNDING
   04        FAMILY PLANNING
   05        DISABILITY
   06        PVV/MEDICARE 100% PAYMENT PROGRAM
   07        INDUCED ABORTION-DANGER TO LIFE
   08        INDUCED ABORTION-RAPE/INCEST VICTIM

Select SPECIAL PROGRAM: 01
```

Figure 3-28: Claim Editor, Page 3, Question 6 Special Program example (1 of 4)

Next, the system asks if this is an EPSDT referral. The answer may be Yes or No.

```
EPSDT REFERRAL?: ??

     Choose from:
       Y        YES
       N        NO
EPSDT REFERRAL?: YES
```

Figure 3-29: Claim Editor, Page 3, Question 6 Special Program example(2 of 4)d

If the response is Yes, then the system prompts for a Referral Reason. Three choices are available, and you may choose more than one reason. Each response selected will appear in CRC03 of the 837 P.

```
Select referral reason(s):??
        You may enter a new REFERRAL REASON, if you wish
   Choose from:
          AV    AVAILABLE-NOT USED
          S2    UNDER TREATMENT
          ST    NEW SERVICES REQUESTED

Select referral reason(s):S2  (S2   UNDER TREATMENT)
Select referral reason(s):
```

Figure 3-30: Claim Editor, Page 3, Question 6 Special Program example (3 of 4)

After all data have been entered, Page 3 will display the Referral Reason information:

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JAMES  [HRN:45613]                        Claim Number: 29586
.............................. (QUESTIONS) ..............................

 [1] Release of Information..: YES   From: 06/09/2006
 [2] Assignment of Benefits..: YES   From: 06/09/2006
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.:
 [6] Special Program.........: YES  EPSDT/CHAP              Referral: S2
 [7] Outside Lab Charges.....:
 [8] Date of First Symptom...:
```

Figure 3-31: Claim Editor, Page 3, Question 6 Special Program example (4 of 4)

3.11 Durable Medical Equipment (DME) Changes

Patch 10 added functionality to allow billing for Durable Medical Equipment (DME) electronically. The Insurer File contains a new question labeled **DME Contractor**, which allows the display of the following questions:

- **Addition of DME Group Number/Name**

  DME payers that require a Group Name or Number to be submitted on their claim forms can enter a default Group Number or Name, which will print on the paper or electronic export.

- **Ability to Report the CLIA Number for All DME Claims**

  Payers that require the CLIA number to be submitted on all DME Claims now have the ability to print the CLIA number on the paper or electronic export. Answering Yes enables the printing of the CLIA number.

```
VISIT                Mode of      Mult  Fee     ----- Flat Rate ------
 Type - Description   Export       Form  Sched   Start    Stop     Rate
=========================================================================
 131 OUTPATIENT        UB-92        NO
 993 MEDICAL SUPPLY  HCFA-1500 Y2K  NO

Select VISIT TYPE..:   MEDICAL SUPPLY
Billable (Y/N/E)....: YES//
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........:
Multiple Forms?.....: NO//
Payer Assigned Provider Number.....: 5511070999//
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.......:
Mode of Export......: HCFA-1500 Y2K//
Block 24K...........: MD PROVIDER NUMBER//
Block 29............:
Block 33 PIN#.......: PROVIDER CODE//
DME Contractor?.....: YES//
DME GROUP NUMBER/NAME: 00098888//
CLIA# req'd for all visits? : YES//
Which CLIA should print? : IN-HOUSE LAB CLIA//
```

Figure 3-32: Example of changes to Durable Medical Equipment (DME) billing

3.12 UB92 Export Mode Changes

3.12.1 RX Number on UB 92

Patch 9 of version 2.5 allowed the RX number (prescription number) to print in Form Locator 44 of the paper UB92. However, some payers may not require the RX number. As a result, a new prompt was added in the Visit Type section of the Insurer file to accommodate printing of the RX number in FL44 of the UB92. The new prompt allows users to choose whether to print/not print the RX number on the paper claim form by answering Yes or No.

```
Visit               Mode of     Mult  Fee    ------- Flat Rate --------
Type - Description   Export     Form Sched   Start      Stop       Rate
=========================================================================
 131   OUTPATIENT           UB-92       NO
 831   AMBULATORY SURGER    UB-92       NO
 994   OPTOMETRY          HCFA-1500 Y2K NO
 997   PHARMACY            ***** (UNBILLABLE) *****
 998   DENTAL              ***** (UNBILLABLE) *****
 999   PROFESSIONAL COMP  HCFA-1500 Y2K N/A

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

Billable (Y/N/E)....: YES//
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before)..: OCT 1,1998
         //
Procedure Coding....: CPT//
Fee Schedule........:
Multiple Forms?.....: NO//
Payer Assigned Provider Number.....:
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.......:
Mode of Export......: UB-92//
Itemized UB?.....: YES//
RX# IN FL44?.....:  Y
```

Figure 3-33: UB92 Export Mode, new prompt for printing RX number

3.12.2 Form Locator 79 and 80

A modification was made to the paper UB92 export mode to print "9" in Form Locator 79 and the ICD-9 procedure code in Form Locator 80, as long as an ICD-9 procedure code exists on Page 5B of the Claim Editor. This allows the reporting/printing of the ICD-9 procedure code rather than the CPT procedure code in the UB92 Form Locator 80 field.

67 PRIN.DIAG.CD.	OTHER DIAG CODES								76 ADM DIAG.CD	77 E-CODE	78
	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE			
455.9									4559		

79 P.C.	80 PRINCIPAL PROCEDURE		81 OTHER PROCEDURE CODE		82 OTHER PROCEDURE		82 ATTENDING PHYS. ID	NM-0018388
	CODE	DATE	CODE	DATE	CODE	DATE		
9	49.03	091006					JOHN Q PROVIDER	
							83 OTHER PHYS. ID	
84 REMARKS							OTHER PHYS.ID	

Figure 3-34: UB92 Export Mode, Form Locators 79, 80 modifications example

3.13 Adding Notes to Dental Claims

An enhancement was added to allow any notes placed on Page 9F - Remarks of the Claim Editor, to print on any paper claim forms that contain a 'Notes' section. This includes the ADA-94, ADA-99 and the ADA-2002 claim forms.

> **Note:** Only a limited number of characters will print on the paper forms, depending on the size of the text box.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9F  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JAMES  [HRN:45613]                          Claim Number: 29707
.............................. (REMARKS) ..............................

                 ADA-2002 REMARKS
      ======================================
       (48 characters x 4 lines max)
     ------------------------------------------------
[1]  TOOTH NUMBER 11 EXTRACTED
[2]
[3]
[4]
     ------------------------------------------------

REMARKS:
TOOTH NUMBER 11 EXTRACTED

  Edit? NO//

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

Figure 3-35: Claim Editor, Page 9F - Remarks, adding notes for Dental claims

3.14 Fix for Error Code – Error 123

This Claim Editor error is labeled "PROCEDURE(S) MISSING THE NUMBER OF UNITS" and usually displays when the units are missing for any CPT charge. Prior to Patch 10, the error was not displaying on Page 8B (Surgical) when the units were missing. This caused the charge to not show up on the electronic claim which resulted in a rejected file.

Patch 10 corrected Page 8B to inform the user if there are no units corresponding to the charge.

3.15 New Error Code – Error 219

A new error code was added to Page 2 - Insurers of the Claim Editor, labeled "MEDICARE ACTIVE INSURER AND DOB MISSING FROM PAT REG PAGE 4." Error Code 219 advises the Billing clerk that the patient has active Medicare coverage and the Date of Birth is missing. The user needs to go to the Medicare Page (Page 4) of the Patient Registration Editor and complete the Date of Birth field.

Note: A missing Date of Birth field will cause claims to reject.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: OLDAGE,LADY  [HRN:99095]                        Claim Number: 29717
.............................. (INSURERS) ..............................

To: TRAILBLAZER HEALTH ENT.LLC          Bill Type...: 131
    12800 INDIAN SCHOOL RD, NE          Proc. Code..: ICD9
    ALBUQUERQUE, NM  87125              Export Mode.: 837 INST (UB)
    (888)763-9836                       Flat Rate...: 193.00
.............................................................................
MSP STATUS AS OF JUN 15, 2004: [B]-BLACK LUNG
.............................................................................

             BILLING ENTITY            STATUS       POLICY HOLDER
     ============================  ==========  ============================
[1]  MEDICARE                      ACTIVE      OLDAGE,LADY M
[2]  BEWARE INSURANCE              PENDING     OLDAGE,LADY
-----------------------------------------------------------------------------
  ERROR:219 - MEDICARE ACTIVE INSURER AND DOB MISSING FROM PAT REG PAGE 4
-----------------------------------------------------------------------------
Desired ACTION (Del/Pick/View/Next/Jump/Back/Quit): N//
```

Figure 3-36: Claim Editor, Page 2 - Insurers, new Error Code 219

3.16 New Error Code – Error 217

A new error code was added to the CPT pages of the Claim Editor, labeled "DX HAS BEEN DELETED THAT IS BEING REFERENCED." Error Code 217 will be displayed, if the ICD-9 diagnosis code was deleted on Page 5A (Diagnosis Page) after the ICD-9 diagnosis code was linked to the CPT code. The user must re-edit the charge and re-link the appropriate ICD-9 diagnosis code to the CPT code. This error attempts to prevent claims from being returned to the provider for correction.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MEGABUCKS,SYLVIA  [HRN:1122]                    Claim Number: 24595
Mode of Export: HCFA-1500 Y2K
.............................. (MEDICAL SERVICES) ............................

     REVN                                                    UNIT       TOTAL
     CODE         CPT - MEDICAL SERVICES                    CHARGE QTY  CHARGE
     ==== ============================================  ====== === =======
[1]  CHARGE DATE: 04/02/2004 (GREEN,TERRY L-R)
     **** 99212 OFFICE/OUTPATIENT VISIT, EST               49.00  1    49.00
                                                                    ========
                                                                      $49.00
------------------------------------------------------------------------------
WARNING:217 - DX HAS BEEN DELETED THAT IS BEING REFERENCED (1)
------------------------------------------------------------------------------

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

Figure 3-37: Claim Editor, new Error Code 217 added to CPT pages

3.17 New Parameter to Allow the Dash (-) to Print in Block 1a of HCFA-1500

A new field has been added to the Visit Type section of the Insurer File in Third Party Billing Table Maintenance, which allows the dash (-) to print in Block 1a of the HCFA-1500. The user may select this option only when the default mode of export is the HCFA-1500 Y2K (14) or the HCFA-1500b (3).

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

Billable (Y/N/E)....: YES//
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before)..: JAN 1,2005
         //
Procedure Coding....: CPT//
Fee Schedule........: 8//
Multiple Forms?.....: NO//
Payer Assigned Provider Number.....: 9900605//
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.......: NO//
Mode of Export......: 837 PROF (HCFA)// 14    HCFA-1500 Y2K     HCFA 1500 Y2K
Block 24K...........: MD PROVIDER NUMBER//
Block 29............:
Block 33 PIN#.......:
Dash in block 1A?: YES
```

Figure 3-38: Example of new parameter in Visit Type section of Insurer file to allow dash (-) to print in HCFA-1500, Block 1a

The user can elect to have this option turned on, if submitting paper claims. Having this option turned on has no effect on the 837 export modes.

3.18 Easier View for Provider Taxonomy

A modification was made to Page 4 - Provider View of the Claim Editor, which displays the provider's taxonomy code prior to creating an electronic batch file.

To display the Provider Taxonomy code, go to Page 4 of the Claim Editor, and at the "Desired Action" prompt, type V (View).

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                          Claim Number: 29716
.......................... (PROVIDER VIEW OPTION) ........................

Attn Prov..: DOCTOR,DOLITTLE                      Phone #....:
Discipline.: PHYSICIAN                            MCR/MCD #..: NM-12345
Affilliation: IHS                                 DEA #......: AB1234567
                                                  Provider Taxonomy:207Q00000X
------------------------------------------------------------------------------
            ***** Provider Information Entered Through PCC *****
PRI        PROVIDER                                DISCIPLINE
=== ==================================   ==============================
 P  DOCTOR,DOLITTLE                      PHYSICIAN
 S  NURSE,BETTY                          LICENSED PRACTICAL NURSE
------------------------------------------------------------------------------

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

Figure 3-39: Claim Editor, Page 4 - Provider View, modification to display Provider Taxonomy code

3.19 Medicare Part D Report

A new report was added to the Eligibility Report Menu labeled "MEDICARE PART D ENROLLEES." This report counts the number of eligible Medicare Part D recipients by Plan Name and is sorted by Service Unit.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                Eligibility Reports Menu                                +
          |                 INDIAN HEALTH HOSPITAL                                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+

   MARP   Listing of Medicare Part A Enrollees
   MBRP   Listing of Medicare Part B Enrollees
   MRDP   Listing of Medicare Part D Enrollees
   MDRP   Listing of Medicaid Enrollees
   PIRP   Private Insurance Eligibility Listing
   VARP   VA Eligibility Listing
   CORP   Listing of Commissioned Officers and Dependents
   VCRP   Visits by Commissioned Officers and Dependents
   PMRP   Listing of Policies and Members by Insurer

Select Eligibility Reports Menu Option: MRDP
```

Figure 3-40: Eligibility Reports Menu, new report option: MRDP - Listing of Medicare Part D Enrollees

After selecting the **MRDP** - Listing of Medicare Part D Enrollees option, the system displays a brief description of the report's search criteria and a list of insurers classified as a Medicare Part D insurance carrier.

The system will screen the Part D payers by the Name of the Plan and/or the Type of Insurer. This means that the report will print data for insurers that have a "D" in the name or contain the insurance type code "MD" (Medicare Part D).

The system prompts, “Do you wish to include any other insurers?” This prompt defaults to No. Typing Yes allows the user to add additional Part D plan names that were not included in the generated list of plans.

```
    +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
    |          THIRD PARTY BILLING SYSTEM - VER 2.5                           |
    +          Listing of Medicare Part D Enrollees                          +
    |                 INDIAN HEALTH HOSPITAL                                 |
    +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: VIGIL-GOMEZ,THELMA                 13-OCT-2006 2:23 PM
  This option will print a list of Patients who are registered at the
  facility you select who are currently enrolled in a Medicare Part D plan.

  You will be asked to enter an "As of" date to be used in determining
  those patients who are "actively" enrolled in a plan.

  The report will be sorted alphabetically by Plan Name.

  The following insurers contain the Insurer Type code of "MD" or contain
  "D-" in the name of the plan:

          ATLAS INSURANCE                     MCR PART D
          D-AARP                              MCR PART D
          D-ALWAYZAGING INSURANCE             MCR PART D
          D-ATLLAS INSURANCE                  MCR PART D
          D-CRITERION                         PRIVATE
          D-DRUG PLAN USA                     MCR PART D
          D-DRUGS UNLIMITED                   MCR PART D
          D-FAMOUS DRUG PLAN                  MCR PART D
          D-HUMANA STANDARD                   MCR PART D
          D-IOWA PHARMACY SERVICE CORP        PRIVATE
          D-MEDICARE PART D PLAN              PRIVATE
          D-PACIFICARE SAVER                  PRIVATE
          D-PRESCRIPTION SOLUTION             MCR PART D
          D-SMITH DRUG PLAN                   PRIVATE
          D-TRIMEE RX PLAN                    PRIVATE

Do you wish to include any other insurers?? N// YES

Select INSURER NAME: GEHA
```

The system prompts the user to “Display eligibility as of what date.” For example:

```
Display eligibility as of what date?:  Today// 6/1/2006  (JUN 1,2006)
```

The default date is Today, but the user can enter a different date.

Next, the system prompts the user to exclude any inactive or deceased patients. Answer this question to proceed to the next prompt, which asks if a detail view of patients should be displayed. For example:

```
Do you wish to view detail (patients)? NO//
```

If the user accepts the default NO, the system will print a report that displays only a count of the number of entries by plan name. If the answer to this prompt is YES, the system will print a report that displays each patient's eligibility under the Plan Name and include the Subscribers Name, Policy Holder ID, and Effective dates.

```
  This option will print a list of Patients who are registered at the
  facility you select who are currently enrolled in a Medicare Part D plan.

  You will be asked to enter an "As of" date to be used in determining
  those patients who are "actively" enrolled in a plan.

  The report will be sorted alphabetically by Plan Name.

  The following insurers contain the Insurer Type code of "MD" or contain
  "D-" in the name of the plan:

          ATLAS INSURANCE                    MCR PART D
          D-AARP                             MCR PART D
          D-ALWAYZAGING INSURANCE            MCR PART D
          D-ATLLAS INSURANCE                 MCR PART D
          D-CRITERION                        PRIVATE
          D-DRUG PLAN USA                    MCR PART D
          D-DRUGS UNLIMITED                  MCR PART D
          D-FAMOUS DRUG PLAN                 MCR PART D
          D-HUMANA STANDARD                  MCR PART D
          D-MEDICARE PART D PLAN             PRIVATE
          D-PACIFICARE SAVER                 PRIVATE
          D-PRESCRIPTION SOLUTION            MCR PART D
          D-SMITH DRUG PLAN                  PRIVATE
          D-TRIMEE RX PLAN                   PRIVATE
          GOV EMPLOYEES HOSPITAL ASSOC       PRIVATE

Do you wish to include any other insurers??  Y//N
Display eligibility as of what date?:  Today//   (OCT 6,2006)
Do you wish to EXCLUDE inactive and deceased patients? YES//
Do you wish to view detail (patients)? NO//
```

Figure 3-41: Example of setting up the MRDP - Listing of Medicare Part D Enrollees Report

When the system prompts for a device, enter a device name and press Enter.

When the report prints, it will display the Medicare Part D information, which includes a

- Total Number of Medicare/Railroad Eligible Enrollees per Service Unit
- Total Number of Active Medicare Part D Enrollees: for All Service Units

Note: The report will not allow the user to print by location

The report includes the date the report was printed, which can be used for tracking purposes.

The following example of an MRDP report is based on a request for Total Number Counts for two Service Units and not a detailed report with patient information.

The Service Unit (SU) for Albuquerque has a total Part D count of **17** Medicare eligible enrollees and the Zuni Service Unit has a total Part D of **3** Medicare eligible enrollees. Keep in mind that you take the numbers from your (SU). If patients were enrolled at an outside SU, they may be duplicates from your home SU.

Also notice the report has a count for every enrollee by plan name registered at each Service Unit.

```
DEVICE: HOME//   Virtual    Right Margin: 80//
OCT 6,2006                                                        Page 1
             REGISTERED PATIENTS - ACTIVE MEDICARE PART D ENROLLEES
                       Actively enrolled as of OCT 6,2006

  Service Unit: ALBUQUERQUE  ALBUQUERQUE, NM

  PLAN NAME                                INS TYPE            COUNT
-------------------------------------------------------------------------
  ATLAS INSURANCE                          MCR PART D              0
  D-AARP                                   MCR PART D              6
  D-ALWAYZAGING INSURANCE                  MCR PART D              0
  D-ATLLAS INSURANCE                       MCR PART D              0
  D-CRITERION                              PRIVATE                 0
  D-DRUG PLAN USA                          MCR PART D              3
  D-DRUGS UNLIMITED                        MCR PART D              1
  D-FAMOUS DRUG PLAN                       MCR PART D              2
  D-HUMANA STANDARD                        MCR PART D              6
  D-IOWA PHARMACY SERVICE CORP             PRIVATE                 0
  D-MEDICARE PART D PLAN                   PRIVATE                 0
  D-PACIFICARE SAVER                       PRIVATE                 0
  D-PRESCRIPTION SOLUTION                  MCR PART D              1
  D-SMITH DRUG PLAN                        PRIVATE                 0
  D-TRIMEE RX PLAN                         PRIVATE                 0

              TOTAL FOR ALBUQUERQUE SERVICE UNIT:                 17
          TOTAL NUMBER OF MEDICARE/RAILROAD ELIG ENROLLEES:       10
```

```
  Service Unit:  ZUNI UNIT  ALBUQUERQUE, NM

  PLAN NAME                                INS TYPE            COUNT
-------------------------------------------------------------------------
  ATLAS INSURANCE                          MCR PART D              0
  D-AARP                                   MCR PART D              1
  D-ALWAYZAGING INSURANCE                  MCR PART D              0
  D-ATLLAS INSURANCE                       MCR PART D              0
  D-CRITERION                              PRIVATE                 0
  D-DRUG PLAN USA                          MCR PART D              0
  D-DRUGS UNLIMITED                        MCR PART D              0
  D-FAMOUS DRUG PLAN                       MCR PART D              0
  D-HUMANA STANDARD                        MCR PART D              0
  D-IOWA PHARMACY SERVICE CORP             PRIVATE                 1
  D-MEDICARE PART D PLAN                   PRIVATE                 0
  D-PACIFICARE SAVER                       PRIVATE                 0
  D-PRESCRIPTION SOLUTION                  MCR PART D              1
  D-SMITH DRUG PLAN                        PRIVATE                 0
  D-TRIMEE RX PLAN                         PRIVATE                 0


              TOTAL  FOR  ZUNI        SERVICE UNIT:           3
          TOTAL NUMBER OF MEDICARE/RAILROAD ELIG ENROLLEES:   0

  TOTAL NUMBER OF ACTIVE MEDICARE PART D ENROLLEES:           20

(REPORT COMPLETE)
```

Figure 3-42: Example of MRDP - Listing of Medicare Part D Enrollees Report

In the report example,

- The totals for the Albuquerque Service Unit include a count of all Medicare Part D enrollees (17).
- The Total Number of Medicare/Railroad Eligibility Enrollees includes all enrollees with Part A and/or B coverage and enrollees with Railroad eligibility (10).

Therefore, this report can be interpreted further as 7 registered Patients that have only Medicare Part D coverage, and no Medicare A and/or B coverage or no eligibility in a Railroad Retiree program.

This next example is an MRDP Detail Report with patient information by Plan Name. Please note the date displayed for tracking purposes.

The detail report displays Plan Name and HRN, Subscriber Name, Insurance Type and effective date, Count and End Dates, and Subscriber's ID number.

