RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing
(ABM)

Addendum to User Manual

Version 2.5 Patch 15
September 2008

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

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1.0 Summary of Changes

1.1 Patch 15 Modifications

Patch 15 corrects several reported errors that were found with version 2.5 of Third Party Billing. This addendum includes an explanation of the new options released in this patch. Inpatient facilities that bill to Medicare will need to complete the Resubmission of Medicare Inpatient Surgery Claims as detailed in Section 2.1.1.

Additional information may be obtained by accessing the Patch 15 notes file.

Patch 15 contains the following modifications:

- A new option has been added (ABMD TSK POS SESSION CLOSER) that should be tasked after hours, to check for open POS Cashiering Sessions and close them on the same day of business as they were created. This is to assist with UFMS reconciliation.
- A new report has been added, called Grand Total All Files by Transmission Date, on the UFMS Reports and is used for reconciling with UFMS
- A new option has been added to the Add/Edit Claim menu, labeled Check Eligibility for a Visit, and is used by Billing staff to validate insurer entries on the claim or to see why a claim has not generated.

1.2 Resolutions to Service Center Calls

- IM28183-Do not write 2310B (rendering provider) segments if visit type is 831 and active insurer is Medicare (ASC billing).
- IM28233-Leave FL2 blank on UB04 for Medi-Cal.
- IM28651-Changed UFMS Export report so cashiering sessions print in same order as displayed at export time.
- IM28709-Removed automatic population of condition code if patient age is >100.
- IM28768-Resolution of <SUBSCR>ABMDEVAR+27^ABMDEVAR programming error.
- IM28796-Make admit/discharge hour 00 if visit time occurs at midnight System was not printing a time at all.
- IM29061-Fix ROI/AOB always being NO.

- IM29121-Added variable to track when in 2420A loop. This is used for local modifications at site.
- IM29177-Corrected total charges on ADA-2006. In some instances, the charge total was not calculating correctly.
- IM29217-Correction to message of User not signed in message when editing claims at satellite.
- IM29218-Modified FL1 of UB04 to strip out dashes/commas for Medi-Cal.
- IM29339-Added Grant Total to VEF View UFMS Export File option for reconciliation purposes.
- IM29362-Made change so NTE segment will not write unless there is something in remarks (and something more meaningful than a space).
- IM29406-Commas removed from coordinating DX field of 1500 (08/05).
- IM29455-Modified Radiology page of claim editor to accept revenue codes 61*.
- IM29516-Skip 2310B REF segment if payer is Oklahoma Medicaid.
- IM29562-Biller for cashiering session not displaying correctly (POS CLAIMS when it should be ADAM,ADAM).
- IM29684-Added option for user to check eligibility for a patient/Date of Service.
- IM29729-<UNDEF>42+30^ABMDF28Y programming error.
- IM29754-If NPI missing for provider it will check for a facility NPI and use that. Ultimate default is null.
- IM30188-Added change to prompt user if they want ICD Poxes on bill or not. If YES or BLANK it will print them on the 837I, UB-04, or UB-92.
- IM30216-Made change so manually created bills could be looked up using IQMG option.
- IM30256-Anesthesia coordinating DX were missing from claim.

2.0 ABM V2.5 Patch 15 Details

2.1 Setting up Insurers that do not Require ICD-9 Procedure Codes

Modifications have been made to the logic that adds the ICD-9 Procedure code to the 837 Institutional and the UB-04 formats when billing for surgical procedures during an inpatient stay.

Users must perform the following set-up tasks upon installation of Patch 15:

1. Identify payers that ***do not*** accept the ICD-9 Procedure Codes on the 837-I or the UB-04.

2. Edit the Insurers that ***do not*** accept the ICD-9 Procedure Codes.

   This is done in the Insurer File via Table Maintenance (TPB > TMTP > INTM > EDIN).