```
OCT 6,2006                                                          Page 1
            REGISTERED PATIENTS - ACTIVE MEDICARE PART D ENROLLEES
                      Actively enrolled as of OCT 6,2006

  Service Unit: ALBUQUERQUE  ALBUQUERQUE, NM

  PLAN NAME                              INS TYPE     COUNT
   HRN         SUBSCRIBER NAME            EFF.DT      END.DT   SUBSCR.ID
-------------------------------------------------------------------------

  D-DRUGS UNLIMITED                     MCR PART D      1
   78794       DEMO,PATIENT A             01/01/2006          XXXXXXXX
  D-FAMOUS DRUG PLAN                    MCR PART D      2
   55222       DEMO,PATIENT B             01/01/2006          XXXXXXXX
   32423       DEMO,PATIENT C             01/01/2006          XXXXXXXXXX
  D-HUMANA STANDARD                     MCR PART D      6
   99155       DEMO,PATIENT D             01/01/2006          XXXXXXXX
   5126        DEMO,PATIENT E             06/01/2006          XXXXXXXX-X
   8172        DEMO,PATIENT F             01/01/2006          XXXXXXXXX
   151486      DEMO,PATIENT G             06/05/2006          XXXXX
   7536        DEMO,PATIENT H             10/31/1995          XXXXXXXX-X
```

Figure 3-43: Example of MRDP - Listing of Medicare Part D Enrollees Detail Report

3.20 Non-Covered Days

The printing of claims that contain Non-Covered days has been modified. In the past, the user would indicate non-covered days but the UB92 did not reflect the non-covered days correctly.

Changes were made to correctly display non-covered days. This affected Form Locator 47 and Form Locator 48 of the UB92

4. Patch 8

Patch 8 includes modifications to the Third Party Billing System v.2.5.

4.1 Dental Billing

4.1.1 ADA-2002

Patch 8 includes a new export form labeled "ADA-2002." This export mode is available on Page 2 of the Claim Editor. Users are also allowed to print this export mode.

The internal entry number for this Export Mode is 25.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,JANE  [HRN:6484]                  Claim Number: 28900
.......................... (CLAIM IDENTIFIERS) .......................

                 [1] Clinic.............: DENTAL
                 [2] Visit Type.........: DENTAL
                 [3] Bill Type..........: 131
                 [4] Billing From Date..: 08/20/2005
                 [5] Billing Thru Date..: 08/20/2005
                 [6] Super Bill #.......:
                 [7] Mode of Export.....: ADA-99
                 [8] Visit Location.....: INDIAN HEALTH HOSPITAL
------------------------------------------------------------------------
WARNING:071 - EMPLOYMENT INFORMATION UNSPECIFIED
------------------------------------------------------------------------

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

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

[7] Mode of Export..: ADA-99// 25  ADA-2002     Dental Claim Form
Dated 2002
```

Figure 4-1: Form ADA-2002

If the payer requires the use of this form for claims submission, the form may be placed as a default in the Insurer File in Table Maintenance. For more information, see the *Third Party Billing (ABM) User's Guide* (Version 2.5, April 2002), Section 8.6.1, "Add/Edit Insurer (EDIN)," Step 5, Action 9.

4.1.2 ADA 99 Version 2000

A newer version of ADA-99 has been released under export mode number 26. This export mode allows for slight alignment changes when printing the newer version of the ADA-99. This form may also be referred to as the "ADA-2000."

4.2 Pending Claims Status and Reports

A new option has been added to the Claim Editor that allows the Billing staff to place a claim into the Pending status, if the biller determines that the claim is unbillable due to incomplete items. The Billing clerk may place the claim into a Pending status for any of the following reasons:

- Claim not coded with ICD codes
- Claim not coded with CPT codes
- Claim not coded with HCPCS codes
- Provider signature missing
- Missing POV
- Lab not final or on file
- Verify Eligibility
- PIN# License Missing
- Cannot locate Medical Record to verify Services
- Record not legible
- Coordination of Benefits from Patient Missing
- Incomplete Policy Holder information
- Transcode missing
- Missing Referring Provider information
- Outpatient Claims - two billing dates
- Out of Date Assignment of Benefits
- Other

Keep in mind that by changing the status, the claim is still open but does not appear on the Brief Claims Listing Report (BRRP). The claim will remain in a pending status until approved or cancelled.

4.2.1 Set Up

There is no current set up to be performed at this time. The list of reasons is from a table that cannot be edited at this time.

4.2.2 Claim Editor

The Pending option is located in the Claim Editor on Page 0, Claim Summary. There is a new ACTION command, labeled "Pend." In response to the "Pending Status" prompt, the Billing clerk enters the number associated with the type of pending status.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                        Claim Number: 26545
............................. (CLAIM SUMMARY) .............................

______ Pg-1 (Claim Identifiers) ___________________ Pg-4 (Providers) ___________
Location..: INDIAN HOSP                 | Attn: DOCTOR,TRUDEL
Clinic....: GENERAL                     |________ Pg-5A (Diagnosis) _________
Visit Type: PROFESSIONAL COMPONENT       | 1) HTN
Bill From: 07-24-2004 Thru: 07-24-2004  | 2) DM II
                                        | 3) ROUTINE EXAM
________ Pg-2 (Billing Entity) _________|______ Pg-8 (CPT Procedures) ________
MEDICARE                         ACTIVE  | 1) OFFICE/OUTPATIENT VISIT, EST
NEVERPAY INSURANCE               PENDING | 2) OFFICE/OUTPATIENT VISIT, EST
                                        |
____________ Pg-3 (Questions) ___________|
Release Info: YES   Assign Benef: YES   |
                                        |
________________________________________|_________________________________________
     *** Claim File ERRORS exist use the VIEW command to list them. ***

Desired ACTION (View/Appr/Pend/Next/Jump/Quit): N// P
PENDING STATUS: ??

   Choose from:
   1            Claim not coded with ICD codes
   2            Claim not coded with CPT codes
   3            Claim not coded with HCPCS codes
   4            Provider signature missing
   5            Missing POV
   6            Lab not final or on file
   7            Verify Eligibility
   8            PIN# License Missing
   9            Cannot locate Medical Record to verify Services
   10           Record not legible
   11           Coordination of Benefits from Patient Missing
   12           Incomplete Policy Holder information
   13           Trancode missing
   14           Missing Referring Provider information
   15           Outpatient Claims - two billing dates
   16           Out of Date Assignment of Benefits
   17           Other

PENDING STATUS: 4  Provider signature missing
```

Figure 4-2: Claim Editor screen for the new "Pend" Action command

When the status has been entered, the user will be able to see the claim status right away. When accessing the Claim Editor, the user may also see the current status of the claim as noted on the bottom of the following screen example.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,JOHN  [HRN:123567]                          Claim Number: 26545
.............................. (CLAIM SUMMARY) ..............................

_______ Pg-1 (Claim Identifiers) ___________________ Pg-4 (Providers) _________
Location..: INDIAN HOSP                  | Attn: DOCTOR,TRUDEL
Clinic....: GENERAL                      |_________ Pg-5A (Diagnosis) _________
Visit Type: PROFESSIONAL COMPONENT       | 1) HTN
Bill From: 07-24-2004 Thru: 07-24-2004   | 2) DM II
                                         | 3) ROUTINE EXAM
________ Pg-2 (Billing Entity) __________|______ Pg-8 (CPT Procedures) _______
MEDICARE                          ACTIVE | 1) OFFICE/OUTPATIENT VISIT, EST
NEVERPAY INSURANCE                PENDING| 2) OFFICE/OUTPATIENT VISIT, EST
                                         |
___________ Pg-3 (Questions) ____________|
Release Info: YES   Assign Benef: YES    |
                                         |
_________________________________________|_____________________________________
     *** Claim File ERRORS exist use the VIEW command to list them. ***

Pending for Provider signature missing by AL

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

Figure 4-3: Claim Editor screen displaying current Pending status of example claim

4.2.3 Running the Pending Report

A new report has been added to the Reports Menu. This report allows the user to print a listing of claims that currently have a status of Pending. This management report can be used as a mechanism to monitor claims that are not approved because of missing or inaccurate data. These claims should be followed up by the Billing clerk in a timely manner to make sure claims are submitted within the payer's timely filing limit.

The user may access the reports using the “Pending Claims Status Reports” option. After accessing the menu option, the following Exclusion Parameters are displayed:

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +              Pending Claims Status Report                              +
          |                 INDIAN HEALTH HOSPITAL                                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                      19-DEC-2005 1:40 PM

  EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
  ========================================================================
  - Claim Status.......: PENDING STATUS
  - Report Type........: BRIEF LISTING (80 Width)

    Select one of the following:

         1         LOCATION
         2         BILLING ENTITY
         3         DATE RANGE
         4         STATUS UPDATER
         5         PROVIDER
         6         ELIGIBILITY STATUS
         7         REPORT TYPE

Select ONE or MORE of the above EXCLUSION PARAMETERS:
```

Figure 4-4: Claim Editor displaying Exclusion Parameters

Selecting 4 (Status Updater) allows the user to see his or her list of Pending claims. Once the selection criteria have been defined, the user also has the option to see one or more Pending categories to report. The user may select the default of All or indicate the Pending status number that they want to display on the report:

```
Select Reason: ALL// 3  Claim not coded with HCPCS codes
Select Another Reason: 5  Missing POV
Select Another Reason: 7  Verify Eligibility
Select Another Reason: 8  PIN# License Missing
Select Another Reason:
```

Figure 4-5: List of available pending categories

4.2.3.1 Pending Claims Detailed Report

The following example displays the detailed report:

```
==========================================================================
PENDING CLAIMS STATUS LISTING                          DEC 19,2005   Page 1
for ALL BILLING SOURCES
==========================================================================
                          Claim   Visit
  Patient         HRN     Number  Date        Clinic        Reason
--------------------------------------------------------------------------
   Visit Location: INDIAN HEALTH HOSPITAL
      Status Updater: LUJAN,ADRIAN M
     Visit Type: OUTPATIENT
           Active Insurer: NON-BENEFICIARY PATIENT

GOODY,THELMA      3644    25665   06/17/2004  GENERAL      Claim not coded
                                                           with ICD codes
                           ------
               Subtotal:  1
     Visit Type: PROFESSIONAL COMPONENT
           Active Insurer: MEDICARE

PATIENT,PAULA     1072    28819   05/22/2005  GENERAL      Provider signature
                                                           missing
DEMO,JOHN         123567  26545   07/24/2004  GENERAL      Provider signature
                                                           missing

      Status Updater: RUNNELS,LETHA

FUSON,TAMMY JEAN  63336   28872   08/31/2005  GENERAL      Other
                           ------
                Subtotal:  3
                           ------
                   Total:  4
```

Figure 4-6: Example of detailed Pending Claims Status Report

4.2.3.2 Pending Claims Summary Report

The following example displays the summary report:

```
================================================================================
PENDING CLAIMS STATUS LISTING                          DEC 19,2005   Page 1
for ALL BILLING SOURCES
================================================================================
                                                                 Number of
  Reason                                                         Claims
--------------------------------------------------------------------------------
   Visit Location: INDIAN HEALTH HOSPITAL
      Status Updater: LUJAN,ADRIAN M
     Visit Type: OUTPATIENT
           Active Insurer: NON-BENEFICIARY PATIENT

  Claim not coded with ICD codes                                 1

                            ------
               Subtotal:                                         1
     Visit Type: PROFESSIONAL COMPONENT
           Active Insurer: MEDICARE

  Provider signature missing                                     2

      Status Updater: RUNNELS,LETHA

  Other                                                          1

                            ------
               Subtotal:                                         3
                            ------
                  Total:                                         4

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

Figure 4-7: Example of summary Pending Claims Status Report

4.3 Un-Coded ICD-9 Code

Depending on the facility's coding process, there may be instances where an ancillary package or the data entry clerk enters the un-coded diagnosis code of .9999. If the code is populated into PCC, the claim generator in the Third Party Billing system will not generate a claim for these visits. These visits are found with an ICD-9 code of .9999 (Uncoded Diagnosis) as the Purpose of Visit.

```
------------------------        V POV       --------------------------
POV: 585.                                   PATIENT NAME: BLUEBIRD,BONNIE
  VISIT: SEP 03, 2005@10:00                 PROVIDER NARRATIVE: ESRD
  FIRST/REVISIT: REVISIT
  ICD NARRATIVE (c): CHRONIC RENAL FAILURE
POV: .9999                                  PATIENT NAME: BLUEBIRD,BONNIE
  VISIT: SEP 03, 2005@10:00                 PROVIDER NARRATIVE: BKA-LRT
  FIRST/REVISIT: REVISIT
  ICD NARRATIVE (c): UNCODED DIAGNOSIS
```

Figure 4-8: Un-coded ICD-9 (9999)

As a result, the Third Party Billed field will display the reason "Uncoded DX Exists on Visit."

```
------------------------     VISIT FILE     --------------------------
VISIT/ADMIT DATE&TIME: SEP 03, 2005@10:00
  DATE VISIT CREATED: SEP 08, 2005          TYPE: IHS
  THIRD PARTY BILLED: UNCODED DX EXISTS ON VISIT
  PATIENT NAME: BLUEBIRD,BONNIE
  LOC. OF ENCOUNTER: INDIAN HEALTH HOSPITAL
  SERVICE CATEGORY: AMBULATORY              CLINIC: NEPHROLOGY
```

Figure 4-9: Visit File

Due to insurance filing limits and other payer requirements, every effort should be made to clean up the list of uncoded diagnosis codes.

4.4 Ambulance Billing

Patch 8 allows the billing of Ambulance-based services. A claim can be generated to send to Medicare, Medicaid, or any Private Insurance plan that accepts claims for these services. New features to this billing type include the addition of a new Visit type, and two new pages to the Claim Editor.

4.4.1 Table Maintenance Setup

4.4.1.1 Visit Type File

A new Visit Type has been added with reference number "902." The user must set up the visit type in the Insurer File along with a default export mode and provider numbers.

4.4.2 Claim Generator

The claim generator has been modified to check for a clinic entry in the Visit File that contains a Clinic Type of Ambulance, which utilizes a clinic type of "A3." If the clinic type equals A3, only *one* claim is generated, regardless of the payer. The ambulance claim will generate with a visit type of AMBULANCE (902).

```
VISIT IEN:  36817
----------------------------     VISIT FILE     ----------------------------
VISIT/ADMIT DATE&TIME: MAY 01, 2005@13:00
  DATE VISIT CREATED: MAY 09, 2005      TYPE: IHS
  THIRD PARTY BILLED: CLAIM CREATED     PATIENT NAME: DEMO,DONNA
  LOC. OF ENCOUNTER: UNSPECIFIED SERVICE UNIT
  SERVICE CATEGORY: AMBULATORY          CLINIC: AMBULANCE
  DEPENDENT ENTRY COUNT: 6              DATE LAST MODIFIED: MAY 31, 2005
  WALK IN/APPT: UNSPECIFIED             CREATED BY USER: ENTRY,DIANA
  USER LAST UPDATE: ENTRY,DIANA         UNIQUE VISIT ID: 2021010000036817
  ORIGINAL DATA ENTRY DATE: MAY 09, 2005
  DATE/TIME LAST MODIFIED: MAY 09, 2005@18:34:36
```

Figure 4-10: Visit Type AMBULANCE screen display

Note: For Medicare purposes, only one claim will be generated with a visit type of Ambulance (902), because:
- Hospital-based ambulance services are billed to Part A *only*.
- Free-standing or Tribally-owned services are billed to Part B *only*.

4.4.3 Claim Editor

Changes have been made in the Claim Editor that require the user to enter additional information that the payer may require.

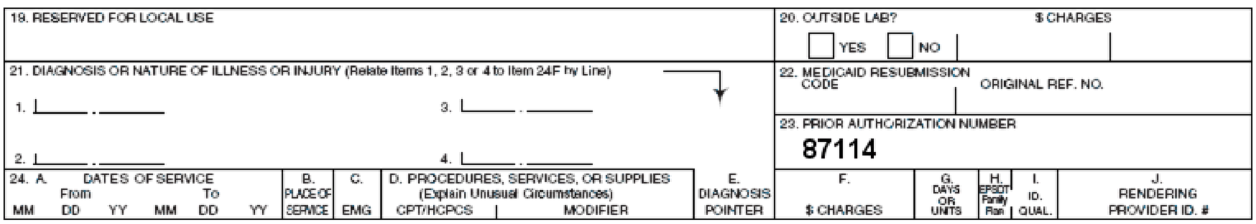
4.4.3.1 Page 3A – Ambulance Questions

A new page, Page 3A - Ambulance Questions, has been added to allow the Billing clerk to enter detailed information for the following:

- Point of Pickup – Exact location from which the patient was transported. The entries for these fields are free-text but can default to the patient’s home.

  ZIP Codes: The originating ZIP Code of the exact location is required since payment is based on the location of pick up. Upon entry, the ZIP Code is populated in certain places on the HCFA-1500 and UB92 export modes.

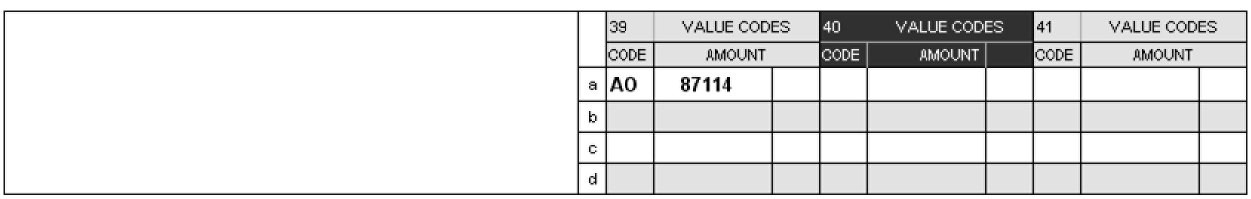
  – HCFA-1500 populates the ZIP Code in Form Locator 23:



19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24F by Line)
1. 3.
2. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
87114
24. A. DATES OF SERVICE From To MM DD YY MM DD YY
B. PLACE OF SERVICE
C. EMG
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER
E. DIAGNOSIS POINTER
F. $ CHARGES
G. DAYS OR UNITS
H. EPSDT Family Plan
I. ID. QUAL.
J. RENDERING PROVIDER ID. #

Figure 4-11: ZIP Code in HCFA-1500, Form Locator 23

  – UB92 populates the ZIP Code in Form Locator 39 with a condition code of A0:



	39 CODE	VALUE CODES AMOUNT		40 CODE	VALUE CODES AMOUNT		41 CODE	VALUE CODES AMOUNT	
a	A0	87114							
b									
c									
d									

Figure 4-12: Populated ZIP Code in UB92, Form Locator 39

- Destination – Exact location to which the patient was transported. Entries for this field are obtained from the Vendor File. This allows the user to quickly enter a location of transport.

- Modifiers – Modifiers that detail ambulance transport are entered on this page. The modifier entry is made when the Billing clerk enters the **Point of Pickup** or the **Destination**.

  The user must enter a single code to designate the following:

Code	Description
D	Diagnostic or therapeutic site/freestanding facility (e.g., radiation therapy center) other than P or H
E	Residential/domiciliary/custodial facility (e.g., non-skilled facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled Nursing Facility (SNF) (swingbed is considered an SNF)
P	Physician's Office (includes HMO and non-hospital facility)
R	Residence (patient's home or any residence)
S	Scene of accident or acute event
X	Intermediate stop at physician's office en route to the hospital (destination code only)

  Modifiers should be used with every ambulance procedure code. When entering Modifiers, it is important to remember that the first alpha character of the modifier represents the point of origin followed by the alpha character for the destination.

  All ambulance codes, drugs, supplies, and mileage should have an origin/destination modifier.

  Complete the full names and address of all origins and destinations. If the origin is the scene of an accident without an address, please submit the distance for the closest town (e.g., two miles north of Houston).

  In the Third Party Billing system, the modifiers entered will be grouped together and will append to the HCPCS code billed.

- Medical Necessity must be established. If the transport was considered medically necessary (per payer guidelines), a reason must be entered. This field is required to be answered with a Yes or No.

  If the Billing clerk indicates that the services were medically necessary, he/she must provide a reason(s) for medical necessity. The reasons supplied are referred to as Condition Indicators. The Billing clerk may enter more than one reason, as they apply.

The following Condition Indicators are contained in Patch 8:

60 Transportation was to the nearest facility
01 Patient was admitted to a hospital
02 Patient was bed confined before the ambulance service
03 Patient was bed confined after the ambulance service
04 Patient was moved by stretcher
05 Patient was unconscious or in shock
06 Patient was transported in an emergency situation
07 Patient had to be physically restrained
08 Patient had visible hemorrhaging
09 Ambulance service was medically necessary

- Mileage is a numerical value indicating the number of miles the patient was transported. This value may or may not be covered by the payer but needs to be recorded.

  According to some payers, only one transport is billed per claim. The mileage entered must reflect that transport. Entries on this field may also require the HCPCS mileage code to be entered on the Ambulance Page (Page 8K).

- Patient Weight is a numerical value that the Third Party Billing system will pick up if the it is entered in the RPMS PCC application. When billing, it is important to remember that patient weight is used to justify the billing for an additional attendant.
- Type of Transport may be used to identify when a patient may be transferred. Please refer to your payer's guidelines for identifying when a patient needs to be transferred.

  If a patient is transferred, one of the following reasons must be entered:

  – Initial Trip (I)
  – Return Trip (R)
  – Transfer Trip (T)
  – Round Trip (X)
- A reason for transport must be entered. The user may choose from the following:
  – Patient was transported to the nearest facility for care of symptoms, complains, or both. Can be used to indicate that the patient was transferred to residential facility
  – Patient was transported for the benefit of a preferred physician
  – Patient was transported for the nearness of family members
  – Patient was transported for the care of a specialist or for availability of specialized equipment
  – Patient transferred to rehabilitation facility

The following example shows values entered for Ambulance data. Page 3A follows Page 3 in the Claim Editor and displays if the clinic type is Ambulance. The user may also be able to access this page by typing in 3A while jumping throughout the Claim Editor.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DAUGHTERS,ANN  [no HRN]                   Claim Number: 29032
....................... (AMBULANCE QUESTIONS) .......................

   [01] Point of Pickup........: WHITE FENCE CONV CTR
                                 3293 NORTHBERRY ROAD
                                 ALBUQUERQUE, NEW MEXICO  87113
        [02] Modifier.........: N  SNF
   [03] Destination............: PRIVATE-PAY HOSPITAL
                                 1303 CENTRAL AVE NE
                                 ALBUQUERQUE, NEW MEXICO  87125-7888
        [04] Modifier.........: H  HOSPITAL

   [05] Mileage (Covered)......: 3
   [06] Mileage (Non-Covered)..:
   [07] Medical Necessity Ind..: Y
         Condition Indicator...: 06 Patient was transported in an
emergency
   [08] Patient Weight (lbs)...:

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

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

Figure 4-13: Values for Ambulance data

4.4.3.2 Page 8K – Ambulance Services

A new page has been added to the Claim Editor to allow the addition and/or modification of HCPCS codes related to Ambulance services. This page will appear if the clinic type is Ambulance. Keep the following properties in mind when using this page:

- The fee schedule must be populated. The user may enter charges into the HCPCS portion of the fee schedule.
- Even though the modifiers are entered onto Page 3, the billing clerk also has the ability to enter the modifier for each charge. The 2-digit modifier can only be used. If the 2-digit modifier is used, such as “GA,” then “GA” will be used for the charge.
- The place of service code will default to 41 – Ambulance Services.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8K  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DAUGHTERS,ANN  [no HRN]                          Claim Number: 29032
Mode of Export: 837 PROF (HCFA)
............................ (AMBULANCE SERVICES) ............................

     REVN                                                    UNIT       TOTAL
     CODE         HCPCS - AMBULANCE SERVICES                CHARGE QTY  CHARGE
     ==== ============================================  ====== === =======
[1]  CHARGE DATE: 05/29/2005@00:08
      540 A0422 AMBULANCE (ALS OR BLS) OXYGEN AND OXYGEN    75.00  1    75.00
                SUPPLIES, LIFE SUSTAINING SITUATION
[2]  CHARGE DATE: 05/29/2005@00:08
      540 A0396 ALS SPECIALIZED SERVICE DISPOSABLE         100.00  1   100.00
                SUPPLIES; ESOPHAGEAL INTUBATION
[3]  CHARGE DATE: 05/29/2005@00:08
      540 A0394 ALS SPECIALIZED SERVICE DISPOSABLE          50.00  1    50.00
                SUPPLIES; IV DRUG THERAPY
                                                                      =======
                                                                      $225.00

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


[1]  A0422

Select MODIFIER:

                     DIAGNOSES
       Seq   ICD9
       Num   Code              Diagnosis Description
       ===  ======   ==========================================
        1   786.03   APNEA

DATE/TIME: MAY 29,2005@00:08//
UNITS: 1//
HCFA POS: 41//        AMBULANCE - LAND
```

Figure 4-14: Page 8K allows addition/modification of HCPCS codes related to Ambulance Services

4.4.3.3 Page 9D – Value Codes

The Value Codes page will need to be utilized if the user is billing using the UB92 or the 837I as the export mode for billing and if the clinic type of the claim is equal to Ambulance (A3).