   Once the insurer has been selected, proceed to the Visit Type and select the visit types affected.

```
Select Insurer File Menu Option: EDIN  Add/Edit Insurer

           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
           +                    Add/Edit Insurer                     +
           |                 INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: LUJAN,ADRIAN M                    27-AUG-2008 11:56 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//   EDIT EXISTING INSURER

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

```
Select INSURER: MEDICARE

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

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

Phone Number.......: (888)763-9836//

Visit                       Mode of     Mult  Fee    ------- Flat Rate --------
Type - Description           Export     Form Sched   Start      Stop       Rate
================================================================================
111   INPATIENT          837 INST (UB) NO         01/01/2003 12/31/2003 1526.00
                                                  01/01/2004 12/31/2004 1512.00
                                                  01/01/2005 12/31/2005 1542.00
                                                  01/01/2006            1660.00
                                                  01/01/2007            1726.00

Select VISIT TYPE..: 111    INPATIENT
         ...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)..:
Procedure Coding....: ICD//
Multiple Forms?.....: NO//
Payer Assigned Provider Number.....: 320099//
EMC Submitter ID #..:
EMC Reference ID....:
Auto Approve?.......: NO//
Mode of Export......: 837 INST (UB)//
Relationship Code?:
Itemized UB?.....: NO//
ICD PX on Claim?: ??

     Choose from:
       Y        YES
       N        NO
ICD PX on Claim?: YES  YES
SUBPART NPI:
DME Contractor?.....:
Revenue Code........: 101//
Revenue Description.:
Bill Type...........: 111//
```

Figure 2-1: Example of Setting up Insurers that do not Require ICD-9 Procedure Codes

The “ICD PX on Claim?” prompt (field) that follows the list of fields used to set up the insurer is new, and it appears if the Export Mode is 837-I, UB-04 or UB-92.

To remove the ICD-9 Procedure codes from the claim, type NO. Typing YES or leaving the field blank allows the Procedure codes to display on the claim.

The recommendation is to set up all insurers and all visit types used to bill ICD-9 Procedures. Modifications made to this field will affect only the UB-92, UB-04 or the 837-I and have no affect on the claim editor.

2.1.1 Resubmission of Medicare Inpatient Surgery Claims

Prior to Version 2.5 Patch 15, the system would place the ICD-9 Procedure code on the claim form, if the

- All-Inclusive Mode was set for the insurer
- Bill Type of the claim was not "131"
- Name of the Active Insurer billed was "Medicaid Exempt"

Prior to Version 2.5 Patch 15, Patch 5 removed all ICD-9 Procedure codes from the UB-04 and the 837 Institutional formats. Trailblazer Health Enterprises published guidelines on correcting and resubmitting claims (See Appendix A).

This section describes the setup and resubmission of Inpatient bills to Medicare that contain ICD-9 procedure codes upon the installation of Patch 15.

> **Note**: If you ***have not*** resubmitted your Inpatient claims upon the installation of Version 2.5 Patch 12, continue with the following task.

1. Contact your RPMS Systems Administrator to request a patch list for the Third Party Billing (ABM) system. Write down the date Patch 5 was installed. You will need this date when creating the electronic batch file.

Your list may look similar to the following example.

```
PACKAGE: IHS 3P BILLING SYSTEM     Aug 28, 2008 8:55 am                PAGE 1
PATCH #              INSTALLED                      INSTALLED BY
-------------------------------------------------------------------------------
-
VERSION: 2.5         JUN 03, 2002                   LUJAN,ADRIAN M
   1                 DEC 16, 2002                   LUJAN,ADRIAN M
   2                 JAN 19, 2003                   LUJAN,ADRIAN M
   3                 MAY 19, 2003                   LUJAN,ADRIAN M
   837               OCT 08, 2003                   LUJAN,ADRIAN M
   4                 FEB 06, 2004                   LUJAN,ADRIAN M
   5                 JUN 24, 2004                   LUJAN,ADRIAN M
   6                 AUG 11, 2004                   LUJAN,ADRIAN M
   8                 FEB 15, 2006                   LUJAN,ADRIAN M
   9                 MAR 20, 2006                   LUJAN,ADRIAN M
   10                MAR 20, 2007                   LUJAN,ADRIAN M
   11                MAY 09, 2007                   LUJAN,ADRIAN M
   12                SEP 21, 2007                   RENDER,SHONDA
   13                JAN 29, 2008                   STARR,MARSHA
   14                APR 28, 2008                   RENDER,SHONDA
   15                AUG 26, 2008                   RENDER,SHONDA
```

Figure 2-2: Example of patch list for the Third Party Billing (ABM) system

2. Select the Recreate batch of ICD-9 bills option from the Print Bills Menu (TPB > PRTP > EMPR).

3. The system displays the criteria for creating an electronic file.

   The system creates a file if the following criteria are met:

   - first two numbers of the bill type equal “11” (inpatient bill)
   - Bill contains ICD-9 Procedure codes
   - Status of bill is active (Billed or Completed)
   - Approved on an 837 Institutional format

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +             Recreate batch of ICD-9 bills               +
          |                 INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    28-AUG-2008 8:48 AM

This option will create a batch of claims that meet the following criteria:
     * Bill type is 11* where * is any number
     * The bill contains ICD Procedure codes
     * Bill status is NOT cancelled
     * 837I export mode only
```

Figure 2-3: Criteria for re-creating a batch of claims

The system also displays what the user needs to enter; for example,

```
You will be asked the following to complete the selection criteria:
     * Insurer (multiple entries not allowed)
     * Date range (either by approval, batch, or visit date)
     * Resubmission note that will be put on ALL claims

Enter RETURN to Continue:
```

4. At the "Select Insurer Name" prompt, type the name of your Medicare insurer and press Enter. (Required); for example,

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

5. The system displays a list of dates to select from. Select **Approval Date**, and specify the From and To date range, as follows:

   a. For the From date, use the entry from the Patch History for when Patch 5 was installed.

      For example, if Patch 5 was installed on June 24, 2004, this is the date to use as the begin date.

   b. For the To date, use the most recent date up to when Patch 15 was installed as your end date.

      For example, if Patch 15 was installed on August 10, 2008, this is the date to use as the end date.

```
     Select one of the following:

          A         APPROVAL DATE
          B         BATCH DATE
          V         VISIT DATE

Apply range to: A <Enter>  APPROVAL DATE
Enter FROM date:  6/24/2004 <Enter>
Enter TO date:  8/10/2008 <Enter>
```

Figure 2-4: Entering From, To Approval Dates

6. The system prompts for a Resubmission Note. Type "Justify: Other Involvement - procedure codes omitted" and press Enter.

This is the note that will be submitted to Medicare that notifies them to reprocess these claims.

```
Resubmission note: Justify: Other Involvement - procedure codes
omitted <Enter>
```

The system re-displays the list of criteria and displays what was entered by the user.

7. If the information you entered is correct, type YES to continue.

```
Bills meeting the following criteria will be recreated in a new batch:
     * Bill type is 11* where * is any number
     * The bill contains ICD Procedure codes
     * Bill status is NOT cancelled
     * 837I export mode only

     * Active insurer is MEDICARE
     * Bills approved between 06/24/2004 and 08/10/2008
     * With the resubmission note: Justify: Other Involvement - procedure
codes omitted

Do you wish to continue? YES <Enter>
```

Figure 2-5: Example of reviewing specifications for Recreating a batch of ICD-9 bills

8. The system prompts for your EMC directory. Accept the default by pressing Enter or type the name of the directory.

9. Type the filename used to create your Medicare files. Follow your guidelines for naming claim files.

The system then does the following:

- Creates your EMC file, which you may use to submit to Medicare.

  Please follow the instructions provided by Trailblazer when submitting claim files, since Customer Service will need to be contacted prior to resubmission.

- Creates an entry in the 3P TX Status file.