The user will need to verify that the Value Code A0 (zero) has been entered. The ZIP code value will need to be entered along with the A0 entry.

If applicable, the user may need to enter a value code of 32, if multiple transports were performed on the same day, as well as the number of transports.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: CHAVEZ,HENRIETTA  [no HRN]                Claim Number: 28887
.......................... (VALUE CODES) ............................

      VALU
      CODE         VALUE CODE DESCRIPTION                      AMOUNT
      ====    ========================================  ========
[1]    A0     Originating zip code-ambulance only          88309

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

Figure 4-15: Value codes for UB92 or 837I

When editing the claim, the billing clerk should be able to approve the claim in the same manner as with billing for other claims.

4.4.4 Exporting

After all claims for ambulance have been approved, they may be exported in the same manner as the current export process that the facility utilizes to submit claims.

Please ensure that your claims are printing according to your payer guidelines. The system has also been modified to allow the Ambulance data to be entered on the 837 Institutional and 837 Professional forms. Please contact the OIT Helpdesk for further assistance on setting up the electronic exports.

4.5 Canceling Claims

The Third Party Billing system allows users to cancel claims that are no longer billable or that may have been generated in error. Patch 8 adds additional functionality that requires the user to enter a reason when canceling the claim. A new report has also been added to print a report of the cancelled claims and the reasons why they were cancelled.

4.5.1 Set Up

No set up process is involved. A new menu option has been added to the Claim/Bill Management Menu (MGTP).

4.5.2 Process

The user can access the Cancel Claim option from the Claim/Bill Management Menu.

```
Select Claim/Bill Management Menu Option: CLMG  Cancel Claim

          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5                          |
          +                      Cancel Claim                                      +
          |                  INDIAN HEALTH HOSPITAL                                |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                      13-SEP-2005 4:05 PM

Select CLAIM or PATIENT: 28883  BAGGER,ELIZABETH
              Clm:28883  07-14-2005 OUTPATIENT  GASTROENTEROLOG  INDIAN HOSP
                        DONOTSMOKE INSURANCE            In EDIT Mode
Correct Claim? YES// YES
WARNING: If you cancel this Claim it will be deleted and no further Editing
         or Approvals can occur.

Do you wish Claim Number 28883 DELETED (Y/N)? YES

Cancellation REASON: 5  BEYOND FILING LIMIT

OK, the claim is being deleted...

Claim Number: 28883 has been Deleted!
```

Figure 4-16: Claim/Bill Management Menu, Cancel Claim option

The user will see the customary prompts when choosing to cancel a bill. However with Patch 8 the user will be prompted to select a cancellation reason. This field must be answered at the time of cancelling the claim. The system will allow the user to choose from the reasons displayed:

```
Cancellation REASON: ??

   Choose from:
   1            ORPHAN CLAIM CREATED IN ERROR
   2            DUPLICATE CLAIM CREATED
   3            ELIGIBILITY NOT FOUND
   4            MANUALLY BILLED CLAIM
   5            BEYOND FILING LIMIT
   6            UNBILLABLE PROVIDER
   7            UNBILLABLE DIAGNOSIS
   8            UNBILLABLE CLINIC TYPE
   9            UNBILLABLE VISIT TYPE
   10           WORKMANS COMP/THIRD PARTY CASE
   11           OTHER
```

Figure 4-17: List of Cancellation reasons

The listed reasons cannot be edited. Every effort should be made to document a specific reason a claim is cancelled rather than using the reason labeled OTHER (11). A report is also available to notify the user of their statistics for canceling claims.

If the user decides not to cancel a claim and types a carat (^) at the reason prompt, the system displays a message, indicating the claim has not been cancelled.

```
Do you wish Claim Number 28875 DELETED (Y/N)? YES <Enter>

Cancellation REASON: ^

CLAIM NOT CANCELLED
```

Figure 4-18: Claim Not Cancelled message display

4.6 Cancelled Claims Report

This report is used to track the number of claims cancelled by one or by multiple users, by cancelled date range, etc.

Any claims cancelled prior to the installation of Patch 8 will not display on the Cancelled Claims Report.

4.6.1 Set Up

There is no set up involved in using this option. The user can access the Cancelled Claims Report through the Reports Menu (RPTP).

4.6.2 Report Examples

The following example displays a Summary Cancelled Claims Report:

```
================================================================================
CANCELLED CLAIMS LISTING for ALL BILLING SOURCES         OCT 6,2005   Page 1
with CANCELLATION DATES from 10/05/2005 to 10/06/2005
================================================================================
                                                          Number of
Location                        Visit Type                  Claims
--------------------------------------------------------------------------------

     Cancelling Official: LUJAN,ADRIAN M

INDIAN HEALTH HOSPITAL          OUTPATIENT                       3
                                LABORATORY                       1
                                PROFESSIONAL COMPONENT           4
                                                               -----
                                                 Subtotal:       8
                                                               -----
                                                    Total:       8

     Cancelling Official: FRAZIER,TIM

INDIAN HEALTH HOSPITAL          OUTPATIENT                       1
                                PROFESSIONAL COMPONENT           1
                                                               -----
                                                 Subtotal:       2
                                                               -----
                                                    Total:       2

(REPORT COMPLETE):
```

Figure 4-19: Cancelled Claims Listing - Summary Report example

The following example displays a Detailed Report

```
================================================================================
CANCELLED CLAIMS LISTING for ALL BILLING SOURCES         OCT 6,2005   Page 1
with CANCELLATION DATES from 10/03/2005 to 10/03/2005
================================================================================
                         Active        Claim      Visit
  Patient         HRN    Insurer       Number     Date         Reason
--------------------------------------------------------------------------------

Cancelling Official: LUJAN,ADRIAN M
   Visit Location: INDIAN HEALTH HOSPITAL
       Visit Type: OUTPATIENT
GOMEZ,THELMA      12759  MUTUAL OF OM  28875   08/07/2005  UNBILLABLE VISIT T
                           ------
                    Count:  1

(REPORT COMPLETE):
```

Figure 4-20: Cancelled Claims Listing - Detail Report example

4.7 CLIA Numbers

If a payer requirement states that a CLIA number is needed when submitting claims for laboratory services performed whether in-house and/or sent to a reference lab, a CLIA number must be submitted on the claim form. If your facility bills for both types of services, there will be two different numbers that must be populated in the Third Party package. Contact your laboratory personnel or administrator to obtain the numbers. You also must obtain the reference lab location(s) information where the laboratory specimens are being sent.

Patch 8 allows the entry of a default CLIA number, but there are a few set up procedures that must be completed.

4.7.1 Set Up

When Patch 8 is installed, the CLIA number is entered into the Site Parameters option located in Table Maintenance. These fields are not required to be completed, but the user is strongly encouraged to enter default values in these fields to save time when editing the claim. If the numbers are not entered at this level, the biller will have to manually enter the information on each claim form.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
           +               Site Parameter Maintenance                +
           |                 INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: LUJAN,ADRIAN M                     12-SEP-2005 3:44
PM

EMC File Preference.............: HOST FILE//
DEFAULT EMC PATH................: c:/rpms///
Facility to Receive Payments....: ALBUQUERQUE ADMINISTRATION
         //
Printable Name of Payment Site..: INDIAN HEALTH HOSPITAL
           Replace
Current Default Fee Schedule....: 9//
Create Bills for all Patients...: NO//
Require that Queing be Forced...: YES//
Display Long ICD/CPT Description: NO//
Backbilling Limit (months)......: 48//
Block 31 (HCFA 1500) print......: ATTENDING/OPERATING PROVIDERS
         //
UB-92 SIGNATURE.................:
Place of Service Code...........: 22//
Bill Number Suffix (fac-code)...: IH//
Append HRN to Bill Number.......: YES//
Allow for CPT Modifiers Prompt..: YES//
Set Prof. Comp. Automatically...: NO//
Days Inactive before Purging....: 730//
Default Version of HCFA-1500....: Y2K Version dated 10-98
         //
Default Form for Dental Billing.: ADA-94//
Select DEFAULT UNBILLABLE CLINICS: TELEPHONE CALL
         //
Select DFLT INVALID PRV DISCIPLINES: ADMINISTRATION
         //
Select DISPLAY UNBILLABLE INSURER(S):
UB-92 Form Locater 38: INSURER ADDRESS//
IN-HOUSE DEFAULT CLIA#:
REFERENCE LAB DEFAULT CLIA#:
ORPHAN VISIT LAG TIME (DAYS)....: 30//
```

Figure 4-21: Site Parameter Maintenance, CLIA fields

4.7.2 In-House CLIA Numbers

If you choose to populate the "IN-HOUSE DEFAULT CLIA#" field, the system allows the CLIA number to be recorded for all facilities that perform CLIA covered laboratory services. These are normally for lab services performed by the billing or rendering provider of the CLIA number. This field requires a 10-character entry, in the format:

NNLNNNNNNN

where “N” is a numeric character and “L” is an alpha character; for example, 12A3456789.

4.7.3 Reference Lab Numbers

Choosing the “REFERENCE LAB DEFAULT CLIA#” field allows the CLIA number to be recorded for any laboratory that has referred tests to another laboratory covered by the CLIA Act. A facility may have more than one Reference Lab location to which they send tests.

4.7.3.1 Set Up

Prior to entering the CLIA number into the Reference Lab field of Site Parameters, the user must first go to the “Add/Edit Reference Lab Locations” option, to add the CLIA numbers for those locations to which labs are sent.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
           +            Add/Edit Reference Lab Locations             +
           |                 INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: LUJAN,ADRIAN M                     14-SEP-2005 11:45 AM
Select 3P REFERENCE LAB LOCATIONS VENDOR NAME: THE REFERENCE LAB INC.
EIN.....: 1850444170    SUFFIX: A1
                                   MAIL TO.: PO BOX 26688, ALBUQUERQUE
  Are you adding 'THE REFERENCE LAB INC.' as
    a new 3P REFERENCE LAB LOCATIONS (the 1ST)? No// YES  (Yes)
CLIA#: 12A3456789
```

Figure 4-22: Example of screen for adding/editing reference lab locations

The Reference Lab location entry must exist in the Vendor File. The user may search through the Vendor File to get the appropriate entry. After the new entry is added, the system prompts for the CLIA number. This field requires a 10-character entry in the format:

NNLNNNNNNN

where “N” is a numeric character and “L” is an alpha character; for example, 12A3456789.

4.7.4 Adding to Site Parameters

After the entry has been added to the Reference Lab CLIA file, it may be used as a default for all Laboratory claims. To do this, enter the Site Parameter file and enter the default Reference Lab location.

```
REFERENCE LAB DEFAULT CLIA#: THE REFERENCE LAB INC.   EIN.....: 1850444170
SUFFIX: A1
                                    MAIL TO.: PO BOX 26688, ALBUQUERQUE#######.
```

Figure 4-23: Example of how to create a default entry for all Laboratory claims

4.7.5 The Claim Editor – Page 3

The default entered from the Site Parameters option displays on Page 3 - Questions of the Claim Editor.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,DEMO       [HRN:7667]                    Claim Number: 28883
................................. (QUESTIONS) ..............................

 [1] Release of Information..: YES   From: 04/27/2004  Thru:
 [2] Assignment of Benefits..: YES   From: 04/27/2004  Thru:
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.:
 [6] Outside Lab Charges.....:
 [7] Date of First Symptom...:
 [8] Date of Similar Symptom.:
 [9] Referring Phys. (FL17)  :
[10] Medicaid Resubmission No:
[11] PRO Approval Number.....:
[12] HCFA-1500B Block 19.....:
[13] Admitting Diagnosis.....:
[14] Reference Lab CLIA#.....:
[15] In-House CLIA#..........: 12A3456789
------------------------------------------------------------------------------

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

Figure 4-24: Example of Page 3 with defaults entered

If the claim lacks a CLIA number, the system will display the following error:

```
  ERROR:200 - CLIA NUMBER MISSING
```

Figure 4-25: Example of Error 200 message

Entering a valid CLIA number in either Field #14 or #15 eliminates this error.

4.7.6 The Claim Editor – Page 8E

The following is a display that Page 8E demonstrating the new fields in Patch 8 in which the biller will populate the CLIA # and the necessary CPT modifier for Reference Lab services.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8E  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: GOMEZ,THELMA  [HRN:3644]                        Claim Number: 28911
Mode of Export: 837 INST (UB)
.......................... (LABORATORY SERVICES) ........................

     REVN                                                  UNIT       TOTAL
     CODE         CPT - LABORATORY SERVICES               CHARGE QTY  CHARGE
     ==== ============================================  ====== === =======

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

===============  ADD MODE - LABORATORY SERVICES  ===============
Select Laboratory (CPT Code): 81007 (81007)
  URINE SCREEN FOR BACTERIA
       Urinalysis; bacteriuria screen, except by culture or dipstick

Select 1st MODIFIER:

   Laboratory UNITS: 1//
   Laboratory PROVIDER:    WHIGHAM,THOMAS E

   Laboratory REVENUE CODE: 307//        LAB/UROLOGY     UROLOGY

   Laboratory IN-HOUSE CLIA#:

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8E  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: GOMEZ,THELMA  [HRN:3644]                        Claim Number: 28911
Mode of Export: 837 INST (UB)
.......................... (LABORATORY SERVICES) ........................

     REVN                                                  UNIT       TOTAL
     CODE         CPT - LABORATORY SERVICES               CHARGE QTY  CHARGE
     ==== ============================================  ====== === =======
[1]  CHARGE DATE: 09/24/2005 (WHIGHAM,THOMAS E)
      307 81007 URINE SCREEN FOR BACTERIA                 22.00  1    22.00
                                                                    ========
                                                                      $22.00
```

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

===============  ADD MODE - LABORATORY SERVICES  ===============
Select Laboratory (CPT Code): 87040 (87040)
  BLOOD CULTURE FOR BACTERIA
     Culture, bacterial; blood, with isolation and presumptive identification
     of isolates (includes anaerobic culture, if appropriate)

Select 1st MODIFIER: 90       REFERENCE (OUTSIDE) LABORATORY
         ...OK? Yes//   (Yes)

Select 2nd MODIFIER:

   Laboratory UNITS: 1//
   Laboratory PROVIDER: LAB,DARREN
   Laboratory REVENUE CODE: 306//     LAB/BACT-MICRO     BACTERIOLOGY & MICRO
BIOLOGY

   Laboratory REFERENCE LAB CLIA#:
```

Figure 4-26: Claim Editor, Page 8E, screen display example

4.7.7 Exporting

The CLIA number entry will appear on the following Export Mode:

HCFA-1500 Y2K (Paper) Form Locator 23

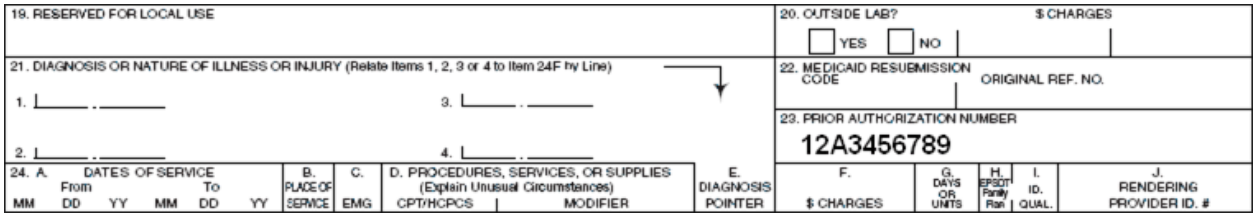


Figure 4-27: Example of HCFA-1500 Y2K Form Locator 23

4.8 Splitting Claims

It may be necessary, at times, to split a claim while editing. Claims may be split and sent to the same insurer, or they may be sent to multiple payers, depending on the payer's claims submission requirements. Charges may be split out to different claims. Claims that are split in RPMS are usually provided with a new claim reference number.

Patch 8 contains new functionality that will allow the user to set up the claims to automatically split. The user is also provided with the functionality to set up the Insurer File with the properties of the split claim.

4.8.1 Set Up

There are several ways to set up the manner in which the system splits out the charges from the original claim. Once the system is set up, the user will be prompted to manually split out the claim.

4.8.1.1 Insurer File

The user must set up the following:

- Determine to what payer the claim will be split-out
- Add billing properties for that payer in the Insurer File
- Set the properties for the Visit Type entry while setting up the insurer
- Replace the insurer name in Table Maintenance
- Provide the effective date of the change and the name of the insurer
- Provide the visit type

The process is illustrated in the following example, which shows Palmetto GBA, the supplier for Region C, being set up to bill for DME services. **Bold** text indicates user responses.

```
Select INSURER:    PALMETTO GBA      SOUTH CAROLINA     29202-3141
         ...OK? Yes//   (Yes)

<--------------- MAILING ADDRESS --------------->
Street...: PO BOX 100141//
City.....: COLUMBIA//
State....: SOUTH CAROLINA//
Zip Code.: 29202-3141//

<--------------- BILLING ADDRESS --------------->
      (if Different than Mailing Address)
Billing Office.: MEDICARE DMERC OPERATIONS  Replace
        Street.:
        City...:
        State..:
        Zip....:

Phone Number.......: (866)238-9650//
Contact Person.....:
AO Control Number..:
Insurer Status.....: BILLABLE//
All Inclusive Mode.:
Backbill Limit (months):
Dental Bill Status.:
Rx Billing Status..:
ENVOY ID MEDICAL:
ENVOY ID HOSPITAL:
ENVOY ID DENTAL:

Select CLINIC UNBILLABLE:

EMC SUBMITTER ID:
EMC PASSWORD:
EMC TEST INDICATOR:
USE PLAN NAME?:
72 HOUR RULE:

GROUP NUMBER:

PROVIDER PIN#
Select PROVIDER:
```

Figure 4-28: Example of process for setting up an insurer

Add the appropriate billing properties for the replacement insurer. The *visit type* entry is required as it will be necessary later during the billing process.

```
Visit                       Mode of     Mult  Fee    ------- Flat Rate -------
Type - Description           Export     Form Sched   Start      Stop     Rate
================================================================================

Select VISIT TYPE..: ??
        You may enter a new VISIT TYPE, if you wish

   Choose from:
   121          ANCILLARY (MCR PART B ONLY)
   131          OUTPATIENT
   831          AMBULATORY SURGERY
   837          PROFESSIONAL
   901          Pharmacy POS
   902          AMBULANCE
   990          MEDICAL/SURGICAL
   991          ACCOMMODATIONS
   992          ANESTHESIA
   993          MEDICAL SUPPLY
   994          OPTOMETRY
   995          RADIOLOGY
   996          LABORATORY
   997          PHARMACY
   998          DENTAL
   999          PROFESSIONAL COMPONENT

Select VISIT TYPE..: 993  MEDICAL SUPPLY
  Are you adding 'MEDICAL SUPPLY' as a new VISIT TYPE (the 1ST for this 3P
INSUR
ER)? No// YES  (Yes)
Billable (Y/N/E)....: Y  YES
Auto-Split this entry?:
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........:
Multiple Forms?.....:
Payer Assigned Provider Number.....:
EMC Reference ID....:
Auto Approve?.......:
Mode of Export......: 837 PROF (HCFA)       837 4010 PROFESSIONAL

Visit                       Mode of     Mult  Fee    ------- Flat Rate -------
Type - Description           Export     Form Sched   Start      Stop     Rate
================================================================================
 993   MEDICAL SUPPLY     837 PROF (HCFA)NO

Select VISIT TYPE..:
```

Figure 4-29: Setting up an insurer, adding billing properties for replacement insurer

Proceed to the insurer file and select the insurer entry you want to edit. This entry will be the name of the insurer that will be "replaced."

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                    Insurer File Menu                    +
          |                  INDIAN HEALTH HOSPITAL                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    6-DEC-2005 10:39 AM

   EDIN   Add/Edit Insurer
   RPIN   Replacement Text for Insurer Lookups
   LSIN   Insurer Listing
   IQIN   Display Insurer Info (Inquire)
   MRIN   Merge Duplicate Insurers

Select Insurer File Menu Option: edin <Enter> Add/Edit Insurer

          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                     Add/Edit Insurer                    +
          |                  INDIAN HEALTH HOSPITAL                 |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    6-DEC-2005 10:39 AM

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

     Select one of the following:

          1         EDIT EXISTING INSURER
          2         ADD NEW INSURER

Select DESIRED ACTION: 1// <Enter>  EDIT EXISTING INSURER

Screen-out Insurers with status of Unselectable? Y// <Enter>  YES

Select INSURER: MEDICARE <Enter>  ( MEDICARE )

The following matches were found:

  1: MEDICARE                          - PO BOX 660159
                                         DALLAS, TX 75266-0159
  2: MEDICARE PART B                   - P.O. 500
                                         CHICO, CA 960030
  3: MEDICARE-CAHABA                   - PO BOX 22545
                                         JACKSON, MS 39225-2545

Select 1-3: 1 <Enter>
```

Figure 4-30: Setting up an insurer, editing the insurer to be replaced

The following prompts are bypassed, and the user proceeds to the Visit Type section.