  To obtain a list of bills included in the file, run the Batch Summary (TPB > EMTP > BSEM).The system will display all bills resubmitted within the time period selected.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5          |
           +                     Batch Summary                      +
           |                 INDIAN HEALTH HOSPITAL                 |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: LUJAN,ADRIAN M                     28-AUG-2008 9:17 AM

Select beginning export batch: T   AUG 28, 2008
  partial match to:  AUG 28, 2008@09:07:52     837 INST (UB)  MEDICARE  MEDICARE
                                                               LUJAN,ADRIAN M
         ...OK? Yes// YES  (Yes)

Select ending export batch: T   AUG 28, 2008
  partial match to:  AUG 28, 2008@09:07:52     837 INST (UB)  MEDICARE  MEDICARE
                                                               LUJAN,ADRIAN M
         ...OK? Yes// YES  (Yes)

Enter DEVICE: HOME//   Virtual

                              BATCH SUMMARY                          Page: 1
BATCH DATE: AUG 28, 2008@09:07:52
INSURER: MEDICARE
FORMAT: 837 4010 INSTITUTIONAL
EMC FILE NAME: E0400101.241                   GROUP CONTROL #: 100513
================================================================================
BILL #       HRN     PATIENT                    SERVICE DATE FROM       AMOUNT
--------------------------------------------------------------------------------

SITE: INDIAN HOSP                        BILL TYPE: 111

   27381A    1522    DEMO,RICH                     AUG 15, 2004       4,536.00
   27382A    1522    DEMO,RICH                     SEP 03, 2004       9,072.00
   27383A    88199   DEMO,JIM                      JUN 09, 2004      46,872.00
   29815A    17081   DEMO,HELEN                    JAN 07, 2007       3,320.00
   30842A    99685   DEMO,DENISE                   NOV 29, 2007       1,726.00
   30847A    12854   DEMO,JOHN                     NOV 29, 2007       1,726.00
   30848A    996523  DEMO,GEORGIA                  NOV 29, 2007       1,726.00

BATCH TOTAL:                            7 bills                      68,978.00

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

Figure 2-6: Example of running a Batch Summary

2.2 Grand Total Report for UFMS Reconciliation

The Grand Total All Files by Transmission Date Report has been added to assist the user in file reconciliation when submitting files to the Unified Financial Management System.

The report is located in the UFMS Reports menu. (TPB > UCSH > RPTS > GTOT). On entry to the Grand Total report, the system requires the entry of the export dates. The export date refers to the date that the user transmitted files to the financial system. A beginning export date and an ending export date must be entered.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |          THIRD PARTY BILLING SYSTEM - VER 2.5          |
           +       Grand Total All Files by Transmission Date       +
           |                 INDIAN HEALTH HOSPITAL                 |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: LUJAN,ADRIAN M                     28-AUG-2008 11:15 AM

Select beginning export: AUG 27, 2008
  partial match to:  AUG 27, 2008@11:06:13       LUJAN,ADRIAN M
         ...OK? Yes//   (Yes)

Select ending export: AUG 27, 2008
  partial match to:  AUG 27, 2008@11:06:13       LUJAN,ADRIAN M
         ...OK? Yes//   (Yes)

Enter DEVICE: HOME// PRINTER
```

Figure 2-7: Example of setting report parameters for the UFMS Grand Total All Files by Transmission Date report

After sending the report to the printer, the system displays the Export Reconciliation Page. This is the page the user sees when transmitting the files.

```
                    ***** UFMS EXPORT RECONCILIATION PAGE *****       Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: AUG 27, 2008@11:06:13
FILE NAME: IHS_TPB_RPMS_INV_202401_20080827_110613_2.05.15k.DAT
================================================================================
                          Approved    | Excluded      Cancelled   Cxl'd    Ben
 Session/User              Bills      |  Bills          Bills     Claims  Bills
                                      |
3080522.132033/LUJAN,A   10  2,127.00 | 0      0.00  3    728.50    0       1
                                      |
3080522.154921/VIGIL-GO  16 96,256.63 | 0      0.00  0      0.00    1       0
                                      |
3080523.102128/POS CLAIMS1      63.98
                                      |
3080523.144837/SISNEROS  3     702.00 | 0      0.00  0      0.00    0       0
                                      |
3080603.125919/SISNEROS  12  2,412.00 | 0      0.00  1    200.00    0       0
                                      |
3080610.102932/VIGIL-GO  15 92,425.04 | 0      0.00  0      0.00    0       2
                                      |
3080717.141445/SISNEROS  6   1,221.00 | 0      0.00  0      0.00    0       0
                                      |
3080811.111941/LUJAN,A   5     712.00 | 0      0.00  0      0.00    0       0
                                      |
3080826.115433/POS CLAIMS1      63.98
--------------------------------------------------------------------------------
TOTALS:                  69195,983.63 | 0      0.00  4    928.50    1       3
```

Figure 2-8: Example of the Export Reconciliation Page of the UFMS Grand Total All Files by Transmission Date report

The Grand Total page of the report displays all sessions used within the transmitted session. The report also displays a breakdown of bills total and bill amounts by location and by Allowance Category.

```
                              UFMS EXPORT SUMMARY                      Page: 1
LOCATION: INDIAN HOSP
EXPORT DATE: AUG 27, 2008@11:06:13
FILE NAME: IHS_TPB_RPMS_INV_202401_20080827_110613_2.05.15k.DAT
EXPORT(S) RESENT:  <<NONE>>
================================================================================
    BUDGET ACTIVITY           BILL CNT     AMOUNT     EXCL.CNT     EXCL.AMT
--------------------------------------------------------------------------------
SESSION ID: 3080522.132033      BILLER: LUJAN,ADRIAN M
SESSION ID: 3080522.154921      BILLER: VIGIL-GOMEZ,THELMA
SESSION ID: 3080523.102128      BILLER: POS CLAIMS
SESSION ID: 3080523.144837      BILLER: SISNEROS,GINA
SESSION ID: 3080603.125919      BILLER: SISNEROS,GINA
SESSION ID: 3080610.102932      BILLER: VIGIL-GOMEZ,THELMA
SESSION ID: 3080717.141445      BILLER: SISNEROS,GINA
SESSION ID: 3080811.111941      BILLER: LUJAN,ADRIAN M
SESSION ID: 3080826.115433      BILLER: POS CLAIMS
--------------------------------------------------------------------------------
INDIAN HEALTH CENTER
   MEDICARE                    1 bill        63.98          0 bills      0.00
     Total for facility        1 bill        63.98

INDIAN HEALTH HOSPITAL
   MEDICAID                   12 bills   72,146.26          0 bills      0.00
   MEDICARE                   29 bills   38,759.33          0 bills      0.00
   OTHER                       9 bills   48,745.03          0 bills      0.00
   PRIVATE INSURANCE          14 bills   27,452.02          0 bills      0.00
     Total for facility       64 bills  187,102.64

     TOTAL BILLS:             65 bills  187,166.62          0 bills      0.00

     TOTAL EXPORTED:          65 bills  187,166.62

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

Figure 2-9: Example of the Grand Total page of the UFMS Grand Total All Files by Transmission Date report

This report may be used during reconciliation, when comparing the number of files or bills transmitted to the finance system against the notification of receipt of files from the Integration Engine.

2.3 Auto-Close of POS USER Session

A new function has been added to provide the Business Office with a Point-of-Sale (POS) session close at a user-specified time. Sites that have the option to capture session data have the choice of closing the POS USER session that is created by the Pharmacy Point-of-Sale system.

To have the POS USER session tasked, you must notify your Systems Administrator to have the option labeled, **ABMD TSK POS SESSION CLOSER**, tasked to run daily. The recommended time to run this is daily at 11:59 p.m. Once tasked, the option looks similar to the following example:

```
Task list  Aug 26, 2008 11:56 am                                    Page 1
------------------------------------------------------------------------------
17231: ABMD TSK POS SESSION CLOSER - Close POS Cashiering Sessions.  No device.
       XXX,XXX.  From Today at 11:55,  By SITEMANGER,BOB.  Scheduled for Today
       at 23:59
------------------------------------------------------------------------------
```

Figure 2-10: Example of ABMD TSD POS SESSION CLOSER task, which closes a Point-of-Sale session at a specified time

Always check to ensure your POS session closed. Keep in mind that a new session will open as soon as a prescription has been filled and processed for payment via the Pharmacy Point-of-Sale application.