```
<--------------- MAILING ADDRESS --------------->
Street...: PO BOX 660159//
City.....: DALLAS//
State....: TEXAS//
Zip Code.: 75266-0159//

<--------------- BILLING ADDRESS --------------->
      (if Different than Mailing Address)
Billing Office.: TRAILBLAZER HEALTH ENT  Replace
        Street.: PO BOX 660030//
        City...: DALLAS//
        State..: TEXAS//
        Zip....: 75266-0030//

Phone Number.......: (888)763-9836//
Contact Person.....: CHERYL COWMAN-SWEETIN  Replace
AO Control Number..: 400//
All Inclusive Mode.: YES//
Backbill Limit (months): 24//
Dental Bill Status.:
Rx Billing Status..: UNBILLABLE//
ENVOY ID MEDICAL:
ENVOY ID HOSPITAL:
ENVOY ID DENTAL:

Select CLINIC UNBILLABLE:

EMC SUBMITTER ID: V00233//
EMC PASSWORD: IHS233//
EMC TEST INDICATOR:
USE PLAN NAME?: NO//
72 HOUR RULE:

GROUP NUMBER: HSZ000//

PROVIDER PIN#
Select PROVIDER: CHIODO,ANTHONY//
  PROVIDER: CHIODO,ANTHONY//
  PIN #: S61007//
Select PROVIDER:
```

Figure 4-31: Example of process for setting up an insurer, continued

```
Visit                       Mode of     Mult  Fee    ------- Flat Rate -------
Type - Description           Export     Form Sched   Start      Stop      Rate
=============================================================================
 24    AUDIOLOGY           UB-92-E V4    NO      01/01/1999              138.00
 110   NON COVERED           UB-92       NO      01/01/2003                0.00
                                                 01/01/2005             1548.00
 111   INPATIENT             UB-92       NO      01/01/1999 12/31/1999 1065.00
                                                 01/01/2000 12/31/2000 1157.00
                                                 01/01/2001 12/31/2001 1306.00
                                                 01/01/2002             1507.00
                                                 01/01/2003             1526.00
                                                 01/01/2004             1512.00
 121   ANCILLARY (MCR PA   ***** (UNBILLABLE) *****
 131   OUTPATIENT          837 INST (UB) NO    1 08/09/1989 12/31/1989   72.00
                                                 01/01/1990 12/31/1990   76.00
                                                 12/31/1997 12/31/1997   78.00
                                                 01/01/1998 12/31/1999  138.00
                                                 01/01/2000 12/31/2000  139.00
                                                 01/01/2001 01/31/2001  157.00
                                                 01/01/2002 12/31/2002  160.00
                                                 01/01/2003 12/31/2003  175.00
                                                 01/01/2004             178.00
Enter RETURN to continue or '^' to exit:
```

Figure 4-32: Setting up an insurer, Visit Type

4.8.1.2 Setting up the Replacement Insurer

In the Visit Type, Add or select the visit type entry you wish to replace. This will be used later in the claim editor when replacing the insurer. At the “Do you want to replace with another insurer/visit type?” prompt, type YES and press Enter.

The system will display the Effective Date. Type the date the insurer can be replaced and press Enter. The date will correspond to the visit date. Next, enter the name of the replaced insurer and press Enter. This is the insurer that will appear when the visit type is changed in the Claim Editor.

```
Visit                       Mode of     Mult  Fee    ------- Flat Rate -------
Type - Description           Export     Form Sched   Start      Stop      Rate
=============================================================================
 200   PI PRIMARY            UB-92       NO    1
 831   AMBULATORY SURGER   UB-92-E V6    NO    2   01/01/1990              76.00
 902   AMBULANCE           HCFA-1500     NO
 994   OPTOMETRY           UB-92-E V4    NO
 996   LABORATORY          HCFA-1500     NO    1
 999   PROFESSIONAL COMP   837 PROF (HCFA)N/A
```

```
Select VISIT TYPE..: MEDICAL
     1   MEDICAL SUPPLY
     2   MEDICAL/SURGICAL
CHOOSE 1-2: 1  MEDICAL SUPPLY
  Are you adding 'MEDICAL SUPPLY' as a new VISIT TYPE (the 7TH for this 3P
INSURER)? No// Y  (Yes)
Billable (Y/N/E)....: Y  YES
Do you want to replace with another insurer/visit type? YES
Select REPLACE INSURER EFFECTIVE DATE: 010105   JAN 01, 2005
   REPLACE INSURER EFFECTIVE DATE END DATE:
   REPLACE INSURER EFFECTIVE DATE REPLACEMENT INSURER: PALMETTO( PALMETTO )

PALMETTO GBA                          - PO BOX 100141
                                        COLUMBIA, SC 29202-3141
 OK? Y//

   REPLACE INSURER EFFECTIVE DATE REPLACEMENT VISIT TYPE: MED
     1   MEDICAL SUPPLY
     2   MEDICAL/SURGICAL
CHOOSE 1-2: 1  MEDICAL SUPPLY

Visit                      Mode of     Mult  Fee    ------- Flat Rate -------
Type - Description          Export     Form Sched   Start      Stop     Rate
================================================================================
 24    AUDIOLOGY          UB-92-E V4    NO      01/01/1999              138.00
 110   NON COVERED          UB-92       NO      01/01/2003               0.00
                                                01/01/2005            1548.00
 111   INPATIENT            UB-92       NO      01/01/1999 12/31/1999 1065.00
                                                01/01/2000 12/31/2000 1157.00
                                                01/01/2001 12/31/2001 1306.00
                                                01/01/2002            1507.00
                                                01/01/2003            1526.00
                                                01/01/2004            1512.00
 121   ANCILLARY (MCR PA   ***** (UNBILLABLE) *****
 131   OUTPATIENT         837 INST (UB) NO   1  08/09/1989 12/31/1989   72.00
                                                01/01/1990 12/31/1990   76.00
                                                12/31/1997 12/31/1997   78.00
                                                01/01/1998 12/31/1999  138.00
                                                01/01/2000 12/31/2000  139.00
                                                01/01/2001 01/31/2001  157.00
                                                01/01/2002 12/31/2002  160.00
                                                01/01/2003 12/31/2003  175.00
                                                01/01/2004             178.00
200   PI PRIMARY           UB-92       NO    1
 831   AMBULATORY SURGER  UB-92-E V6    NO    2   01/01/1990              76.00
 902   AMBULANCE          HCFA-1500     NO
 993   MEDICAL SUPPLY      ** Replace with: PALMETTO GBA **
 994   OPTOMETRY          UB-92-E V4    NO
 996   LABORATORY         HCFA-1500     NO    1
 999   PROFESSIONAL COMP  837 PROF (HCFA)N/A

Select VISIT TYPE..:
```

Figure 4-33: Example of setting up the replacement insurer

Note that the insurer has been changed. In the next example, the former insurer, Medical Supply, has been replaced with Palemtto GBA.

4.8.2 Claim Editor

Splitting claims is a function that the user must perform manually.

From the Third Party Billing Menu, select EDTP, then EDCL to navigate the Claim Editor. In the next example you will see that the patient has several claims. The user had split the first claim entry (Claim #29063), which will be used to bill to the replaced insurer.

```
PATIENT:  DRIP,JIM     M  03/23/1949  505-03-2319  HRN: 88199
================================================================================

(1)  Claim# 29063   11/20/2005 OUTPATIENT             URGENT CARE
      INDIAN HOSP    MEDICARE                      Status: In EDIT Mode


(2)  Claim# 29062   11/20/2005 PROFESSIONAL COMPONENT  URGENT CARE
      INDIAN HOSP    MEDICARE                      Status: In EDIT Mode

(3)  Claim# 29061   11/20/2005 OUTPATIENT             URGENT CARE
      INDIAN HOSP    MEDICARE                      Status: Flagged as Billable

Select 1 to 4: 1 <Enter>

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

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

Release of Information..: YES        From: 05/26/2004  Thru: Assignment of
Benefits..: NO

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DRIP,JIM  [HRN:88199]                            Claim Number: 29063
.......................... (CLAIM SUMMARY) ..............................

_______ Pg-1 (Claim Identifiers) ___________________ Pg-4 (Providers) _________
Location..: INDIAN HOSP                 | Attn: KITTYSON,NANCY E
Clinic....: URGENT CARE                 |
Visit Type: OUTPATIENT                  |
Bill From: 11-20-2005 Thru: 11-20-2005  |
                                        |_________ Pg-5A (Diagnosis) _________
________ Pg-2 (Billing Entity) __________| 1) ANKLE SPRAIN
MEDICARE                         ACTIVE | 2) ANKLE SPRAIN
BC/BS OF ARIZONA INC             PENDING |
                                        |
___________ Pg-3 (Questions) ____________|
Release Info: YES   Assign Benef: NO    |______ Pg-5B (ICD Procedures) ______
Accident Rel: YES                       |
________________________________________|_____________________________________
WARNING:213 - PHARMACY DATA EXISTS IN PCC THAT IS NOT ON CLAIM
--------------------------------------------------------------------------------
```

```
     *** Claim File ERRORS exist use the VIEW command to list them. ***

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

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DRIP,JIM  [HRN:88199]                              Claim Number: 29063
.......................... (CLAIM IDENTIFIERS) ............................

                [1] Clinic.............: URGENT CARE
                [2] Visit Type.........: OUTPATIENT
                [3] Bill Type..........: 131
                [4] Billing From Date..: 11/20/2005
                [5] Billing Thru Date..: 11/20/2005
                [6] Super Bill #.......:
                [7] Mode of Export.....: 837 INST (UB)
                [8] Visit Location.....: INDIAN HEALTH HOSPITAL

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

Desired FIELDS:  (1-8): 1-8// 2 <Emter>

 [2] Visit Type......: OUTPATIENT// MED
     1   MEDICAL SUPPLY
     2   MEDICAL/SURGICAL
CHOOSE 1-2: 1 <Enter> MEDICAL SUPPLY

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DRIP,JIM  [HRN:88199]                              Claim Number: 29063
.......................... (CLAIM IDENTIFIERS) ............................

                [1] Clinic.............: URGENT CARE
                [2] Visit Type.........: MEDICAL SUPPLY
                [3] Bill Type..........: 131
                [4] Billing From Date..: 11/20/2005
                [5] Billing Thru Date..: 11/20/2005
                [6] Super Bill #.......:
                [7] Mode of Export.....: 837 INST (UB)
                [8] Visit Location.....: INDIAN HEALTH HOSPITAL

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

Figure 4-34: Example of split claim

In this example the user has edited the Visit Type. The visit type selected is the visit type that was set up in the Insurer file as the replaced insurer.

After the visit type has been changed, an asterisk appears on the screen next to the newly replaced insurer (Palmetto GBA) on Page 2 in the Billing Entity area.

The Billing clerk can now proceed to edit the claim according to the billing guidelines for the active insurer.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DRIP,JIM  [HRN:88199]                              Claim Number: 29063
.............................. (INSURERS) ..................................

To: MEDICARE DMERC OPERATIONS           Bill Type...: 131
    PO BOX 100141                       Proc. Code..: CPT4
    COLUMBIA, SC  29202-3141            Export Mode.: 837 INST (UB)
    (866)238-9650                       Flat Rate...: N/A
.....................................................................

             BILLING ENTITY          STATUS       POLICY HOLDER
     ============================  ==========  ==============================
[1] *PALMETTO GBA                    ACTIVE      DRIP,JIM
[2]  BC/BS OF ARIZONA INC            PENDING     DRIP,JIM
---------------------------------------------------------------------------

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

PATIENT:  DRIP,JIM     M  03/23/1949  505-03-2319  HRN: 88199
===========================================================================

(1)  Claim# 29063   11/20/2005 MEDICAL SUPPLY          URGENT CARE
      INDIAN HOSP    PALMETTO GBA                Status: In EDIT Mode

(2)  Claim# 29062   11/20/2005 PROFESSIONAL COMPONENT  URGENT CARE
      INDIAN HOSP    MEDICARE                    Status: In EDIT Mode

(3)  Claim# 29061   11/20/2005 OUTPATIENT            URGENT CARE
      INDIAN HOSP    MEDICARE                    Status: Flagged as Billable
```

Figure 4-35: Example of split claim, continued

Select the View action to display the replaced insurer. The View screen will indicate the insurer being replaced:

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DRIP,JIM  [HRN:88199]                          Claim Number: 29063
.......................... (INSURER - VIEW OPTION) ........................

Insurer..: PALMETTO GBA                     Phone....: (866)238-9650
Prov. No.: 320057                           Contact..:
     **This insurer replaces MEDICARE for this claim only!
------------------------------------------------------------------------------
Policy Number....: 505032319-A              Coverage(s).....:
Group Name.......:                          Group Number....:
   Elig date.....: FEB 01, 1999              Elig end date..:
------------------------------------------------------------------------------
Policy Holder.: DRIP,JIM                       Relationship..: SELF
                PO BOX 83823                   Home Phone....:
                SHONTO, AZ  88144

   Employer...: ARIZONA ENGINEERS              Empl. Status..: RETIRED
                6543 W. THUNDERBIRD            Work Phone....: 6029287456
                PHOENIX, AZ  85241
------------------------------------------------------------------------------

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

Figure 4-36: Example of split claim, View screen

4.9 Table Maintenance Site Parameter Report

The Table Maintenance Site Parameter Report allows the ability to audit and print changes made to certain Table Maintenance functionality. To fulfill these requirements, certain changes were made to audit fields within the Site Parameters.

A new report has been added to Patch 8 that allows users to print changes to the following fields:

- Printable Name of Payment Site
- Facility to Receive Payments

Managers will be able to access this menu option which is located in the Table Maintenance section of the billing application. Only users with access to ABMZ SITE SETUP will be able to access this option.

The report identifies the date and time a value was changed, the old and the new value and the user that made the change. The following steps allow you to access this option. An example of the screen is also provided.

- Select the Reports Menu Option for Table Maintenance Site Parameters Report (TMRP).
- Select 2, the Date Range.
- Enter the beginning and ending dates for the date range you need to view.
- When prompted to again select either LOCATION or DATE RANGE, just press Enter, and a listing of audited fields will be displayed.

```
Select Reports Menu Option: TMRP <Enter>  Table Maintenance Site Parameters
Report

          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +        Table Maintenance Site Parameters Report         +
          |                 INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    15-DEC-2005 11:03 AM

   EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
   ========================================================================

     Select one of the following:

          1         LOCATION
          2         DATE RANGE

Select ONE or MORE of the above EXCLUSION PARAMETERS: 2 <Enter>  DATE RANGE

 ============ Entry of EDIT DATE Range =============

Enter STARTING EDIT DATE for the Report:  010101 <Enter>  (JAN 01, 2001)

Enter ENDING DATE for the Report:  T <Enter>  (DEC 15, 2005)

   EXCLUSION PARAMETERS Currently in Effect for RESTRICTING the EXPORT to:
   ========================================================================
   - Edit Date Range....:01/01/2001  to: 12/15/2005

     Select one of the following:


          1         LOCATION
          2         DATE RANGE

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

Output DEVICE: HOME// <Enter>
```

```
================================================================================
LISTING of Audited fields                                DEC 15,2005   Page 1
================================================================================
Date/Time        User              Old Value              New Value
--------------------------------------------------------------------------------

     3P PARAMETERS  Fld: FACILITY TO RECEIVE PAYMENT
09/07/2005@15:19 RUNNELS,LETHA  ALBUQUERQUE ADMINISTRA ABERDEEN ADMINISTRATIO
09/08/2005@17:48 RUNNELS,LETHA  ABERDEEN ADMINISTRATIO ALBUQUERQUE ADMINISTRA

     3P PARAMETERS  Fld: PRINTABLE NAME OF PAYMENT SITE
09/12/2005@16:25 LUJAN,ADRIAN M                        INDIAN HEALTH HOSPITAL

(REPORT COMPLETE):
```

Figure 4-37: Third Party Revenue Policy Reports

4.10 837 Corrections

4.10.1 REF Segment – New Mexico Medicaid

Patch 8 modifications include an additional "REF" segment for the Pay-to-Provider Loop (Loop 2010AB) for New Mexico Medicaid.

4.10.2 Provider Number Fix for Satellite Facilities

The 837 formats have been corrected to allow facility group numbers to correctly display on the all 837 export modes if the A/R Parent/Satellite option is set to "YES."

This modification also allows the PIN and Group Numbers to display correctly on all 837 formats.

4.10.3 Incorrect Amounts on the 837 Export Modes

Corrections were made to the 837 and to the paper export formats to correctly display the billed amount for All-Inclusive payers when a Flat Rate Adjustment exists. Since CMS does not publish the All-Inclusive rates in a timely manner, sites continue to bill using the old rates.

If a Flat Rate Adjustment is done in the Claim/Bill Management menu, the system will update the billed amounts for all billed claims affected by the updated rate.

Prior to Patch 8, the system would print both the new and the old rates. Patch 8 will print the adjusted bill amount.

4.10.4 Correction to Accident Date and Time

Corrections were made to the 837 formats for the Accident Time to correctly format the time if the accident was between 1:00 AM and 9:00 AM (0100 to 0900).

4.10.5 Inclusion of Modifications to Accommodate the IHS Pharmacy Automated Dispensing Interface System

This modification applies to sites that have purchased the Omnicell or Pyxis commercial off-the-shelf (COTS) software systems.

when medications are dispensed from the Pharmacy COTS system, the IHS Pharmacy Automated Dispensing Interface System sends information from the COTS system to RPMS. This information is stored in the I H S HL7 SUPPLY INTERFACE file.

When a claim is edited, if there are medications and/or supplies on file for the dates covered by the claim, the Billing clerk will be able to review the medications/supplies and decide which ones should be added to the claim.

5. Patch 6

Patch 6 corrects several known errors that were found with version 2.5 of Third Party Billing, as well as issues found in patch 5. This addendum also includes an explanation of the logic behind the mapping of a Taxonomy code (required for the 837 format) to the Provider Class or Person Class on Page 4 of the Claim Editor.

5.1 Updated Referring Physician Functionality

Patch 6 updates the functionality of the Referring Physician question on page 3 of the Claim Editor that was introduced in patch 5 (section 6.11). Now after entering the provider UPIN, you will be prompted to populate either:

- Person Class
- Provider Class
- Taxonomy Code

One of the three must be populated for the 837. An error message will display if none of the above are populated or if the Person or Provider class code is not linked to a provider taxonomy code. "Appendix A: Mapped Taxonomy Codes by Provider Class" and "Appendix B: Mapped Taxonomy Codes by Person Class" contain a list of codes mapped to a taxonomy code.

- Person Class looks for a mapped entry in the 3P Provider Taxonomy file. If no mapped taxonomy code is found, then an error is displayed in the Claim Editor.
- Provider Class looks for a mapped entry in the 3P Provider Taxonomy file. If no mapped taxonomy code is found an error is displayed in the Claim Editor.
- Provider Taxonomy code is a straight lookup into 3P Provider Taxonomy file. This is obviously a mapped taxonomy code.

> **Note**: The X12 code/Provider taxonomy in the persons class file is not used at this time. The long-term goal is to have this field updated and use it, but these updates are currently not timely from the VA so this field is not used.

To use the Referring Physician field, the transmission type must be set to 837 PROF (HCFA).

To edit the Referring Physician field, follow these steps:

1. At the "Desired ACTION" prompt, Type **E** and then the appropriate number of the Referring Phys. (FL17) field.

2. At the "Name of Referring Physician" prompt, type the name of the referring physician. This is a free text name field and does not point to any provider files.

3. At the "Referring Physician I.D. No" prompt, type the referring physician's UPIN number.

4. At the "Which would you like to enter?" prompt, type **1** for Person Class, **2** for Provider Class, or **3** for Taxonomy Code.

   If this field has already been populated, a message appears informing you that one of these three mandatory fields has already been populated and what the existing code is. Even if this message appears, you can still edit this field.

```
Person Class already entered:  Physicians (M.D. and D.O.)
```

Figure 5-1: Person Class field already populated message

```
Provider Class already entered:  00  PHYSICIAN
```

Figure 5-2: Provider Class field already populated message

```
Taxonomy Code already entered:  208D00000X
```

Figure 5-3: Taxonomy Code field already populated message

   a. The Person Class Option looks at the Person Class file.

      Based on the Person Class entered, the system searches for a linked taxonomy code in the 3P Provider Taxonomy file and displays Error Message 201 if no match is found. A match must be found for the taxonomy code to show up in the 837 file.

   b. The Provider Class option looks at the Provider Class file.

      Based on the Provider Class entered, the system searches for a linked taxonomy code in the 3P Provider Taxonomy file and displays Error Message 202 if no match is found. A match must be found for the taxonomy code to show up in the 837 file.

   c. The Taxonomy Code option is a direct link to the 3P Provider Taxonomy file.

      You will only be able to enter codes that exist in this file. This will eliminate any problems that may occur from populating the provider with a Person or Provider Class code that is not mapped to a taxonomy code.

5. Type the number for the Person Class, Provider Class, or Taxonomy Code that you selected.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: Patient,Jim  [HRN:32456]                        Claim Number: 3138
.............................. (QUESTIONS) ..............................

 [1] Release of Information..: NO
 [2] Assignment of Benefits..: NO
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.: NO
 [6] Outside Lab Charges.....: NO
 [7] Date of First Symptom...:
 [8] Date of Similar Symptom.:
 [9] Referring Phys. (FL17)  :
[10] Medicaid Resubmission No:
[11] PRO Approval Number.....:
[12] HCFA-1500B Block 19.....:
[13] Supervising Prov.(FL19): SMITH              Date Last Seen: 05/24/2004
[14] Date of Last X-Ray......:
[15] Referral Number.........:
[16] Prior Authorization #...:

WARNING:058 - RELEASE OF INFORMATION UNOBTAINED
WARNING:059 - ASSIGNMENT OF BENEFITS UNOBTAINED
------------------------------------------------------------------

Desired ACTION (Edit/Next/View/Jump/Back/Quit): N// E9 <Enter>

[9] Name of Referring Physician: SMITH,BOB <Enter>
    Referring Physician I.D. No: 123456 <Enter>

     Select one of the following:

          1         Person Class
          2         Provider Class
          3         Taxonomy Code

Which would you like to enter?:
```

Figure 5-4: Adding a referring provider (steps 1-4)

6. If the Person Class or Provider Class is properly mapped to a Taxonomy code, you will not see an error, and you continue with the claim process as normal.

   If the Person Class or Provider Class is not mapped to a Taxonomy code, you will see one of a number of errors. Refer to Section 5.2 for more details on the possible errors and how to correct them.

As depicted in the warnings section of the next screen, when a taxonomy code is properly populated, there will be no error. Any error message will display in the error section.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: Patient,Jim  [HRN:43568]                          Claim Number: 3138
.................................. (QUESTIONS) ..............................
 [1] Release of Information..: NO
 [2] Assignment of Benefits..: NO
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.: NO
 [6] Special Program.........: NO
 [7] Outside Lab Charges.....: NO
 [8] Date of First Symptom...:
 [9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17)  : SMITH,BOB    I.D. Number: 123456
[12] Case No. (External ID)..:
[13] Medicaid Resubmission No:
[14] PRO Approval Number.....:
[15] HCFA-1500B Block 19.....:
[16] Supervising Prov.(FL19):                      Date Last Seen:
[17] Date of Last X-Ray......:
[18] Prior Authorization #...:
[19] Homebound Indicator.....:
[20] Hospice Employed Prov...:
-------------------------------------------------------------------------------
WARNING:058 - RELEASE OF INFORMATION UNOBTAINED
WARNING:059 - ASSIGNMENT OF BENEFITS UNOBTAINED
-------------------------------------------------------------------------------
```

Figure 5-5: Adding a referring provider (step 6)

5.2 New Error Messages on Page 3

5.2.1 Error 193

What does error 201 mean?

Referring Provider has a UPIN but no Person Class, Provider Class, or Taxonomy Code.

How do I correct it?

Edit the Referring Physician on Page 3 and then add a Referring Physician Person/Provider Class or Taxonomy code. If information is not properly entered, then an error message will be displayed on the screen after the warnings.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: Patient,Jim  [HRN:43568]                          Claim Number: 3138
................................. (QUESTIONS) ..............................
 [1] Release of Information..: NO
 [2] Assignment of Benefits..: NO
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.: NO
 [6] Special Program.........: NO
 [7] Outside Lab Charges.....: NO
 [8] Date of First Symptom...:
 [9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17)  : SMITH,BOB    I.D. Number: 123456
[12] Case No. (External ID)..:
[13] Medicaid Resubmission No:
[14] PRO Approval Number.....:
[15] HCFA-1500B Block 19.....:
[16] Supervising Prov.(FL19) :                    Date Last Seen:
 [17] Date of Last X-Ray.....:
[18] Prior Authorization #...:
[19] Homebound Indicator.....:
[20] Hospice Employed Prov...:
------------------------------------------------------------------------------
WARNING:058 - RELEASE OF INFORMATION UNOBTAINED
WARNING:059 - ASSIGNMENT OF BENEFITS UNOBTAINED
  ERROR:193 - PIN/PERSON CLASS MISSING FROM REFERRING PROVIDER
------------------------------------------------------------
```

Figure 5-6: Example of error 193

5.2.2 Error 201

What does error 201 mean?

The referring provider has a non-mapped Person Class.

How do I correct it?

Change the Person Class for the Provider to a mapped taxonomy (see "Appendix A: Mapped Taxonomy Codes by Provider Class"). If information is not properly entered, then an error message will be displayed, such as the 201 error shown in the following screen example.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: Patient,Jim  [HRN:43568]                          Claim Number: 3138
................................ (QUESTIONS) ..............................
 [1] Release of Information..: NO
 [2] Assignment of Benefits..: NO
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.: NO
 [6] Special Program.........: NO
 [7] Outside Lab Charges.....: NO
 [8] Date of First Symptom...:
 [9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17)  : SMITH,BOB    I.D. Number: 123456
[12] Case No. (External ID)..:
[13] Medicaid Resubmission No:
[14] PRO Approval Number.....:
[15] HCFA-1500B Block 19.....:
[16] Supervising Prov.(FL19) :                   Date Last Seen:
[17] Date of Last X-Ray......:
[18] Prior Authorization #...:
[19] Homebound Indicator.....:
[20] Hospice Employed Prov...:
------------------------------------------------------------------------------
WARNING:058 - RELEASE OF INFORMATION UNOBTAINED
WARNING:059 - ASSIGNMENT OF BENEFITS UNOBTAINED
  ERROR:201 - TAXONOMY CODE MISSING FOR PERSON CLASS
------------------------------------------------------------------------------
```

Figure 5-7: Example of error 201

5.2.3 Error 202

What does error 201 mean?

The referring provider does not have a mapped Provider Class.

How do I correct it?

Change Provider class to a mapped taxonomy (see "Appendix A: Mapped Taxonomy Codes by Provider Class"). If information is not properly entered, then an error message will be displayed on the screen after the warnings.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: Patient,Jim  [HRN:43568]                          Claim Number: 3138
.................................. (QUESTIONS) ..............................
 [1] Release of Information..: NO
 [2] Assignment of Benefits..: NO
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.: NO
 [6] Special Program.........: NO
 [7] Outside Lab Charges.....: NO
 [8] Date of First Symptom...:
 [9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17)  : SMITH,BOB    I.D. Number: 123456
[12] Case No. (External ID)..:
[13] Medicaid Resubmission No:
[14] PRO Approval Number.....:
[15] HCFA-1500B Block 19.....:
[16] Supervising Prov.(FL19) :                   Date Last Seen:
[17] Date of Last X-Ray......:
[18] Prior Authorization #...:
[19] Homebound Indicator.....:
[20] Hospice Employed Prov...:
------------------------------------------------------------------------------
WARNING:058 - RELEASE OF INFORMATION UNOBTAINED
WARNING:059 - ASSIGNMENT OF BENEFITS UNOBTAINED
  ERROR:202 - PROVIDER CLASS NOT MAPPED TO TAXONOMY CODE
------------------------------------------------------------------------------
```

Figure 5-8: Example of error 202

5.3 Page 4

In support of the 837 transaction, Page 4 of the Claim Editor will now automatically search for a mapped Taxonomy Code for the listed provider. Any provider that you choose will have to be listed in the New Person file (File 200). This provider must have either a Person Class or a Provider Class assigned to them. Assigning a Person Class or Provider Class is done within the New Person file.

When an 837 transaction is created, a check is done to see if a Person Class is assigned. If there is a Person Class assigned, the system uses this and attempts to match the code to a mapped Taxonomy Code in the 3P Provider Taxonomy file. If a match is found, then no further action is needed. If a Person Class is not found or if a matching Taxonomy code is not found, then the system then looks at the Provider Class assignment. If a Provider Class is found, then the system attempts to match it to a Taxonomy code. If a match is found, then no further action is needed. If a match is not found then the provider taxonomy code field on the 837 will not be populated.

The flowchart in the following section details how the system checks for a Taxonomy code.

5.3.1 How Page 4 Checks for a Taxonomy Code

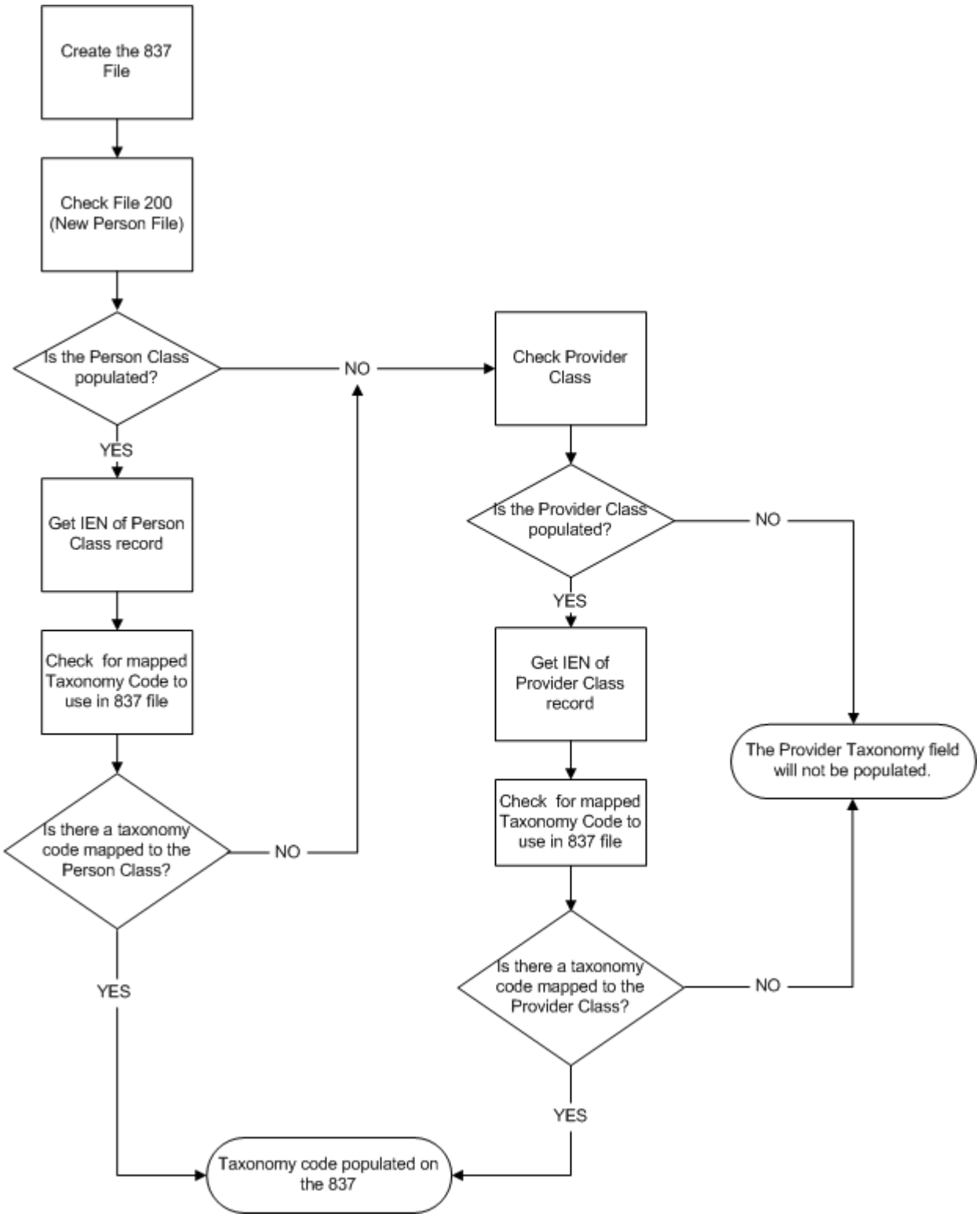


Figure 5-9: Flow chart depicting how Page 4 searches for a Taxonomy Code

5.4 Understanding the 3P Provider Taxonomy File

The 3P Provider Taxonomy file contains:

- The 837 Taxonomy codes
- Person Class mapping
- Provider Class mapping

The 3P Taxonomy file contains a listing of all the 837 Taxonomy codes and maps each of the codes to the appropriate codes in the Person Class and Provider Class.

Note: All the Person Classes are not mapped at this time.

5.5 Type of Service Auto-Population

Patch 6 removed the auto-population feature for the Type of Service field from the 837.

5.6 Discharge Status

The TPB system has been corrected to make Discharge Status default on Page 3 of Claim Editor.

5.7 Medicare 837 Fix

Patch 6 contains a fix to remove QTY segment from Medicare 837 file if the patient is not an inpatient.

6. Patch 5

Patch 5 consists of modifications that are a result of the 837 testing.

6.1 Patient Health Record Number

Sites may elect to bill for services that are performed outside of their primary facility. Generally, these sites may have the Parent/Satellite option set to Yes. When this option is set, the ABM system will utilize the A/R Parent/Satellite setup. Claims are then created under a parent facility which can be the primary billing location.

The ABM system has been modified to allow the Health Record Number (HRN) to be populated under the Parent Billing location. For example, if HRNs are issued at a parent facility, but the claim is generated for the satellite facility, ABM will check the HRN for the Visit location, Parent location, and then the Satellite.

6.2 Removal of "Unknown" Entry

The ABM system was populating the Group Name field on the 837 with "Unknown." Sites that were submitting to Medicare were experiencing batch rejections due to the entry being populated.

The entry of "Unknown" was removed from all 837 formats (837-I, 837-P and 837-D) for Medicare Payers.

6.3 Removal of ICD-9 Surgical Procedures for Flat Rate Claims

The 837 transactions send the ICD-9 Surgical Procedures, regardless of the procedure coding. Surgical procedures were being sent for flat rate claims. This was causing claim batch rejections for Flat Rate payers since the payers were not expecting any procedures to be submitted.

If the properties from the Insurer File indicate the claim to be submitted in a flat rate manner, then the ABM system will remove all Surgical Procedure Codes (ICD-9) from all 837 formats.

6.4 Population of the Sixth Diagnosis Code on the 837

The current 837 formats did not populate the sixth diagnosis piece on the 837.

The ABM system has been programmed to ensure the sixth diagnosis piece has been populated.

6.5 Removal of Trailing Spaces from the Patient/Policy Holder's Address

There may be occurrences in the Patient Registration system where the user may have entered a trailing space after the patient or policy holder's address. The screen might look like the following example. Notice that trailing spaces may exist after the street and city address fields.

```
IHS REGISTRATION EDITOR  (page 1)                    INDIAN HEALTH HOSPITAL
================================================================================
STICK,PENCIL                          (upd:APR 27, 2004) HRN:99093
================================================================================
 1.      ELIGIBILITY STATUS : DIRECT ONLY
 2.                     DOB : 08/17/1982
 3.           CITY OF BIRTH : SANTA FE      4.ST : NM
 5.                     SEX : FEMALE
 6.                     SSN : 555558741(Not yet verified by the SSA)
 7.          MARITAL STATUS :
 8.       CURRENT COMMUNITY : SANTA FE
--------------------------------------------------------------------------------
 9.  MAILING ADDRESS-STREET : 334 E MANCHESTER
 10.STREET ADDRESS [LINE 2] :
 11.STREET ADDRESS [LINE 3] :
 12.   MAILING ADDRESS-CITY : SANTA FE      13.ST : NM
 14.    MAILING ADDRESS-ZIP : 90111
 15.       LOCATION OF HOME :
--------------------------------------------------------------------------------
 16.             HOME PHONE : 512-8412
 17.           OFFICE PHONE :
 18.            OTHER PHONE :
================================================================================
CHANGE which item? (1-18) NONE//:
```

Figure 6-1: Removal of Trailing Spaces from the Patient/Policy Holder's Address

The ABM system has been programmed to remove the trailing space from all 837 formats only. You may not even be aware a space was entered after the Street Name or City Name. This will not be identified to you to fix so be aware that there may still be incorrect entries in Patient Registration.

6.6 Send Only Four Corresponding Diagnosis Codes per Line of Service

The ABM system has always allowed claims to contain up to 99 entries of the diagnosis to be entered on Page 5A of the claim editor. The system also allows the diagnosis to be linked to a charge on the CPT pages (Pages 8A to 8J). Payers have been denying claim batch files due to too many diagnosis codes being linked on the 837 Professional format.

In this patch, the ABM system will still allow you to link the diagnosis to the CPT code but if you elect to link more than four diagnosis codes and are billing using the 837 Professional Format, then the electronic batch will only transmit the first four diagnosis codes that were sequenced to the charge. You will not be informed that only four diagnosis codes will be sent.

6.7 New Error Code in the Claim Editor

Injury data can be extracted from PCC visit data to the ABM system. Since PCC allows you to enter incomplete dates of injury, the ABM system will allow the approval of a claim with imprecise dates. Payers were denying these claims for lack of specific information.

The ABM system has been modified to display an error on Page 3 of the claim editor to prevent approving a claim if the injury date is incomplete. You must enter the date in MM/DD/CCYY format on Page 3. In the example below you will see that an imprecise date was entered in the EMPLOYMENT RELATED field, causing zeros to be shown for the day.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,SUE  [HRN:1072]                          Claim Number: 25166
.............................. (QUESTIONS) ..............................

 [1] Release of Information..: YES   From: 04/04/2004  Thru:
 [2] Assignment of Benefits..: YES   From: 04/04/2004  Thru:
 [3] Accident Related........: YES  EMPLOYMENT RELATED 04/00/2004 9900 HRS
 [4] Employment Related......: YES
 [5] Emergency Room Required.: NO
 [6] Special Program.........: NO
 [7] Blood Furnished.(pints).: NO
 [8] PRO Approval Number.....:
 [9] Type of Admission.......:
[10] Source of Admission.....:
[11] Discharge Status........:
[12] Admitting Diagnosis.....:
[13] Referral Number.........:
[14] Prior Authorization #...:
------------------------------------------------------------------------------
  ERROR:192 - IMPRECISE INJURY DATE
------------------------------------------------------------------------------
Desired ACTION (Edit/Next/View/Jump/Back/Quit): N// E <Enter>

Desired FIELDS:  (1-14): 1-14// 3 <Enter>

[3] Was the Visit Related to an Accident? Y// <Enter>

     Select one of the following:

          1         AUTO ACCIDENT
          2         AUTO-NO FAULT INSURANCE INVOLVED
          3         COURT ACTION POSSIBLE
          5         OTHER ACCIDENT

Type of Accident: 4// 5  OTHER ACCIDENT

Accident Date:  04/00/2004// 04/18/2004 <Enter>  (APR 18, 2004)

Accident Hour:  (0-23): 11 <Enter>
```

Figure 6-2: New Error Code in the Claim Editor

Error Code 192 labeled “Imprecise Injury Date” will display on Page 3 of the Claim Editor, if this error exists. Remember: claims cannot be approved if errors exist.

6.8 Deny Claim Cancellation If a Bill Is Already Tied to the Claim

The ABM system contains a claim cancellation function in the Claim/Bill Management Menu. This function is used to delete old claims from the system when they are no longer used. The system will also deny claims that have been previously billed. This was causing problems for users who may need to access that claim at a later point in time since the claim cannot be re-created once it has been deleted.

The system has been modified to prevent you from deleting or canceling claims that have been billed. The system will display a message advising you they will not be able to delete.

```
Select Claim/Bill Management Menu Option: CLMG <Enter>  Cancel Claim

          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +                     Cancel Claim                        +
          |                 INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                  18-MAY-2004 3:49 PM

Select CLAIM or PATIENT: 24534 <Enter>  PATIENT,PATTY
          Clm:24534  04-27-2004 OUTPATIENT  GENERAL        INDIAN HOSP
                      EXPLOSIVE ARMS INSURANCE        Claim Completed
Correct Claim? YES// YES <Enter>
An active bill exists for this claim.  Cancelling of claim not
allowed!
```

Figure 6-3: Deny Claim Cancellation If a Bill Is Already Tied to the Claim

6.9 Admission Source, Admission Type, and Discharge Status Default

The ABM system uses defaults for certain fields that may display on the claim form. If the visit or claim was an Outpatient service (excluding Day Surgery), then the TPB system would not display a value for the Admission Source (UB-92 Form Locator 20), Admission Type (UB-92 Form Locator 19) and Discharge Status (UB-92 Form Locator 18).

The system has now been modified to allow the user to complete the Admission Source, Admission Type and the Discharge Status when the mode of export is UB-92 (paper), UB-92 (NSF) or 837 Institutional.

The following defaults will be automatically populated for non inpatient claims:

- Type of Admission = 2 – Urgent
- Source of Admission = 1 – Physician Referral
- Discharge Status = 01 – Discharged to Home

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,HENRIETTA  [HRN:1072]            Claim Number: 25235
.............................. (QUESTIONS) ..............................

 [1] Release of Information..: YES   From: 12/01/2001  Thru:
 [2] Assignment of Benefits..: YES   From: 12/01/2001  Thru:
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.: YES
 [6] Special Program.........: NO
 [7] Blood Furnished.(pints).: NO
 [8] PRO Approval Number.....:
 [9] Type of Admission.......:  2  URGENT
[10] Source of Admission.....:  1  PHYSICIAN REFERRAL
[11] Discharge Status........:  01 Discharge to Home
[12] Admitting Diagnosis.....:
[13] Referral Number.........:
[14] Prior Authorization #...:

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

Figure 6-4: Admission Source, Admission Type, and Discharge Status Default

6.10 Place of Service/Type of Service Modification

The Place of Service and Type of Service codes are used to describe the location the services were rendered and the type of service that was obtained. The Third Party Billing system has always tried to determine the correct codes based on the built in logic. This was causing claims to deny, as there were some POS (Place of Service) or TOS (Type of Service) codes that were submitted with the incorrect data.

6.10.1 Place of Service and Type of Service Fields

To permit better access of the CPT pages (Pages 8A to 8H) two fields have been added that allow you to edit the Place of Service and Type of Service codes by line item. You may access these fields when adding a new charge or when editing an existing charge. These two fields will only display when the mode of export is HCFA-1500 (electronic or paper) or 837-P. You will see them at the bottom of the screen in the following example.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT ,LUCINDA M  [HRN:5650]                  Claim Number: 25190
Mode of Export: 837 PROF (HCFA)
.............................. (MEDICAL SERVICES) ............................

     REVN                                                  UNIT       TOTAL
     CODE         CPT - MEDICAL SERVICES                  CHARGE QTY  CHARGE
     ==== ============================================  ====== === ========
[1]  CHARGE DATE: 04/20/2004
          99212 OFFICE/OUTPATIENT VISIT, EST              86.00  1     86.00
                                                                    ========
                                                                      $86.00

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

[1]  99212

Select 1st MODIFIER:

                     DIAGNOSES
       Seq   ICD9
       Num   Code              Diagnosis Description
       ===  ======   ========================================
        1   473.9    CHRONIC SINUSITIS NOS

DATE/TIME: APR 20,2004// <Enter>
UNITS: 1// <Enter>
PROVIDER: PROVIDER,NANCY E// <Enter>
PLACE OF SERVICE: 22//<Enter>
TYPE OF SERVICE: 1//
```

Figure 6-5: Place of Service/Type of Service Modification (added fields)

A new table has been added to RPMS that will allow the user to further define the Type of Service code. The following table displays the entries added:

Code	Description
0	Whole Blood
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Laboratory
6	Therapeutic Radiology
7	Anesthesia
8	Assistant at Surgery
9	Other Medical Items or SERVICES
A	Used DME
B	High Risk Screening Mammography
C	Low Risk Screening Mammography
D	Ambulance
E	Enteral/Parenteral Nutrients/Supplies
F	Ambulatory Surgical Center
G	Immunosuppressive Drugs
H	Hospice
J	Diabetic Shoes
K	Hearing Items and Services
L	ESRD Supplies
M	Monthly Capitation Payment for Dialysis
N	Kidney Donor
P	Lump Sum Purchase of DME, Prosthetics, Orthotics
Q	Vision Items or Services
R	Rental of DME
S	Surgical Dressings or Other Medical Supplies
T	Outpatient Mental Health Treatment Limitation
U	Occupational Therapy
V	Pneumococcal/Flu Vaccine
W	Physical Therapy

The Charge Summary screen has also been modified to allow the user to identify when a form Locator Override edit has been used for the POS/TOS fields of the HCFA-1500. The following message may display when the user types in "Approve" at Page 0:

```
                  ***** 837 PROF (HCFA) CHARGE SUMMARY *****
                                                  Corr
 Charge Date       POS TOS   Description          Diag       Charge      Qty
-------------------------------------------------------------------------------

04-20-2004         11   1     99212                1,2         86.00      1

04-20-2004         11   1     J0706                1,2          8.00      1

04-20-2004         11   9     A4200                1,2          1.00      1
                                                              ----------
          TOTAL CHARGE                                          95.00

Form Locator Override edits exist for POS/TOS
```

Figure 6-6: Place of Service/Type of Service Modification (charge summary screen)

Keep in mind that Form Locator Override will always override entries that were placed into the claim editor.

6.11 Fix for Referring Provider

> **Note**: This functionality was updated in patch 6 (see Section 5.1).

The Referring Phys. (FL17) question on Page 3 of the claim editor allows you to enter the name of an ordering/referring physician and their UPIN. This information is needed if you are billing for diagnostic laboratory or radiology services, consultative services and when billing for medical equipment. Since the implementation of the 837-P, the Referring Provider and their UPIN was being entered but was also lacking a provider taxonomy code. This was resulting in rejected claim batches.

The Third Party Billing system has been modified to allow you to enter the appropriate provider taxonomy for the Referring/Ordering provider. This prompt will display immediately after the "Referring Physician I.D. No." prompt. You may type in the provider discipline, refer to the provider taxonomy code list, or also reference the Web site that contains the taxonomy codes by using the following link: http://www.wpc-edi.com/codes/Codes.asp.

7. Patch 1

7.1 Selecting an 837 Format Export Mode

Patch 1 of the Third Party Billing package addresses issues related to recent HIPAA Title II requirements. This patch contains three new export modes and software to generate ANSI 837 claims. The new export modes are 837 Institutional, 837 Professional, and 837 Dental. When you are selecting a mode of export for an insurer's visit type, you will see three additional modes of export.

When an existing insurer is ready to receive their bills in the 837 format, you will need to change the mode of export to one of these three new export modes.

```
Mode of Export......: ?? <Enter>

Choose from:
   1      UB-82      OMB NO. 0938-0279
   2      HCFA-1500A      Old Version Dated 1-84
   3      HCFA-1500B      New Version Dated 12-90
   4      ADA-90      Dental Claim Form Dated 1990
   10     UB-92-E V4      UB-92 Electronic (NSF Version 4)
   11     UB-92      OMB NO. 0938-0279
   12     ADA-94      DENTAL ADA-94 FORM
   13     UB-92-E V5      Electronic UB-92 (NSF Version 5)
   14     HCFA-1500 Y2K      HCFA 1500 Y2K version
   15     HCFA-1500-E      Electronic HCFA-1500 (NSF Version 2.0)
   16     UB-92-E ENVOY      Electronic UB-92 (Envoy/NEIC version)
   17     UB-92-E V6      Electronic UB-92 (NSF Version 6)
   18     ADA-99      Dental Claim Form Dated 1999
   19     HCFA-1500-E ENVOY      Electronic HCFA-1500 Envoy (NSF V 2.0)
   20     HCFA-1500-E V3.01      Electronic HCFA-15000 (NSF V3.01)

   21     837 INST      837 4010 INSTITUTIONAL
   22     837 PROF      837 4010 PROFESSIONAL
   23     837 DENTAL      837 4010 DENTAL

Mode of Export......:
```

Figure 7-1: Selecting an 837 Format Export Mode

7.2 Setting up Provider's Person Classes

Select the User Management option from the main menu, then the Person Class Edit option from the User Management menu. Type the name of the provider you need to add a person class to at the "Select New Person Name:" prompt.

```
   CORE   IHS Core ...
   DEV    Device Management ...
   FM     VA FileMan ...
   MAN    Manage Mailman ...
   MM     Menu Management ...
   PROG   Programmer Options ...
   SM     Operations Management ...
   SPL    Spool Management ...
   TM     Taskman Management ...
   UE     User Management ...
   SS     System Security ...
   UIHS   Unix IHS Utilities ...
   UXSY   Unix System Administration ...
          Application Utilities ...

Select IHS Kernel Option: UE  User Management

          Add a New User to the System
          Grant Access by Profile
          Edit an Existing User
          Deactivate a User
          Reactivate a User
          List users
          User Inquiry
          Switch Identities
          File Access Security ...
             **> Out of order:  ACCESS DISABLED
          Clear Electronic signature code
          Electronic Signature Block Edit
          Manage User File ...
          Person Class Edit
          Reprint Access agreement letter

Select User Management Option: PERSON CLASS EDIT

Select NEW PERSON NAME: DEMO,USER
```

Figure 7-2: Setting Up Provider's Person Classes (select new person)

Type the desired person class number at the Person Class prompt (or type two question marks (??) for a list of available person classes). If you wish to add the selected person class, type Y at the "Are you adding [*person class*] as a new Person Class?" prompt.

```
                              Edit of Person Class
NAME: DEMO,USER
_____________________________________________________________________________
Person Class                                        Effective     Expired
 59


_____________________________________________________________________________
  Dietary & Nutritional Service Providers
                    Nutritionist
                         Nutrition, Education
  Are you adding 'Dietary & Nutritional Service Providers' as
    a new PERSON CLASS? No// Y
```

Figure 7-3: Setting Up Provider's Person Classes (select person class number)

Type the effective date in the next field and, if necessary, the expired date in the field after that. Repeat until you have added all applicable Person Classes for this provider.

```
                              Edit of Person Class
NAME: DEMO,USER
_____________________________________________________________________________

Person Class                                      Effective     Expired
 Dietary & Nutritional Service Providers          JUL 11,2002


_____________________________________________________________________________


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

Figure 7-4: Setting Up Provider's Person Classes (select effective date)

Once you have finished adding person classes to the provider go to the command line, save your changes, and exit the option.

8. Contact Information

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

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4199

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov

Appendix A: Mapped Taxonomy Codes by Provider Class

Table of Taxonomy Codes: Individual or Groups (of Individuals)

Updated 10/24/03

RPMS Provider Code	RPMS Name	Taxonomy Code	Taxonomy Name
10	PHYSICAL THERAPIST	225100000X	PHYSICAL THERAPIST
11	PHYSCIAN ASSISTANT	363A00000X	PHYSICIAN ASSISTANT
12	PSYCHOLOGIST	103T00000X	PSYCHOLOGIST
13	CHN/AIDES	376K00000X	NURSE'S AIDE
14	SCHOOL NURSE	163WS0200X	SCHOOL, REGISTERED NURSE
15	OTHER	See HC Prov Tax Manual	See HC Prov Tax Manual
16	PEDIATRIC NURSE PRACT.	363LP0200X	PEDIATRICS (NURSE PRACTITIONER)
17	NURSE MIDWIFE	367A00000X	MIDWIFE, CERTIFIED NURSE
18	PHYSICIAN (CONTRACT)	208D00000X	GENERAL PRACTICE
19	MENTAL HEALTH	101YM0800X	MENTAL HEALTH (COUNSELOR)
20	MEDICAL STUDENT	390200000X	STUDENT IN AN ORGANIZED HEALTH CARE EDUCATION/TRAINING PROGRAM
21	NURSE PRACTITIONER	363L00000X	NURSE PRACTITIONER
22	NURSE ASSISTANT	376K00000X	NURSE'S AIDE
23	LABORATORY TECHNICIAN	246RM2200X	MEDICAL LABORATORY (TECHNICIAN, PATHOLOGY)
24	CONTRACT OPTOMETRIST	152W00000X	OPTOMETRIST
25	PODIATRIST (CONTRACT)	213E00000X	PODIATRIST
26	RESPIRATORY THERAPIST	227900000X	RESPIRATORY THERAPIST, REGISTERED
27	NURSING STUDENT	See HC Prov Tax Manual	See HC Prov Tax Manual
28	AUDIOLOGIST	231H00000X	AUDIOLOGIST
29	DIETICIAN	133V00000X	DIETITIAN, REGISTERED
30	PHARMACY PRACTITIONER	183500000X	PHARMACIST

RPMS Provider Code	RPMS Name	Taxonomy Code	Taxonomy Name
31	OPTOMETRIC ASSISTANT	156FX1201X	OPTOMETRIC ASSISTANT
32	CHN (CONTRACT)	See HC Prov Tax Manual	See HC Prov Tax Manual
33	PODIATRIST	213E00000X	PODIATRIST
34	NUTRITIONIST (CONTRACT/TRIBAL)	133N00000X	NUTRITIONIST
35	OUTREACH WORKER	See HC Prov Tax Manual	See HC Prov Tax Manual
36	EYE CARE SPECIALIST	156F00000X	TECHNICIAN/TECHNOLOGIST
37	FAMILY PLANNING COUNSELOR	106H00000X	MARRIAGE & FAMILY THERAPIST
38	EMT/PARAMEDIC	146L00000X	EMERGENCY MEDICAL TECHNICIAN, PARAMEDIC
39	SPEECH THERAPIST	235Z00000X	SPEECH-LANGUAGE PATHOLOGIST
40	AMBULANCE DRIVER	172A00000X	DRIVER
41	OB/GYN (CONTRACT)	207V00000X	OBSTETRICS & GYNECOLOGY
42	SPEECH /LANGUAGE PATHOLOGIST	235Z00000X	SPEECH-LANGUAGE PATHOLOGIST
43	AUDIOMETRIC TECHNICIAN	235500000X	SPECIALIST/TECHNOLOGIST (AUDIOLOGY)
44	PHYSICIAN (TRIBAL)	208D00000X	GENERAL PRACTICE
45	OSTEOPATH	207R00000X	INTERNAL MEDICINE
46	DENTAL HYG/ASSISTANT	124Q00000X	DENTAL HYGIENIST
47	CRNA	367500000X	NURSE ANESTHETIST, CERTIFIED REGISTERED
48	ALCOHOLISM/SUB ABUSE COUNSELOR	101YA0400X	ADDICTION (SUBSTANCE USE DISORDER) (COUNSELOR)
49	CONTRACT PHYCHIATRIST	2084P0800X	PSYCHIATRY
50	CONTRACT PHSYCHOLOGIST	103T00000X	PSYCHOLOGIST
51	NUTRITION PROGRAM (PAPAGO)	133N00000X	NUTRITIONIST
52	DENTIST	1223G0001X	GENERAL PRACTICE (DENTIST)
53	COMMUNITY HEALTH REP.	374H00000X	HOME HEALTH AIDE
54	DENTAL ASSIST. (PRENATAL)	126800000X	DENTAL ASSISTANT
55	DISEASE CONTROL PROGRAM	not applicable	not applicable

RPMS Provider Code	RPMS Name	Taxonomy Code	Taxonomy Name
56	HEALTH RECORDS	247000000X	TECHNICIAN, HEALTH INFORMATION
57	ADMINISTRATION	not applicable	not applicable
58	SPEECH THER-DISCONTINUE	Discontinued	Discontinued
59	X-RAY TECHNICIAN	247100000X	RADIOLOGIC TECHNOLOGIST
60	DENTAL ASSISTANT	126800000X	DENTAL ASSISTANT
61	DENTAL LAB	126900000X	DENTAL LABORATORY TECHNICIAN
62	SOCIAL WORKER LICENSED	1041C0700X	CLINICAL (SOCIAL WORKER)
63	CONTRACT SOCIAL WORKER	1041C0700X	CLINICAL (SOCIAL WORKER)
64	NEPHROLOGY	207RN0300X	NEPHROLOGY
65	OPTOMETRY STUDENT	156FX1201X	OPTOMETRIC ASSISTANT
66	CASE MANAGERS	251B00000X	CASE MANAGEMENT
67	CLINICAL PHARMACY SPECIALIST	1835G0000X	PHARMACIST. GENERAL PRACTICE
68	EMERGENCY ROOM PHYSICIAN	207PE0004X	EMERGENCY MEDICAL SERVICES (EMER. MED.)
69	CHIROPRACTOR	111N00000X	CHIROPRACTOR
70	CARDIOLOGIST	207RC0000X	CARDIOVASCULAR DISEASE (INTERNAL MEDICINE)
71	INTERNAL MEDICINE	207RA0401X	INTERNAL MEDICINE
72	OB/GYN	207V00000X	OBSTETRICS & GYNECOLOGY
73	ORTHOPEDIST	207X00000X	ORTHOPEDIC SUGERY
74	OTOLARYNGOLOGIST	207Y00000X	OTOLARYNGOLOGY
75	PEDIATRICIAN	208000000X	PEDIATRICS
76	RADIOLOGIST	2085R0202X	DIAGNOSTIC RADIOLOGY
77	SURGEON	208600000X	SURGERY
78	UROLOGIST	208800000X	UROLOGY
79	OPHTHALMOLOGIST	207W00000X	OPHTHALMOLOGY
80	FAMILY PRACTICE	207Q00000X	FAMILY PRACTICE
81	PSYCHIATRIST	2084P0800X	PSYCHIATRY
82	ANESTESIOLOGIST	207L00000X	ANESTHESIOLOGY
83	PATHOLOGIST	207ZP0105X	CLINICAL PTHOLOGY/LABORATORY MEDICINE

RPMS Provider Code	RPMS Name	Taxonomy Code	Taxonomy Name
84	PEDORTHIST	225000000X	ORTHOTICS/PROSTHETICS FITTER
85	NEUROLOGIST	207T00000X	NEUROLOGICAL SURGERY
86	DERMATOLOGIST	207N00000X	DEMATOLOGY
87	ULTASOUND TECHNICIAN	247100000X	RADIOLOGIC TECHNOLOGIST
88	CODING/DATA ENTRY	246Y00000X	SPECIALIST/TECHNOLOGIST, HEALTH INFORMATION
89	AUDIOLOGY HEALTH TECHNICIAN	235500000X	SPECIALIST/TECHNOLOGIST (AUDIOLOGY)
90	OCCUPATIONAL THERAPIST	225X00000X	OCCUPATIONAL THERAPIST
91	PHN DRIVER/INTERPRETER	172A00000X	DRIVER
92	PSYCHOTHERAPIST	103TP2700X	PSYCHOTHERAPY
93	TRADITIONAL MEDICINE PRACTITIONER	175F00000X	NATUROPATH
94	MENTAL HEALTH (BA/BS ONLY)	101YM0800X	MENTAL HEALTH (COUNSELOR)
95	MENTAL HEALTH (MASTERS ONLY)	101YM0800X	MENTAL HEALTH (COUNSELOR)
96	FAMILY THERAPIST	106H00000X	MARRIAGE & FAMILY THERAPIST
97	NUTRITION TECHNICIAN	133NN1002X	NUTRITION, EDUCATION
98	FOOD SERVICE SUPERVISOR	not applicable	not applicable
99	DIETETIC TECHNICIAN	136A00000X	DIETETIC TECHNICIAN, REGISTERED
00	PHYSICIAN	208D00000X	GENERAL PRACTICE
01	REGISTERED NURSE	163W00000X	REGISTERED NURSE
02	ENVIRONMENTAL HEALTH	not applicable	not applicable
03	HEALTH AIDE	374U00000X	HOME HEALTH AIDE
04	HEALTH EDUCATOR	174400000X	SPECIALIST
05	LICENSED PRACTICAL NURSE	164W00000X	LICENSED PRACTICAL NURSE
06	SOCIAL WORKER UNLICENSED	104100000X	SOCIAL WORKER
07	NUTRITIONIST	133N00000X	NUTRITIONIST
08	OPTOMETRIST	152W00000X	OPTOMETRIST
09	PHARMACIST	1835G0000X	GENERAL PRACTICE (PHARMACIST)

RPMS Provider Code	RPMS Name	Taxonomy Code	Taxonomy Name
A1	SPORTS MEDICINE	207QS0010X	SPORTS MEDICINE (FAMILY PRACTICE)
A2	MEDICAL TECHNOLOGIST	246QM0706X	MEDICAL TECHNOLOGIST
A3	NATUROPATH DOCTOR	175F00000X	NATUROPATH
A4	NATUROPATH PHYSICIAN	175F00000X	NATUROPATH
A5	ACUPUNCTURIST	171100000X	ACUPUNCTURIST
A6	IN SCHOOL THERAPY	101YS0200X	SCHOOL (COUNSELOR)
A7	DOMESTIC VIOLENCE COUNSELOR	101Y00000X	COUNSELOR
A8	PHARMACY TECHNICIAN	183700000X	PHARMACY TECHNICIAN
A9	HEPATOLOGIST	207RI0008X	HEPATOLOGY
B1	GASTROENTEROLOGIST	207RG0100X	GASTROENTEROLOGY
B2	ENDOCRINOLOGIST	207RE0101X	ENDOCRINOLOGY, DIABETES & METABOLISM
B3	RHEUMATOLOGIST	207RR0500X	RHEUMATOLOGY
B4	ONCOLOGIST-HEMATOLOGIST	207RH0003X	HEMATOLOGY & ONCOLOGY
B5	PULMONOLOGIST	207RP1001	PULMONARY DISEASE
B6	NEUROSURGEON	207T00000X	NEUROLOGICAL SURGERY

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Non-Individual (Facility) Taxonomy Codes

Facility Type	Taxonomy Code	Taxonomy Name
HOSPITAL	282N00000X	GENERAL ACUTE CARE HOSPITAL
AMBULATORY CLINIC	261QP0904X	PUBLIC HEALTH, FEDERAL (AMB. HEALTH CARE)
CRITICAL ACCESS HOSPITAL	282NC0060X	CRITICAL ACCESS (GENERAL ACUTE CARE HOSP)
FQHC	261QF0400X	FEDERAL QUALIFIED HEALTH CENTER (AMB. HC)
MEDICAL CENTER	2865M2200X	MEDICAL CENTER
*** RESIDENTIAL TREATMENT FACILITY	323P00000X	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
SKILLED NURSING FACILITY	314000000X	SKILLED NURSING FACILITY

*** See HC Prov Tax V3.1 Manual for Definition

Appendix B: Mapped Taxonomy Codes by Person Class

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Physicians (M.D. and D.O.)	Physician/Osteopath	Addiction Medicine	PHYSICIAN ASSISTANT	2084A0401X
Physicians (M.D. and D.O.)	Physician/Osteopath	Allergy & Immunology		207K00000X
Physicians (M.D. and D.O.)	Physician/Osteopath	Immunology, Clinical & Laboratory: Allergy & Immunology		207KI0005X
Physicians (M.D. and D.O.)	Physician/Osteopath	Allergy		207KA0200X
Physicians (M.D. and D.O.)	Physician/Osteopath	Anesthesiology	ANESTHESIOLOGIST	207L00000X
Physicians (M.D. and D.O.)	Physician/Osteopath	Critical Care Medicine: Anesthesiology		207LC0200X
Physicians (M.D. and D.O.)	Physician/Osteopath	Pain Management - Anesthesiology		208VP0000X
Physicians (M.D. and D.O.)	Physician/Osteopath	Body Imaging		2085B0100X
Physicians (M.D. and D.O.)	Physician/Osteopath	Cardiology	CARDIOLOGIST	207RC0000X
Physicians (M.D. and D.O.)	Physician/Osteopath	Dermatology	DERMATOLOGIST	207N00000X
Physicians (M.D. and D.O.)	Physician/Osteopath	Dermatopathology: Dermatology		207ZD0900X
Physicians (M.D. and D.O.)	Physician/Osteopath	Toxicology, Medical: Emergency Medicine		207P00000X
Physicians (M.D. and D.O.)	Physician/Osteopath	General Practice	PHYSICIAN (CONTRACT)	208D00000X
Podiatric Medicine and Surgery Service	Assistant, Podiatric			211D00000X
Podiatric Medicine and Surgery Service	Podiatrist		PODIATRIST (CONTRACT)	213E00000X
Podiatric Medicine and Surgery Service	Podiatrist	Surgery, Foot & Ankle		213ES0103X
Podiatric Medicine and Surgery Service	Podiatrist	Surgery, Foot		213ES0131X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Podiatric Medicine and Surgery Service	Podiatrist	General Practice		213EG0000X
Podiatric Medicine and Surgery Service	Podiatrist	Primary Podiatric Medicine		213EP1101X
Podiatric Medicine and Surgery Service	Podiatrist	Preventive Medicine: Public Health		213EP0504X
Podiatric Medicine and Surgery Service	Podiatrist	Radiology		213ER0200X
Podiatric Medicine and Surgery Service	Podiatrist	Sports Medicine		213ES0000X
Chiropractors	Chiropractor		CHIROPRACTOR	111N00000X
Chiropractors	Chiropractor	Internist		111NI0900X
Chiropractors	Chiropractor	Neurology		111NN0400X
Chiropractors	Chiropractor	Nutrition		111NN1001X
Chiropractors	Chiropractor	Occupational Medicine		111NX0100X
Chiropractors	Chiropractor	Orthopedic		111NX0800X
Chiropractors	Chiropractor	Radiology		111NR0200X
Chiropractors	Chiropractor	Sports Physician		111NS0005X
Chiropractors	Chiropractor	Thermography		111NT0100X
Physician Assistants & Advanced Practice Nursing	Physician Assistant		PHYSICIAN ASSISTANT	363A00000X
Physician Assistants & Advanced Practice Nursing	Physician Assistant	Surgical		363AS0400X
Physician Assistants & Advanced Practice Nursing	Physician Assistant	Medical		363AM0700X
Dental Service	Dental Assistant		LICENSED MEDICAL SOCIAL WORKER	126800000X
Dental Service	Dental Hygienist		DENTAL HYGIENIST	124Q00000X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Dental Service	Dental Laboratory Technician		NEPHROLOGIST	126900000X
Dental Service	Dentist		DENTIST	122300000X
Dental Service	Dentist	Endodontics		1223E0200X
Dental Service	Dentist	Surgery, Oral & Maxillofacial		1223S0112X
Dental Service	Dentist	Pathology, Oral & Maxillofacial		1223P0106X
Dental Service	Dentist	Orthodontics		1223X0400X
Dental Service	Dentist	Pediatrics Dentistry (Pedodontics)		1223P0221X
Dental Service	Dentist	Periodontics		1223P0300X
Dental Service	Dentist	Prosthodontics		1223P0700X
Dental Service	Dentist	Dental Public Health		1223D0001X
Eye and Vision Services	Technician/Technologist	Contact Lens Fitter		156FC0801X
Eye and Vision Services	Technician/Technologist	Contact Lens		156FC0800X
Eye and Vision Services	Technician/Technologist	Ocularist		156FX1700X
Eye and Vision Services	Technician/Technologist	Ophthalmic Medical Assistant		156FX1101X
Eye and Vision Services	Technician/Technologist	Ophthalmic		156FX1100X
Eye and Vision Services	Technician/Technologist	Optician		156FX1800X
Eye and Vision Services	Optometrist		CONTRACT OPTOMETRIST	152W00000X
Eye and Vision Services	Optometrist	Low Vision		152WL0500X
Eye and Vision Services	Optometrist	Sports Vision		152WS0006X
Eye and Vision Services	Optometrist	Pediatrics		152WP0200X
Eye and Vision Services	Optometrist	Occupational Vision		152WX0102X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Eye and Vision Services	Optometrist	Vision Therapy		152WV0400X
Eye and Vision Services	Technician/Technologist	Orthoptist		156FX1900X
Speech, Language and Hearing Service	Audiologist		AUDIOLOGIST	231H00000X
Speech, Language and Hearing Service	Audiologist-Hearing Aid Fitter			237600000X
Speech, Language and Hearing Service	Hearing Instrument Specialist			237700000X
Speech, Language and Hearing Service	Speech-Language Pathologist		SPEECH THERAPIST	235Z00000X
Speech, Language and Hearing Service	Specialist/Technologist	Speech-Language Assistant		2355S0801X
Pharmacy Service	Pharmacist		PHARMACY PRACTICIONER	183500000X
Pharmacy Service	Pharmacist	General Practice	CLINICAL PHARMACY SPECIALIST	1835G0000X
Pharmacy Service	Pharmacist	Nuclear Pharmacy		1835N0905X
Pharmacy Service	Pharmacist	Nutrition Support		1835N1003X
Pharmacy Service	Pharmacist	Pharmacotherapy		1835P1200X
Pharmacy Service	Pharmacist	Psychopharmacy		1835P1300X
Nursing Service	Registered Nurse	Psychiatric/Mental Health, Adult		163WP0809X
Nursing Service	Registered Nurse	Administrator		163WA2000X
Nursing Service	Nurse Massage Therapist (NMT)			163WM1400X
Nursing Service	Registered Nurse		REGISTERED NURSE	163W00000X
Nursing Service	Registered Nurse	Addiction (Substance Use Disorder)		163WA0400X
Nursing Service	Registered Nurse	Post-Anesthesia, Ambulatory		163WP2201X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Nursing Service	Registered Nurse	Women's Health Care, Ambulatory		163WW0101X
Nursing Service	Registered Nurse	Cardiac Rehabilitation		163WC3500X
Nursing Service	Registered Nurse	Case Management		163WC0400X
Nursing Service	Registered Nurse	College Health		163WC1400X
Nursing Service	Registered Nurse	Community Health		163WC1500X
Nursing Service	Registered Nurse	Continence Care		163WC2100X
Nursing Service	Registered Nurse	Critical Care Medicine		163WC0200X
Nursing Service	Registered Nurse	Diabetes Educator		163WD0400X
Nursing Service	Registered Nurse	Emergency		163WE0003X
Nursing Service	Registered Nurse	Enterstomal Therapy		163WE0900X
Nursing Service	Registered Nurse	Flight		163WF0300X
Nursing Service	Registered Nurse	Gastroenterology		163WG0100X
Nursing Service	Registered Nurse	General Practice		163WG0000X
Nursing Service	Registered Nurse	Gerontology		163WG0600X
Nursing Service	Registered Nurse	Hemodialysis		163WH0500X
Nursing Service	Registered Nurse	Obstetric, High-Risk		163WX0002X
Nursing Service	Registered Nurse	Home Health		163WH0200X
Nursing Service	Registered Nurse	Hospice		163WH1000X
Nursing Service	Registered Nurse	Infection Control		163WI0600X
Nursing Service	Registered Nurse	Obstetric, Inpatient		163WX0003X
Nursing Service	Registered Nurse	Infusion Therapy		163WI0500X
Nursing Service	Registered Nurse	Lactation Consultant		163WL0100X
Nursing Service	Registered Nurse	Neonatal, Low-Risk		163WN0003X
Nursing Service	Registered Nurse	Maternal Newborn		163WM0102X
Nursing Service	Registered Nurse	Medical-Surgical		163WM0705X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Nursing Service	Registered Nurse	Neonatal Intensive Care		163WN0002X
Nursing Service	Registered Nurse	Nephrology		163WN0300X
Nursing Service	Registered Nurse	Neuroscience		163WN0800X
Nursing Service	Registered Nurse	Continuing Education/Staff Development		163WC1600X
Nursing Service	Registered Nurse	Nutrition Support		163WN1003X
Nursing Service	Registered Nurse	Occupational Health		163WX0106X
Nursing Service	Registered Nurse	Oncology		163WX0200X
Nursing Service	Registered Nurse	Ophthalmic		163WX1100X
Nursing Service	Registered Nurse	Orthopedic		163WX0800X
Nursing Service	Registered Nurse	Ostomy Care		163WX1500X
Nursing Service	Registered Nurse	Otorhinolaryngology & Head-Neck		163WX0601X
Nursing Service	Registered Nurse	Pain Management		163WP0000X
Nursing Service	Registered Nurse	Pediatrics		163WP0200X
Nursing Service	Registered Nurse	Pediatric Oncology		163WP0218X
Nursing Service	Registered Nurse	Perinatal		163WP1700X
Nursing Service	Registered Nurse	Dialysis, Peritoneal		163WD1100X
Nursing Service	Registered Nurse	Surgery, Plastic		163WS0121X
Nursing Service	Registered Nurse	Psychiatric/Mental Health		163WP0808X
Nursing Service	Registered Nurse	Rehabilitation		163WR0400X
Nursing Service	Registered Nurse	Reproductive Endocrinology/Infertility		163WR1000X
Nursing Service	Registered Nurse	School		163WS0200X
Nursing Service	Registered Nurse	Urology		163WU0100X
Nursing Service	Registered Nurse	Wound Care		163WW0000X
Nursing Service	Licensed Practical Nurse		LICENSED PRACTICAL NURSE	164W00000X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Nursing Service	Licensed Vocational Nurse			164X00000X
Dietary and Nutritional Service	Nutritionist		NUTRITIONIST (CONTRACT/TRIBAL)	133N00000X
Dietary and Nutritional Service	Nutritionist	Nutrition, Education	NUTRITION TECHNICIAN	133NN1002X
Dietary and Nutritional Service	Dietetic Technician		DIETETIC TECHNICIAN	136A00000X
Dietary and Nutritional Service	Dietician, Registered		DIETICIAN	133V00000X
Dietary and Nutritional Service	Dietician, Registered	Nutrition, Metabolic		133VN1006X
Dietary and Nutritional Service	Dietician, Registered	Nutrition, Pediatric		133VN1004X
Dietary and Nutritional Service	Dietician, Registered	Nutrition, Renal		133VN1005X
Emergency Medical Service	Emergency Medical Technician, Basic			146N00000X
Emergency Medical Service	Emergency Medical Technician, Intermediate			146M00000X
Emergency Medical Service	Emergency Medical Technician, Paramedic		EMT/PARAMEDIC	146L00000X
Behavioral Health and Social Service	Psychologist		PSYCHOLOGIST	103T00000X
Behavioral Health and Social Service	Psychologist	Behavioral		103TB0200X
Behavioral Health and Social Service	Psychologist	Clinical		103TC0700X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Behavioral Health and Social Service	Neuropsychologist	Clinical		103GC0700X
Behavioral Health and Social Service	Psychologist	Counseling		103TC1900X
Behavioral Health and Social Service	Psychologist	Family		103TF0000X
Behavioral Health and Social Service	Psychologist	Forensic		103TF0200X
Behavioral Health and Social Service	Psychologist	Health		103TH0100X
Behavioral Health and Social Service	Psychologist	School		103TS0200X
Behavioral Health and Social Service	Counselor			101Y00000X
Behavioral Health and Social Service	Counselor	Addiction (Substance Use Disorder)	ALCOHOLISM/SUB ABUSE COUNSELOR	101YA0400X
Behavioral Health and Social Service	Marriage & Family Therapist		FAMILY PLANNING COUNSELOR	106H00000X
Behavioral Health and Social Service	Counselor	Mental Health	MENTAL HEALTH	101YM0800X
Behavioral Health and Social Service	Counselor	Pastoral		101YP1600X
Behavioral Health and Social Service	Counselor	Professional		101YP2500X
Behavioral Health and Social Service	Counselor	School		101YS0200X
Behavioral Health and Social Service	Social Worker		MEDICAL SOCIAL WORKER	104100000X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Behavioral Health and Social Service	Social Worker	Clinical	DENTAL ASSISTANT (PRENATAL)	1041C0700X
Behavioral Health and Social Service	Social Worker	School		1041S0200X
Respiratory, Rehabilitative and Restorative Service	Pulmonary Function Technologist			225B00000X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist		PHYSICAL THERAPIST	225100000X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist	Cardiopulmonary		2251C2600X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist	Electrophysiology, Clinical		2251E1300X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist	Geriatrics		2251G0304X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist	Neurology		2251N0400X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist	Orthopedic		2251X0800X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist	Pediatrics		2251P0200X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist	Sports		2251S0007X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist	Hand		2251H1200X
Respiratory, Rehabilitative and Restorative Service	Physical Therapy Assistant			225200000X
Respiratory, Rehabilitative and Restorative Service	Rehabilitation Practitioner			225400000X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Respiratory, Rehabilitative and Restorative Service	Rehabilitation Counselor			225C00000X
Respiratory, Rehabilitative and Restorative Service	Occupational Therapist		OCCUPATIONAL THERAPIST	225X00000X
Respiratory, Rehabilitative and Restorative Service	Occupational Therapy Assistant			224Z00000X
Respiratory, Rehabilitative and Restorative Service	Occupational Therapist	Hand		225XH1200X
Respiratory, Rehabilitative and Restorative Service	Art Therapist			221700000X
Respiratory, Rehabilitative and Restorative Service	Specialist/Technologist	Athletic Trainer		2255A2300X
Respiratory, Rehabilitative and Restorative Service	Dance Therapist			225600000X
Respiratory, Rehabilitative and Restorative Service	Massage Therapist			225700000X
Respiratory, Rehabilitative and Restorative Service	Music Therapist			225A00000X
Respiratory, Rehabilitative and Restorative Service	Specialist/Technologist	Rehabilitation, Blind		2255R0406X
Respiratory, Rehabilitative and Restorative Service	Orthotics/Prosthetics Fitter		PEDORTHIST	225000000X
Respiratory, Rehabilitative and Restorative Service	Recreation Therapist			225800000X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Pathology	Laboratory Management, Diplomate		246QL0901X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Pathology	Hemapheresis Practitioner		246QH0401X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Technologists, Technicians and Other Technical Service	Technician, Pathology	Histology		246RH0600X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Pathology	Histology		246QH0600X
Technologists, Technicians and Other Technical Service	Technician, Pathology	Medical Laboratory	LABORATORY TECHNICIAN	246RM2200X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Pathology	Medical Technologist	MEDICAL TECHNOLOGIST	246QM0706X
Technologists, Technicians and Other Technical Service	Technician, Pathology	Phlebotomy		246RP1900X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Pathology	Blood Banking		246QB0000X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Pathology	Chemistry		246QC1000X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Pathology	Cytotechnology		246QC2700X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Pathology	Hematology		246QH0000X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Pathology	Microbiology		246QM0900X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Pathology	Immunology		246QI0000X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Other	Biomedical Engineering		246ZB0301X
Technologists, Technicians and Other Technical Service	Technician, Other	Biomedical Engineering		2472B0301X
Technologists, Technicians and Other Technical Service	Technician, Other	EEG		2472E0500X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Other	EEG		246ZE0500X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Other	Electroneurodiagnostic		246ZE0600X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Other	Graphics Methods		246ZG0701X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Other	Geneticist, Medical (PhD)		246ZG1000X
Technologists, Technicians and Other Technical Service	Technician, Other	Renal Dialysis		2472R0900X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Other	Surgical		246ZS0400X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Technologists, Technicians and Other Technical Service	Radiologic Technologist	Cardiovascular-Interventional Technology: Radiography		2471C1101X
Technologists, Technicians and Other Technical Service	Technician, Other	Darkroom		2472D0500X
Technologists, Technicians and Other Technical Service	Radiologic Technologist	Sonography, Diagnostic Medical		2471S1302X
Technologists, Technicians and Other Technical Service	Radiologic Technologist	Mammography: Radiography		2471M2300X
Technologists, Technicians and Other Technical Service	Radiologic Technologist	Nuclear Medicine Technology		2471N0900X
Technologists, Technicians and Other Technical Service	Radiologic Technologist	Radiation Therapy		2471R0002X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Other	Biomedical Photographer		246ZB0302X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Other	Biostatistician		246ZB0600X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Other	Art, Medical		246ZA2600X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Other	Illustration, Medical		246ZI1000X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Technologists, Technicians and Other Technical Service	Technician, Other	Veterinary		2472V0600X
Other Service	Acupuncturist			171100000X
Other Service	Driver		DENTAL LAB	172A00000X
Other Service	Contractor	Home Modifications		171WH0202X
Other Service	Homeopath			175L00000X
Other Service	Midwife, Lay (Non-nurse)			175M00000X
Other Service	Naturopath		TRADITIONAL MEDICINE PRACTITIONER	175F00000X
Behavioral Health and Social Service	Psychologist	Addiction (Substance Use Disorder)		103TA0400X
Behavioral Health and Social Service	Psychologist	Adult Development & Aging		103TA0700X
Behavioral Health and Social Service	Psychologist	Child, Youth & Family		103TC2200X
Behavioral Health and Social Service	Psychologist	Educational		103TE1000X
Behavioral Health and Social Service	Psychologist	Exercise & Sports		103TE1100X
Behavioral Health and Social Service	Psychologist	Men & Masculinity		103TM1700X
Behavioral Health and Social Service	Psychologist	Mental Retardation & Developmental Disabilities		103TM1800X
Behavioral Health and Social Service	Psychologist	Psychotherapy	PSYCHOTHERAPIST	103TP2700X
Behavioral Health and Social Service	Psychologist	Psychotherapy, Group		103TP2701X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Behavioral Health and Social Service	Psychologist	Rehabilitation		103TR0400X
Behavioral Health and Social Service	Psychologist	Women		103TW0100X
Eye and Vision Services	Technician / Technologist	Optometric Assistant	OPTOMETRIC ASSISTANT	156FX1201X
Eye and Vision Services	Technician / Technologist	Optometric Technician		156FX1202X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Acute Care		364SA2100X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Adult Health		364SA2200X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Critical Care Medicine		364SC0200X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Chronic Care		364SC2300X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Emergency		364SE0003X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Ethics		364SE1400X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Family Health		364SF0001X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Home Health		364SH0200X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Holistic		364SH1100X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Informatics		364SI0800X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Long-Term Care		364SL0600X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Neonatal		364SN0000X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Neuroscience		364SN0800X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Pediatrics		364SP0200X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Psychiatric/Mental Health		364SP0808X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Psychiatric/Mental Health, Adult		364SP0809X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Psychiatric/Mental Health, Child & Family		364SP0810X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Psychiatric/Mental Health, Chronically Ill		364SP0811X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Psychiatric/Mental Health, Community		364SP0812X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Psychiatric/Mental Health, Geropsychiatric		364SP0813X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Perinatal		364SP1700X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Perioperative		364SP2800X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Rehabilitation		364SR0400X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	School		364SS0200X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Transplantation		364ST0500X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Women's Health		364SW0102X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Occupational Health		364SX0106X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Oncology		364SX0200X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Oncology, Pediatrics		364SX0204X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Acute Care		363LA2100X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Critical Care Medicine		363LC0200X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Community Health		363LC1500X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Neonatal: Critical Care		363LN0005X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Pediatrics: Critical Care		363LP0222X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Psychiatric/Mental Health		363LP0808X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Perinatal		363LP1700X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Primary Care		363LP2300X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Women's Health		363LW0102X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Occupational Health		363LX0106X
Nursing Service	Registered Nurse	Psychiatric/Mental Health, Child & Adolescent		163WP0807X
Other Service	Funeral Director			176P00000X
Respiratory, Rehabilitative and Restorative Service	Orthotist			222Z00000X
Respiratory, Rehabilitative and Restorative Service	Prosthetist			224P00000X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist	Ergonomics		2251E1200X
Respiratory, Rehabilitative and Restorative Service	Physical Therapist	Human Factors		2251H1300X
Respiratory, Rehabilitative and Restorative Service	Rehabilitation Counselor	Assistive Technology Supplier		225CA2500X
Respiratory, Rehabilitative and Restorative Service	Occupational Therapist	Ergonomics		225XE1200X
Respiratory, Rehabilitative and Restorative Service	Occupational Therapist	Human Factors		225XH1300X
Respiratory, Rehabilitative and Restorative Service	Occupational Therapist	Neurorehabilitation		225XN1300X
Respiratory, Rehabilitative and Restorative Service	Occupational Therapist	Pediatrics		225XP0200X
Respiratory, Rehabilitative and Restorative Service	Occupational Therapist	Rehabilitation, Driver		225XR0403X
Respiratory, Rehabilitative and Restorative Service	Kinesiotherapist			226300000X
Speech, Language and Hearing Service	Audiologist	Assistive Technology Practitioner		231HA2400X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Speech, Language and Hearing Service	Audiologist	Assistive Technology Supplier		231HA2500X
Speech, Language and Hearing Service	Specialist / Technologist	Audiology Assistant		2355A2700X
Other Service	Specialist	Prosthetics Case Management		1744P3200X
Technologists, Technicians and Other Technical Service	Specialist / Technologist, Pathology	Laboratory Management		246QL0900X
Technologists, Technicians and Other Technical Service	Specialist / Technologist, Health Information	Coding Specialist, Hospital Based		246YC3301X
Technologists, Technicians and Other Technical Service	Specialist / Technologist, Health Information	Coding Specialist, Physician Office Based		246YC3302X
Technologists, Technicians and Other Technical Service	Specialist / Technologist, Other	Biochemist		246ZB0500X
Technologists, Technicians and Other Technical Service	Specialist / Technologist, Other	Nephrology		246ZN0300X
Technologists, Technicians and Other Technical Service	Radiologic Technologist	Computed Tomography: Radiation Therapy		2471C3401X
Technologists, Technicians and Other Technical Service	Radiologic Technologist	Computed Tomography: Radiography		2471C3402X
Technologists, Technicians and Other Technical Service	Radiologic Technologist	Magnetic Resonance Imaging (MRI): Radiographer		2471M1202X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Technologists, Technicians and Other Technical Service	Radiologic Technologist	Quality Management: Radiation Therapy		2471Q0001X
Other Service	Legal Medicine			173000000X
Other Service	Specialist	Graphics Designer		1744G0900X
Other Service	Specialist	Research Data Abstracter/Coder		1744R1103X
Other Service	Specialist	Research Study		1744R1102X
Other Service	Veterinarian	Medical Research		174MM1900X
Technologists, Technicians and Other Technical Service	Specialist/Technologist, Health Information	Registered Record Administrator		246YR1600X
Technologists, Technicians and Other Technical Service	Technician, Health Information	Assistant Record Technician		2470A2800X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist			364S00000X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Community Health/Public Health		364SC1501X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Gerontology		364SG0600X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Medical-Surgical		364SM0705X
Physician Assistants & Advanced Practice Nursing	Clinical Nurse Specialist	Psychiatric/Mental Health, Child & Adolescent		364SP0807X
Physician Assistants & Advanced Practice Nursing	Nurse Anesthetist, Certified Registered		CRNA	367500000X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner		NURSE PRACTICIONER	363L00000X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Adult Health		363LA2200X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Family		363LF0000X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Gerontology		363LG0600X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Neonatal		363LN0000X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Obstetrics & Gynecology		363LX0001X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	Pediatrics	PEDIATRIC NURSE PRACT.	363LP0200X
Physician Assistants & Advanced Practice Nursing	Nurse Practitioner	School		363LS0200X
Nursing Service Related	Christian Science Practitioner/Nurse			374T00000X
Nursing Service Related	Home Health Aide		HEALTH AIDE	374U00000X
Nursing Service Related	Homemaker			376J00000X
Nursing Service Related	Nurse's Aide		CHN/AIDES	376K00000X
Nursing Service Related	Technician	Personal Care Attendent		3747P1801X
Nursing Service Related	Nursing Home Administrator			376G00000X
Behavioral Health and Social Service	Neuropsychologist			103G00000X
Dietary and Nutritional Service	Dietary Manager			132700000X
Eye and Vision Services	Technician / Technologist		EYE CARE SPECIALIST	156F00000X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Other Service and Other Technical Service	Medical Genetics	Technologists, Technicians		170100000X
Other Service	Contractor			171W00000X
Other Service	Specialist		HEALTH EDUCATOR	174400000X
Other Service	Veterinarian			174M00000X
Other Service	Midwife, Certified			176B00000X
Respiratory, Rehabilitative and Restorative Service	Specialist / Technologist			225500000X
Respiratory, Rehabilitative and Restorative Service	Respiratory Therapist			227800000X
Respiratory, Rehabilitative and Restorative Service	Respiratory Therapist			227900000X
Speech, Language and Hearing	Specialist / Technologist		AUDIOMETRIC TECHNICIAN	235500000X
Technologists, Technicians and Other Technical Service	Specialist / Technologist	Pathology		246Q00000X
Technologists, Technicians and Other Technical Service	Technician, Pathology			246R00000X
Technologists, Technicians and Other Technical Service	Technician, Cardiology			246W00000X
Technologists, Technicians and Other Technical Service	Specialist / Technologist	Health Information	CODING/DATA ENTRY	246Y00000X
Technologists, Technicians and Other Technical Service	Specialist / Technologist	Other		246Z00000X

Person Class	Category	Area of Specialty	Provider Class	Provider Taxonomy
Technologists, Technicians and Other Technical Service	Technician	Health Information	HEALTH RECORDS	247000000X
Technologists, Technicians and Other Technical Service	Radiologic Technologist		X-RAY TECHNICIAN	247100000X
Technologists, Technicians and Other Technical Service	Technician, Other			247200000X
Physician Assistants & Advanced Practice Nursing	Midwife, Certified Nurse		NURSE MIDWIFE	367A00000X
Nursing Service Related	Technician			374700000X

Appendix C: HIPAA Standard Adjustment Codes Mapped to RPMS

As of February 22, 2006

HIPAA Standard		RPMS			
Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
1	Deductible Amount	13	DEDUCTIBLE	29	Deductible Amount
2	Coinsurance Amount	14	CO-PAY	602	Coinsurance Amount
3	Co-payment Amount	14	CO-PAY	27	Co-Payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	4	NON PAYMENT	604	Code Err Proc Inconst w Mod
5	The procedure code/bill type is inconsistent with the place of service.	4	NON PAYMENT	605	Code Err Proc/BT Inconst w POS
6	The procedure code is inconsistent with the patient's age.	4	NON PAYMENT	606	Code Err Proc Inconst w Pt Age
7	The procedure code is inconsistent with the patient's gender.	4	NON PAYMENT	607	Code Err Proc Inconst w Pt Gdr
8	The procedure code is inconsistent with the provider type.	4	NON PAYMENT	608	Code Err Proc Inconst w ProvTp
9	The diagnosis is inconsistent with the patient's age.	4	NON PAYMENT	609	Code Err DX Inconst w Pt Age
10	The diagnosis is inconsistent with the patient's gender.	4	NON PAYMENT	610	Code Err DX Inconst w Pt Gdr
11	The diagnosis is inconsistent with the procedure.	4	NON PAYMENT	611	Code Err DX Inconst w Procdr
12	The diagnosis is inconsistent with the provider type.	4	NON PAYMENT	612	Code Err DX Inconst w Prov Tp
13	The date of death precedes the date of service.	4	NON PAYMENT	613	Death Precedes Date of Service
14	The date of birth follows the date of service.	4	NON PAYMENT	614	Birth Follows Date of Service
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	4	NON PAYMENT	615	Pymt Adj Inadeq Auth Number

HIPAA Standard		RPMS			
Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4	NON PAYMENT	616	Clm/Srvc Lacks Info For Adjud
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	4	NON PAYMENT	617	Pymt Adj Info Incomplete
18	Duplicate claim/service.	3	WRITE OFF	135	Duplicate Claim/Service
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	4	NON PAYMENT	619	Clm Denied work related injury
20	Claim denied because this injury/illness is covered by the liability carrier.	4	NON PAYMENT	620	Clm Den Injry Covrd Liab Carr
21	Claim denied because this injury/illness is the liability of the no-fault carrier.	4	NON PAYMENT	621	Clm Den Injry Covrd NoFlt Carr
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	4	NON PAYMENT	622	Pymt Adj Care Covrd Diff Payer
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.	4	NON PAYMENT	623	Pymt Adj Chrgs Pd by Diff Pyr
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	4	NON PAYMENT	624	Pymt Adj Chrgs Covrd Capit Agr
25	Payment denied. Your Stop loss deductible has not been met.	4	NON PAYMENT	625	Pymt Den StopLoss Ded Not Met
26	Expenses incurred prior to coverage.	4	NON PAYMENT	626	Expnse Incrrd Prior to Coverag
27	Expenses incurred after coverage terminated.	4	NON PAYMENT	627	Expnse Incrrd Aft Cov Termnatd
28	Coverage not in effect at the time the service was provided.	4	NON PAYMENT	628	Coverage Not in Effect on DOS
29	The time limit for filing has expired.	4	NON PAYMENT	134	Time Limit for Filing Expired

HIPAA Standard		RPMS			
Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	4	NON PAYMENT	630	Pymt Adj Pt Not Met Requiremts
31	Claim denied as patient cannot be identified as our insured.	4	NON PAYMENT	166	Clm Den Pt Not Identifd Isurd
32	Our records indicate that this dependent is not an eligible dependent as defined.	4	NON PAYMENT	632	Records Indicate Dep Not Elig
33	Claim denied. Insured has no dependent coverage.	4	NON PAYMENT	633	Clm DenInsured No Depend Cove
34	Claim denied. Insured has no coverage for newborns.	4	NON PAYMENT	17	Clm Den Insured no Cov for NB
35	Benefit maximum has been reached.	4	NON PAYMENT	167	Benefit Maximum Reached
36	Balance does not exceed co-payment amount.	4	NON PAYMENT	636	Bal does not Exceed CoPymt Amt
37	Balance does not exceed deductible.	4	NON PAYMENT	637	Bal Does not Exceed Deductible
38	Services not provided or authorized by designated (network) providers.	4	NON PAYMENT	638	Serv Not Auth by Designtd Prov
39	Services denied at the time authorization/pre-certification was requested.	4	NON PAYMENT	639	Srvcs Den At Time Auth Rqsted
40	Charges do not meet qualifications for emergent/urgent care.	4	NON PAYMENT	640	Chrgs DoNotMeet Criteria ER/UC
41	Discount agreed to in Preferred Provider contract.	4	NON PAYMENT	168	Disc Agrmt Pref Prov contract
42	Charges exceed our fee schedule or maximum allowable amount.	4	NON PAYMENT	21	Chrgs Excd Max Allowable Amt
43	Gramm-Rudman reduction.	4	NON PAYMENT	643	Gramm-Rudman Reduction
44	Prompt-pay discount.	4	NON PAYMENT	644	Prompt Pay Discount
45	Charges exceed your contracted/ legislated fee arrangement.	4	NON PAYMENT	645	Chrgs Excd Contrct Fee Arrngmt
46	This (these) service(s) is (are) not covered.	4	NON PAYMENT	122	Services Not Covered

HIPAA Standard		RPMS			
Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
47	This these) diagnosis(es) is (are) not covered, missing, or are invalid.	4	NON PAYMENT	647	Dx not Covered Missing Invald
48	This (these) procedure(s) is (are) not covered.	4	NON PAYMENT	648	Proc Not Covered
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	4	NON PAYMENT	20	Non Cov Srv Routine Exam
50	These are non-covered services because this is not deemed a `medical necessity' by the payer.	4	NON PAYMENT	169	Non Cov Srv Not Medically Nec
51	These are non-covered services because this is a pre-existing condition	4	NON PAYMENT	19	NonCov Srv Preexsting Cndition
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	4	NON PAYMENT	178	Prov Not Elig to Prov Serv Bil
53	Services by an immediate relative or a member of the same household are not covered.	4	NON PAYMENT	653	Serv by Mbr of Hshld Not Cover
54	Multiple physicians/assistants are not covered in this case .	4	NON PAYMENT	654	Mult Prov Not Cov in This Case
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.	4	NON PAYMENT	655	Clm Den Froc/Tx Experimental
56	Claim/service denied because procedure/treatment has not been deemed `proven to be effective' by the payer.	4	NON PAYMENT	656	Clm Den Proc not Effc by Payer
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	4	NON PAYMENT	657	Pymt Den Info submtd Not Suff
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	4	NON PAYMENT	658	Pymt Adj Tx Prov Invalid POS
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	4	NON PAYMENT	659	Chrgs Adj Mult Surg Anesth Rul

HIPAA Standard		RPMS			
Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
60	Charges for outpatient services with this proximity to inpatient services are not covered.	4	NON PAYMENT	660	Chrgs Outpt Serv Not Covered
61	Charges adjusted as penalty for failure to obtain second surgical opinion.	4	NON PAYMENT	661	Chrgs Adj Penlty No Secnd Opin
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	15	PENALTY	92	Pymt Den/Reducd No Precrt Auth
63	Correction to a prior claim.	4	NON PAYMENT	663	Correction to Prior Claim
64	Denial reversed per Medical Review.	22	GENERAL INFORMATION	664	Denial Reversed per Med Review
65	Procedure code was incorrect. This payment reflects the correct code.	4	NON PAYMENT	665	ProcCode Incorrect PymtRerCorr
66	Blood Deductible.	13	DEDUCTIBLE	666	Blood Deductible
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)	4	NON PAYMENT	667	Lifetime Reserve Days
68	DRG weight. (Handled in CLP12)	16	GROUPER ALLOWANCE	93	DRG Weight
69	Day outlier amount.	4	NON PAYMENT	669	Day Outlier Amount
70	Cost outlier - Adjustment to compensate for additonal costs.	4	NON PAYMENT	670	Cost Outlr Adj to CompAdd Cost
71	Primary Payer amount.	4	NON PAYMENT	165	Primary Payer Amount
72	Coinsurance day. (Handled in QTY, QTY01=CD)	14	CO-PAY	672	Coinsurance Day
73	Administrative days.	4	NON PAYMENT	673	Administrative Days
74	Indirect Medical Education Adjustment.	4	NON PAYMENT	674	Indirect Medical Educ Adj
75	Direct Medical Education Adjustment.	4	NON PAYMENT	675	Direct Medical Educ Adj
76	Disproportionate Share Adjustment.	4	NON PAYMENT	676	Disproportionate Share Adj
77	Covered days. (Handled in QTY, QTY01=CA)	4	NON PAYMENT	677	Covered Days
78	Non-Covered days/Room charge adjustment.	4	NON PAYMENT	678	Non Covered Days/Room Chrg Adj
79	Cost Report days. (Handled in MIA15)	4	NON PAYMENT	679	Cost Report Days
80	Outlier days. (Handled in QTY, QTY01=OU)	4	NON PAYMENT	680	Outlier Days

HIPAA Standard		RPMS			
Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
81	Discharges.	4	NON PAYMENT	681	Discharges
82	PIP days.	4	NON PAYMENT	682	PIP Days
83	Total visits.	4	NON PAYMENT	683	Total Visits
84	Capital Adjustment. (Handled in MIA)	4	NON PAYMENT	684	Capital Adjustment
85	Interest amount.	4	NON PAYMENT	685	Interest Amount
86	Statutory Adjustment.	4	NON PAYMENT	686	Statutory Adjustment
87	Transfer amount.	4	NON PAYMENT	687	Transfer Amount
88	Adjustment amount represents collection against receivable created in prior overpayment.	21	PENDING	688	Adj Amt Rep Rec Prior OvrPymt
89	Professional fees removed from charges.	4	NON PAYMENT	689	Pro Fees Removed From Charges
90	Ingredient cost adjustment.	4	NON PAYMENT	690	Ingredient Cost Adj
91	Dispensing fee adjustment.	3	WRITE OFF	691	Dispensing Fee Adj
92	Claim Paid in full.	22	GENERAL INFORMATION	692	Claim Paid in Full
93	No Claim level Adjustments.	22	GENERAL INFORMATION	693	No Claim Level Adjustments
94	Processed in Excess of charges.	16	GROUPER ALLOWANCE	694	Processed in Excess of Charges
95	Benefits adjusted. Plan procedures not followed.	4	NON PAYMENT	695	Ben Adj Plan Proc Not Followed
96	Non-covered charge(s).	4	NON PAYMENT	696	Non-covered Charge(s)
97	Payment is included in the allowance for another service/procedure.	4	NON PAYMENT	697	Pymt IncludeAllow for Diff Srv
98	The hospital must file the Medicare claim for this inpatient non-physician service.	21	PENDING	698	Hosp Must File Medicare Claim
99	Medicare Secondary Payer Adjustment Amount.	4	NON PAYMENT	699	MSP Adjustment Amount
100	Payment made to patient/insured/responsible party.	4	NON PAYMENT	23	Pymt Made to Pt/Insrd/Rsp Prty
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	21	PENDING	701	Predetermined Antcptd Pymt
102	Major Medical Adjustment.	4	NON PAYMENT	702	Major Medical Adjustment

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Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
103	Provider promotional discount (e.g., Senior citizen discount).	4	NON PAYMENT	703	Provider Promotional Discount
104	Managed care withholding.	4	NON PAYMENT	704	Managed Care Withholding
105	Tax withholding.	4	NON PAYMENT	705	Tax Withholding
106	Patient payment option/election not in effect.	4	NON PAYMENT	706	Pt Pymt Optn/Elect Not inEffct
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.	4	NON PAYMENT	707	Clm Den Reltd Srv Not Identifd
108	Payment reduced because rent/purchase guidelines were not met.	4	NON PAYMENT	708	Pymt Reduce-Guidelines Not Met
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	4	NON PAYMENT	709	Clm not Covered by Payer
110	Billing date predates service date.	4	NON PAYMENT	710	Billing Date Precedes DOS
111	Not covered unless the provider accepts assignment.	4	NON PAYMENT	711	Not Cov Unlss Prov Acpts Asnmt
112	Payment adjusted as not furnished directly to the patient and/or not documented.	4	NON PAYMENT	180	Pymt Adj Not Furn or Prov toPT
113	Payment denied because service/procedure was provided outside the United States or as a result of war.	4	NON PAYMENT	713	Pymt Den Srv Prov Outside US
114	Procedure/product not approved by the Food and Drug Administration.	4	NON PAYMENT	714	Proc/Src Not approved by FDA
115	Payment adjusted as procedure postponed or canceled.	4	NON PAYMENT	715	Pymt Adj Proc Postponed Cancel
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.	4	NON PAYMENT	716	Pyt Den Adv Indmn Ntc NotCmply
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.	4	NON PAYMENT	717	Pymt Adj Transp Covrd CloseFac
118	Charges reduced for ESRD network support.	4	NON PAYMENT	718	Charges Redcd for ESRD Support

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Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
119	Benefit maximum for this time period has been reached.	4	NON PAYMENT	719	Max Benefits for Time Period
120	Patient is covered by a managed care plan.	4	NON PAYMENT	720	Pt Cov'd by Managed Care Plan
121	Indemnification adjustment.	4	NON PAYMENT	721	Indemnification Adjustment
122	Psychiatric reduction.	4	NON PAYMENT	722	Psychiatric Reduction
123	Payer refund due to overpayment.	22	GENERAL INFORMATION	723	Payer Refund Due to Overpymt
124	Payer refund amount - not our patient.	22	GENERAL INFORMATION	724	Payer Refund Amt - Not Our Pt
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	4	NON PAYMENT	725	Pymt Adj Due to Billing Errors
126	Deductible -- Major Medical	13	DEDUCTIBLE	726	Deductible - Major Medical
127	Coinsurance -- Major Medical	14	CO-PAY	727	Coinsurance - Major Medical
128	Newborn's services are covered in the mother's Allowance.	4	NON PAYMENT	728	NB Srvc Cov'd in Mothers Allow
129	Payment denied - Prior processing information appears incorrect.	4	NON PAYMENT	164	Pymt Den Prior Info Incorrect
130	Claim submission fee.	4	NON PAYMENT	141	Pymt/Red for Req charges/taxes
131	Claim specific negotiated discount.	4	NON PAYMENT	731	Clm Specific Negotiated Disct
132	Prearranged demonstration project adjustment.	4	NON PAYMENT	732	Pre-Arranged Demo Proj Adj
133	The disposition of this claim/service is pending further review.	21	PENDING	733	Claim Pending Further Review
134	Technical fees removed from charges.	4	NON PAYMENT	734	Tech Fees Removed From Charges
135	Claim denied. Interim bills cannot be processed.	4	NON PAYMENT	735	Clm Den Intrm bill Cannot Proc
136	Claim Adjusted. Plan procedures of a prior payer were not followed.	4	NON PAYMENT	736	Clm Adj Plan Proc Prior Payer
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	4	NON PAYMENT	730	Claim Submission Fee

HIPAA Standard		RPMS			
Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
138	Claim/service denied. Appeal procedures not followed or time limits not met.	4	NON PAYMENT	738	Clm Den Appeal Proc Not Follow
139	Contracted funding agreement - Subscriber is employed by the provider of services.	4	NON PAYMENT	739	Contracted funding Agreement
140	Patient/Insured health identification number and name do not match.	4	NON PAYMENT	740	Pt ID# & Name do not match
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	4	NON PAYMENT	125	Clm Adj Spans Elig/Inelig Date
142	Claim adjusted by the monthly Medicaid patient liability amount.	4	NON PAYMENT	742	Clm Adj Mnth Medcd Pt Liab Amt
143	Portion of payment deferred.	21	PENDING	743	Portion of Payment Deferred
144	Incentive adjustment, e.g. preferred product/service.	4	NON PAYMENT	744	Incentive Adjustment
145	Premium payment withholding	21	PENDING	745	Premium Pmt Withholding
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	4	NON PAYMENT	746	Pmt Den DX Invalid for DOS
147	Provider contracted/negotiated rate expired or not on file.	4	NON PAYMENT	747	Prv Rate Expired/Not on file
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	4	NON PAYMENT	748	Clm/Srv Rej Info Incomplete
149	Lifetime benefit maximum has been reached for this service/benefit category.	4	NON PAYMENT	749	Lifetime Ben Max for Srv/Ben
150	Payment adjusted because the payer deems the information submitted does not support this level of service.	4	NON PAYMENT	750	PayAdj No Info for Lgthof Svc
151	Payment adjusted because the payer deems the information submitted does not support this many svcs.	4	NON PAYMENT	751	PayAdj No Info for Lgth of Svc

HIPAA Standard		RPMS			
Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
152	Payment adjusted because the payer deems the information submitted does not support this length of service.	4	NON PAYMENT	752	PayAdj No Info for Dosage
153	Payment adjusted because the payer deems the information submitted does not support this dosage.	4	NON PAYMENT	753	PayAdj No Info for Days Supply
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.	4	NON PAYMENT	754	PayAdj No Info for Lvl of Svc
155	This claim is denied because the patient refused the service/procedure	4	NON PAYMENT	755	Clm DEn Pt Refused Srv/Proc
156	Flexible spending account payments.	22	GENERAL INFORMATION	756	Flex Spending Accts Payable
157	Payment denied/reduced because service/procedure was provided as a result of an act of war.	4	NON PAYMENT	757	Pmt Den/Red Result Act of War
158	Payment denied/reduced because service/procedure was provided outside the United States.	4	NON PAYMENT	758	Pmt Den/Red Outside US
159	Payment denied/reduced because service/procedure was provided as a result of terrorism.	4	NON PAYMENT	759	Pmt Den/Red Result of Terrorsm
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.	4	NON PAYMENT	760	Pmt Den/Red Activity Ben Excl
163	Claim/Service adjusted because the attachment referenced on the claim was not received	4	NON PAYMENT	763	Clm/Svc Adj No Attachment Recvd
164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion	4	NON PAYMENT	764	ClmSvc Adj Attach not Recvd timely
165	Payment denied/reduced for absence of, or exceeded referral	4	NON PAYMENT	765	Pmt Den/Red no or exceed ref
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	4	NON PAYMENT	766	Svc sub after plan ended
167	This (these) diagnosis(es) is (are) not covered.	4	NON PAYMENT	767	This diagnosis is not covered.

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Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
168	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	4	NON PAYMENT	768	Benefits not avail under dental plan
169	Payment adjusted because an alternate has been provided.	4	NON PAYMENT	769	Pmt Adj alternate provided
170	Payment is denied when performed/billed by this type of provider.	4	NON PAYMENT	770	Pmt Den due to type of provider
171	Payment is denied when performed/billed by this type of provider in this type of facility.	4	NON PAYMENT	771	Pmt Den due to type of facility
172	Payment is adjusted when performed/billed by a provider of this specialty.	4	NON PAYMENT	772	Pmt Adj due to type of provider
173	Payment adjusted because this service was not prescribed by a physician.	4	NON PAYMENT	773	Pmt Adj not prescrib by physician
174	Payment denied because this service was not prescribed prior to delivery.	4	NON PAYMENT	774	Pmt Den Svc not presc prior del
175	Payment denied because the prescription is incomplete.	4	NON PAYMENT	775	Pmt Den prescrip incomplete
176	Payment denied because the prescription is not current.	4	NON PAYMENT	776	Pmt Den prescrip not current
177	Payment denied because the patient has not met the required eligibility requirements.	4	NON PAYMENT	777	Pmt Den elig req not met
178	Payment adjusted because the patient has not met the required spend down requirements.	4	NON PAYMENT	778	Pmt Adj spend down not met
179	Payment adjusted because the patient has not met the required waiting requirements.	4	NON PAYMENT	779	Pmt Adj waiting req not met
180	Payment adjusted because the patient has not met the required residency requirements.	4	NON PAYMENT	780	Pmt Adj residency req not met
181	Payment adjusted because this procedure code was invalid on the date of service.	4	NON PAYMENT	781	Pmt Adj proc code invalid for date
182	Payment adjusted because the procedure modifier was invalid on the date of service.	4	NON PAYMENT	782	Pmt Adj mod invalid for date

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Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
183	The referring provider is not eligible to refer the service billed.	4	NON PAYMENT	783	Ref Prov not elig to refer for svc
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	4	NON PAYMENT	784	Provider not elig to order svc
185	The rendering provider is not eligible to perform the service billed.	4	NON PAYMENT	785	Rend Prov not elig to perf svc
186	Payment adjusted since the level of care changed.	4	NON PAYMENT	786	Pmt Adj level of care chg
187	Health Savings account payments.	4	NON PAYMENT	787	Health Savings account payments
188	This product/procedure is only covered when used according to FDA recommendations.	4	NON PAYMENT	788	Prd/proc only cov for FDA rec
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	4	NON PAYMENT	789	Need specific proc code for proc/svc
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	4	NON PAYMENT	790	Pmt incl in SNF qual stay
191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier.	4	NON PAYMENT	791	Clm Den not work related
192	Non Standard adjustment code from paper remiitance advice.	4	NON PAYMENT	792	Non std adj code paper RA
193	Original payment decision is being maintained. This claim was processed properly the first time.	22	GENERAL INFORMATION	793	Clm proc properly first time
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician	22	GENERAL INFORMATION	794	Pay adj for anesthesia
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service	22	GENERAL INFORMATION	795	Refund to erroneous payer
A0	Patient refund amount.	19	REFUND	800	Patient Refund Amount
A1	Claim denied charges.	4	NON PAYMENT	801	Claim Denied Charges

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Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
A2	Contractual adjustment.	4	NON PAYMENT	802	Contractual Adjustment
A3	Medicare Secondary Payer liability met.	4	NON PAYMENT	803	MSP Liability Met
A4	Medicare Claim PPS Capital Day Outlier Amount.	4	NON PAYMENT	804	Medicare Claim PPS Day Outlier
A5	Medicare Claim PPS Capital Cost Outlier Amount.	4	NON PAYMENT	805	Medicare Claim PPS CostOutlier
A6	Prior hospitalization or 30 day transfer requirement not met.	4	NON PAYMENT	806	PriorHosp 30day transf not met
A7	Presumptive Payment Adjustment	4	NON PAYMENT	807	Presumptive pymt adjustment
A8	Claim denied; ungroupable DRG	4	NON PAYMENT	808	Clm Den Ungroupable DRG
B1	Non-covered visits.	4	NON PAYMENT	851	Non-Covered Visits
B2	Covered visits.	4	NON PAYMENT	852	Covered Visits
B3	Covered charges.	4	NON PAYMENT	853	Covered Charges
B4	Late filing penalty.	15	PENALTY	854	Late Filing Penalty
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4	NON PAYMENT	855	Pymt Adj Guidelines Not Met
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	4	NON PAYMENT	856	Pymt Adj Due to Type of Prvder
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	4	NON PAYMENT	857	Prov Not Certified for Proc
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	4	NON PAYMENT	858	Clm Not Covd Altrnt Serv Avail
B9	Services not covered because the patient is enrolled in a Hospice.	4	NON PAYMENT	859	Srvc Not Covd Pt Enrll Hospice
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	4	NON PAYMENT	860	Amt Reduced Portion of Proc pd

HIPAA Standard		RPMS			
Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	4	NON PAYMENT	861	Clm transfer to proper payer
B12	Services not documented in patients' medical records.	4	NON PAYMENT	862	Service not documented in MR
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	4	NON PAYMENT	863	Payment made in prev payment
B14	Payment denied because only one visit or consultation per physician per day is covered.	4	NON PAYMENT	864	Pymt Den 1 Vt Per Prov Per Day
B15	Payment adjusted because this procedure/service is not paid separately.	4	NON PAYMENT	865	Pymt Adj Proc Not Pd Separate
B16	Payment adjusted because `New Patient' qualifications were not met.	4	NON PAYMENT	866	PymtAdj New Pt Qualifn Not Met
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	4	NON PAYMENT	867	Adj Not Prescr by MD,RX Incmpl
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	4	NON PAYMENT	868	Pymt Den Proc Code/Mod Invalid
B19	Claim/service adjusted because of the finding of a Review Organization.	4	NON PAYMENT	869	Clm Adj Post Rev Org Finding
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	4	NON PAYMENT	870	PymtAdj Proc Prtly by DiffProv
B21	The charges were reduced because the service/care was partially furnished by another physician.	4	NON PAYMENT	871	ChrgRdc Proc Prtly by DiffProv
B22	This payment is adjused based on the diagnosis.	4	NON PAYMENT	872	Pymt Adj Based on Diagnosis
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.	4	NON PAYMENT	873	Pymt Den Prov Fail Profcy Test
D1	Claim/service denied. Level of subluxation is missing or inadequate.	4	NON PAYMENT	901	Clm Den Level of Sublxtn Inadq

HIPAA Standard		RPMS			
Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
D2	Claim lacks the name, strength, or dosage of the drug furnished.	4	NON PAYMENT	902	Claim lacks Drug Information
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.	4	NON PAYMENT	903	ClmDen Info on Pt Eqpmt Missng
D4	Claim/service does not indicate the period of time for which this will be needed.	4	NON PAYMENT	904	Clm Does Not Show Time Period
D5	Claim/service denied. Claim lacks individual lab codes included in the test.	4	NON PAYMENT	905	Clm Den Lacks Indvdl Lab Codes
D6	Claim/service denied. Claim did not include patient's medical record for the service.	4	NON PAYMENT	906	Clm Den Did Not Includ MR Copy
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.	4	NON PAYMENT	907	Clm Den Lacks Date of RecVisit
D8	Claim/service denied. Claim lacks indicator that `x-ray is available for review.'	4	NON PAYMENT	908	Clm Den Lacks Indctr Xray Avlbl
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.	4	NON PAYMENT	909	Clm Den Lacks Inv Crtfy LnsCost
D10	Claim/service denied. Completed physician financial relationship form not on file.	4	NON PAYMENT	910	Clm Den MD FinRel Form NotFile
D11	Claim lacks completed pacemaker registration form.	4	NON PAYMENT	911	Clm Lacks Compl Pcmkr Reg Form
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.	4	NON PAYMENT	912	Clm Den No Idtfr Who Did DxTst
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.	4	NON PAYMENT	913	Clm Den Ordr MD Has Fin Intrst
D14	Claim lacks indication that plan of treatment is on file.	4	NON PAYMENT	914	Clm Lacks Tx Plan on File
D15	Claim lacks indication that service was supervised or evaluated by a physician.	4	NON PAYMENT	915	Clm Lacks Indctn Srv Sprvs byMD

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Code	**Description**	**Code**	**Adjustment Category**	**Code**	**Adjustment Reason**
D16	Claim lacks prior payer payment information	4	NON PAYMENT	916	Clm Lacks prior payr pay info
D17	Claim/service has invalid non-covered days	4	NON PAYMENT	917	Clm/Svc invld non-covered days
D18	Claim/service has missing diagnosis information	4	NON PAYMENT	918	Clm/Svc miss diagnosis info
D19	Claim/service lacks Physician/Operative or other supporting documentation	4	NON PAYMENT	919	Clm lacks supporting doc
D20	Claim/service missing service/product information	4	NON PAYMENT	920	Clm/Svc miss svc/prod info
D21	This(these) diagnosis(es) is (are) missing or are invalid.	4	NON PAYMENT	921	Diag missing or invalid
W1	Workers Compensation State Fee Schedule Adjustment	3	WRITE OFF	15	Wrkrs comp State Fee Sched Adj