2.4 Check Patient Eligibility Option

A new option has been added that enables the user to view the logic used by the claim generator when displaying billable insurance entries on the claim. This option is useful when troubleshooting to see why an insurer did not appear on the claim. Typing the name and visit date displays the criteria the claim generator used to generate eligible entries on the claim.

The new option, **CKCL - Check Eligibility for a Visit**, is located under the Add/Edit Claim Option. (TPB > EDTP > CLCL)

The user must have the name of the patient and the visit date and time. Upon entry to the option, the user types the name of the patient. The Visit Date must be entered on confirmation of the patient entry.

Once the visit has been selected, the system displays a list of Insurers, the priority set for each insurer, and the billable status for each entry.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |          THIRD PARTY BILLING SYSTEM - VER 2.5           |
          +             Check Eligibility for a Visit               +
          |                 INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    26-AUG-2008 3:14 PM
Select PATIENT NAME: DEMO,JANE             F                         IHH 1072

Select VISIT:    7-12-2008@14:00:00     DEMO,JANE     INDIAN HEALTH HOSPI
TAL     AMBULATORY     GENERAL

For patient DEMO,JANE, for visit 07/12/2008@14:00
PRIORITY INSURER                      STATUS       REASON UNBILLABLE
--------------------------------------------------------------------------------
  1      MEDICARE(2)                  BILLABLE
  3      BC/BS OF OKLAHOMA(866)       BILLABLE
  4      BC/BS OF ARIZONA INC(123)    BILLABLE
  5      NEW MEXICO MEDICAID(409)     BILLABLE
  6      BENEFICIARY PATIENT (825)    BILLABLE
  99     GOVERNMENT EMPLOYEES(802)    UNBILLABLE   (37)PRIVATE INSURANCE; VISIT O
  99     NM BC/BS DENTAL CLAS(864)    UNBILLABLE   (43)INSURER DESIGNATED AS UNBI
  99     PRESBYTERIAN SALUD(869)      UNBILLABLE   (36)MEDICAID COVERAGE; VISIT O
  99     CIMARRON SALUD(876)          UNBILLABLE   (36)MEDICAID COVERAGE; VISIT O
  99     BCBS OF NEW MEXICO(903)      UNBILLABLE   (37)PRIVATE INSURANCE; VISIT O
  99     D-AARP(1001)                 UNBILLABLE   (44)VISIT TYPE SPECIFIED AS UN

 REASON UNBILLABLE KEY:
   36 - MEDICAID COVERAGE; VISIT OUTSIDE ELIGIBILITY DATES (NE)
   37 - PRIVATE INSURANCE; VISIT OUTSIDE ELIGIBILITY DATES (NE)
   43 - INSURER DESIGNATED AS UNBILLABLE (NE)
   44 - VISIT TYPE SPECIFIED AS UNBILLABLE FOR INSURER (NE)

Select PATIENT NAME:
```

Figure 2-11: Example of checking patient eligibility for a visit

The user can then record the entries that need to be researched. Another patient and visit date may also be entered and checked on.

2.5 Service Center Calls

2.5.1 HIPAA 837 Export Mode Modifications

- IM28183 - Removal of Rendering Provider from the 837I for Day Surgery Claims

  The system has been modified to remove the Rendering Provider from the 837 Professional export mode when billing for Outpatient Surgical visits. This will only affect those claims that have been billed using the 831 – Ambulatory Surgery Visit Type.

- IM29362 - Removal of Notes segment from the 837 if there is no data to print

  The system has been modified to remove the NTE (billing notes) segment if the segment contains no data or if the user accidently types spaces into the notes field of the Claim Editor (Page 9).

- IM29516 - Removal of 2310B REF segment for Oklahoma Medicaid

  At the request of the Oklahoma Area, the 2310B REF segment will not transmit on the 837 Professional export mode. The REF segment usually contains the Rendering or Attending provider's legacy number.

2.5.2 Paper Claim Form Modifications

- IM28233 - Removal of Data from Form Locator 2 on the UB-04 for Medi-Cal claims

  At the request of the California Area, the information that prints in Form Locator 2 of the UB-04 paper export mode has been removed. No location data will print if using the Medi-Cal insurer name.

- IM29177 - Correction to ADA-2006 to correct calculation of total charges
- IM29218 - Modification to the UB-04 to remove Dashes or Commas from Form Locator 1 for Medi-Cal

  At the request of the California Area, the information that prints in Form Locator 1 of the UB-04 paper export mode has been modified to not print the dash in the facility ZIP Code. The system will also remove the comma that separates the City from the State code.

- IM29406 - Removed commas from Block 24E of the CMS-1500 (08/05) for all payers.

  In order to correctly print the CMS-1500 paper export mode correctly, the comma has been removed in Form Locator 24E (Diagnosis Pointer) for all payers. The system will now print the Diagnosis Code Pointer in the following format:

  For example, “123” will print instead of “1,2,3”

2.5.3 Claim Editor Modifications

- IM30256 - Anesthesia coordinating DX were Missing from Claim

  Locations that bill for Anesthesia services on the CMS-1500 format reported rejected claims for CPT codes missing a diagnosis pointer of the claim contained more than one diagnosis code. The Claim Editor, Page 8G - Anesthesia was modified to prompt the user for the diagnosis code pointer which will print on the claim form.

- IM29754 - If Provider NPI is missing, check for a Facility NPI and use that.

  The Claim Editor and Export Modes have been modified to display and use the NPI of the Visit Location used when approving a claim. This was in response to locations that bill for services where the Attending Provider was not needed and a generic provider is used instead (for example, when the EMT is the provider for ambulance visits).

  The Claim Editor will display an error on Page 4 (Provider Page) if the location NPI is being used. The NPI will also have an asterisk following the NPI.

  Billing staff will need to exercise caution when using the location NPI in place of the provider NPI. Please follow the payers NPI guidelines.

- IM29061 – Fix ROI/AOB always being NO

  The Release of Information and Assignment of Benefits questions on Page 3 of the Claim Editor have been smartened up to find the most recent ROI/AOB in the Patient Registration application. If the questions have been answered, the system will default the questions to Yes to indicate they ROI/AOB have been received. If the ROI/AOB questions have not been populated in Registration, the system will default to No.

3.0 Appendix A: TrailBlazer

Trailblazer Health Enterprises has published guidelines on correcting and resubmitting claims. In an IHS listserv email, dated April 5, 2007, TrailBlazer sent the following notification:

"TrailBlazer is issuing this listserv to notify the Part A community of important updates concerning Indian Health Services (IHS). Please share this information with other members of your staff.

TrailBlazer News to Use

Alert - Indian Health Service Inpatient Claims Issue - IHS providers have alerted TrailBlazer to a system issue affecting the payment of inpatient claims. Due to a RPMS software problem, the system inadvertently eliminated all inpatient procedure codes from inpatient claims resulting in a lower weighted DRG reimbursement.

Affected providers may submit an adjustment for claims that paid incorrectly from October 1, 2002, to current including the following information:

- The adjustments should include remarks to indicate the reason for the adjustment. This will ensure timeliness edits are bypassed.
- Providers should document "Justify: Other Involvement - procedure codes omitted" in the "Remarks" section.

As providers identify older claims to be adjusted that are off-line, please contact the Part A Customer Service Provider Contact Center at **(888) 763-9836**. Claims are retrieved over the weekend and will be available for access the following Tuesday.

Please share this listserv with others in your organization who would benefit from receiving timely and accurate Medicare information pertaining to this specialty. Instructions to join the TrailBlazer general and specialty listservs are linked for their reference.

We welcome feedback on this and other provider notifications to help improve our communication processes. The toll-free Provider Feedback Line is (866) 237-4483, Option 3.

4.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4297

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov