RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing
(ABM)

Addendum to User Manual

Version 2.6 Patch 6
May 2011

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Division of Information Resource Management
Albuquerque, New Mexico

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1.0 Introduction

1.1 Summary of Changes

Patch 6 provides two enhancements to Third Party Billing system version 2.6. The first allows the user to use and bill with the ASC X12 837 Professional Version 5010. The changes made to the system are mainly in the Claim Editor and the EMC File creation process. In addition to adding the 837P 5010, the system has been modified to allow for a "clearinghouse" process. This process allows the user to submit electronic bills for one or multiple payers within a single export file. The necessary setup is outlined below.

The second major enhancement is a new report that allows sites to view their Inpatient Covered Days for Medicare, Medicaid, Private Insurance, State Children's Health Insurance Program (SCHIP) and Other. This data provides the user with the covered days for paid inpatient services.

1.1.1 Patch 6

Modifications:

- 5010 Modifications that include:
  - New SGTM 837 Segment Override menu option for 837 segment override. Located on the TMTP Table Maintenance Menu.
  - Added help text to both EMC SUBMITTER ID fields in the Add/Edit Insurer option. These fields populated ISA06 element.
  - Added help text to 3P Parameter field ISA08 VALUE. This field will populate ISA08. If blank, it will then check Insurer fields X12 TRADING PARTNER ID and AO CONTROL NUMBER.
  - Added new field REPORTING PURPOSES ONLY to the Add/Edit Insurer option under the Visit Type section. If **YES** is entered, will populate 837 element BHT06 with RP. Otherwise, BHT06 will contain CH.
  - Added Page 3B to the claim editor for Third Party Liability and Worker's Comp questions. Added Property and Casualty Claim Number fields as well as the Patient Identifier and Patient Number field.
  - Added Error 235 to Page 1 of Claim Editor if facility National Provider Identifier (NPI) is missing.
  - Changed SBR01 so it will do more than (P)rimary, (S)econdary, and (T)ertiary. Refer to Page 116 of 837P Implementation Guide for a complete list.

- Added Error Code 236 to Page 2 of the Claim Editor if the Policy Holder Identifier is missing. This populates NM109 when the qualifier is IL (loop 2010BA).
- Added Error Code 237 on Page 9E of the Claim Editor if billing on the 837P v5010 and special program code is *not* 02, 03, 05, or 09.
- Added Delayed Reason Code called 15 NATURAL DISASTER.
- Modification to put Last Menstrual Period from Page 9A in segment DTP*484 if populated on claim.
- Added Hearing and Vision Prescription Date to Page 3 of the Claim Editor. This will populate DTP*471 if populated on claim.
- Added Start/End Disability dates to Page 3 of the Claim Editor. This will populate the DTP segment with either 360(start only), 361(end only), or 314 (both). Added a Warning 238 on Page 3 if both dates aren't populated.
- Added the DATE LAST WORKED question to new Page 3B of claim editor.
- Added Date Authorized to Return to work on new Page 3B of claim editor.
- Added Assumed/Relinquished Care Dates to Page 3 of claim editor.
- Added Property/Casualty Date of 1st Contact to Page 3 of claim editor.
- Added the additional choices for claim attachments to Page 9G of the claim editor. Also added FT File Transfer for a report transmission code.
- Added Patient Paid Amount to Page 3 in claim editor.
- Added Spinal Manipulation Cond Code to Page 3 of claim editor. Will only display this question if clinic is CHIROPRACTIC.
- Added code to report Condition codes in HI segment with BG qualifier.
- Added fields to Page 8H if insurer is DME CONTRACTOR. Fields are: QTY/LENGTH MEDICAL NECESSITY, MONETARY AMT/DME RENTAL PRICE, MONETARY AMT/DME PURCHASE PRICE, FREQUENCY CODE/RENTAL UNIT PRICE INDICATOR. If populated, they will populate the SV5 segment.
- DATE WRITTEN from Page 8D of the claim editor will now create a DTP segment (471) in the 837P file if populated.
- Added PATIENT COUNT to Page 3A for ambulance. Will create a QTY segment (PT) for each line item when this field is populated and the patient count is greater than 1.
- Added W to ASSIGNMENT OF BENEFITS; use when patient refuses to assign benefits.
- Added help text to RELEASE OF INFORMATION letting user know YES will be Y, but everything else will be I on the 837P.
- Added LIN segment in Loop 2410 to report Drug NDC if service line is Pharmacy.

- Added CTP segment in Loop 2410 to report Drug Quantity (units) if service line is Pharmacy.
- Added REF segment in Loop 2410 to report Prescription Number if service line is Pharmacy. Also added Error 239 to page 8D if neither Rx number is populated.
- Added question VISION CONDITION INFO to Page 3 if clinic is Optometry. Question will ask Vision Condition Info, Vision Certification Condition Indicator, and VISION CONDITION INDICATORS. These fields will create Loop 2300 CRC segment for Patient Condition Information: Vision.
- Clearinghouse changes. Added new menu on the Table Maintenance menu, ECTM Electronic Claims Setup. This menu contains three new options.
  - SGTM 837 Segment Override. This option will allow the user to override select loops/segments/elements of the 837, or not send a whole segment.
  - CHEC Clearinghouse Setup. This option will allow the setup of a clearinghouse, so claims for multiple insurers can go into one electronic claim file and be submitted to one place.
  - CHRP Clearinghouse Report. This option reports all entries in the 3P Receiver file and their associated data.

- New report to calculate facility criteria

  Report is located at RPTP->MURP->FCMU. The user will be prompted for which fiscal year they want to run the report, and if they want detail, summary, or both. The summary page will print first, listing the number of discharges for Medicare, Medicaid, Private, and Other. Insurer types are divided into these categories the same as Unified Financial Management System (UFMS) uses. The detail portion could be large based on the facility size. It will print a line for each bill, divided by Medicare, Medicaid, Private, and Other, but also subdivided by the same subcategories as the number of discharges reports (Inpatient [IP] Discharges, Outpatient [OP] All-Inclusive, and OP Itemized.

- HEAT tickets included:
  - Correction to Page 2 of the Claim Editor to allow a tenth or greater insurer to be selected. Prior to the fix, the Claim Editor wouldn't allow anything greater than the ninth insurer to be selected.
  - Correction to the Jumping Function in the Claim Editor to allow the user to jump from Page 9 to Page 5.
  - Correction to the Claim Editor to fix the error, <NOLINE>SCRN+2^ABMDE.
  - Addition of a new reason code to the 3P Cancel Claim Reason codes. The new reason code will read as *PHARMACY BILLED VIA POS*.

- NOHEAT–Expanded Supervising Prov(FL19) field to accommodate 25 characters.
- Added local modifications for Albuquerque Indian Dental Center that makes changes to the ADA-2006.
- NOHEAT–Added field to 3P Bill file to store OTHER BILL IDENTIFIER.
  - For TPB it can be either the RX number (for Pharmacy POS bills), or a partial bill number if the bill number is longer than 14 characters. This information is also passed to the A/R Bill OTHER BILL IDENTIFIER field.
- Modification to the Claim Editor, Page 7–Inpatient Data to prevent an error resulting from an invalid date being entered as an Admission, Discharge, Service From, or Service To date. An error occurred when the user entered a three-digit year.
- Addition of Place of Service Code 05 and 06 to indicate *Indian Health Service Free-Standing Facility* and *Indian Health Service Provider-Based Facility*, respectively.
- 7254–Added PRV segment to 837D format.
- 11745–Made FL27 of ADA-2006 print tooth mnemonic, not tooth synonym. Reporting site was having 7D print instead of D.
- 18507–Added insurer parameter to allow medications to be split into 2 lines on UB-04.
- 26023–Made local modifications for San Felipe Pueblo.
- 27136–Fixed issue with cashiering sessions when there are two parent locations on the same database.
- 27940–Modified ADA-94 format to print originate print date or today's date.
- 28427–Made change for Point of Sale (POS) claims when filing them into cashiering session for UFMS. The claims were getting stored under the wrong budget category if a similar budget category had already been used (For example, it was filing an M insurer type and there was already an MD entry).
- 28632–Made change to REEX option to stop error <SUBSCR>CHECKBAL+17^ABMDREEX from occurring. Happens when a satellite location is present.
- 28973–If modifier 55 is present on Page 8B of the claim editor, the units will print but 1 will be used for the line item charge when calculating the amount.
- 29380–Made any G-code on the laboratory page cause a Clinical Laboratory Improvement Amendments (CLIA) number segment to print in the 837P file.
- 29426–Made change to correct <UNDEF>PRTTXT+3^ABMDWRAP error. Occurs when site chooses to display long description on Page 5 of claim editor and the ICD on Page 5 doesn't have a long description. It will now default to the short description if there isn't a long one.

- 29755–For locations like Ambulance, look to see if they have an NPI assigned. If they do, use it.

2.0 Patch 6 Details

2.1 Claim Editor Modifications

2.1.1 Claim Editor, Page 1–Claim Identifiers

Error 235–Facility NPI Missing has been added to Page 1 of the Claim Editor if the Facility NPI is missing. The NPI must be added to the Institution File *or* the USE NPI OF must be populated in 3P's Site Parameters for outside locations.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,VINCENT  [HRN:4466]                      Claim Number: 32379
..................... (CLAIM IDENTIFIERS) ............................

                [1] Clinic.............: GENERAL
                [2] Visit Type.........: OUTPATIENT
                [3] Bill Type..........: 131
                [4] Billing From Date..: 02/26/2011
                [5] Billing Thru Date..: 02/26/2011
                [6] Super Bill #.......:
                [7] Mode of Export.....: 837P (HCFA) 5010
                [8] Visit Location.....: MERCY MEDICAL CENTER HOSPITAL
------------------------------------------------------------------------
ERROR:235 - Facility NPI missing
------------------------------------------------------------------------
Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//
```

Figure 2-1: Error 235 is displayed

2.1.2 Claim Editor, Page 2–Insurers

A new Error Code has been added to Page 2 of the Claim Editor. Error 236–Subscriber Primary Identifier missing will display if the Policy Holder ID is missing on the active insurer. If this error is displayed, the user may need to cancel and recreate the claim to capture eligibility.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: GREEN,APPLE  [HRN:6670]                        Claim Number:
32406
............................ (INSURERS) ..............................

                          PAGE 2 - INSURER INFORMATION

To: BC/BS OF ARIZONA INC                Bill Type...: 131
    PO BOX 13466                        Proc. Code..: CPT4
    PHOENIX, AZ  85002-3466             Export Mode.: 837P (HCFA) 5010
    (800)232-2345                       Flat Rate...: N/A


      BILLING ENTITY            STATUS       POLICY HOLDER
==============================  ==========  ==============================
```

```
[1]  BC/BS OF ARIZONA INC            ACTIVE      GREEN,APPLE
------------------------------------------------------------------------------
ERROR:236 - Subscriber Primary Identifier missing
------------------------------------------------------------------------------
Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//
```

Figure 2-2: Error 236 is displayed

2.1.3 Claim Editor, Page 8D–Medications

Error 239–Prescription Number Missing (##) has been added to Page 8D of the Claim Editor if the RX or Prescription number is *not* populated.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8D  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: GREEN,FLOWER  [HRN:3369]                     Claim Number: 32381
Mode of Export: 837P (HCFA) 5010
........................... (MEDICATIONS) ..............................
REVN  CHARGE                                          DAYS          TOTAL
CODE  DATE               MEDICATION                   SUPPLY  QTY   CHARGE
==============================================================================
[1]  0250  12/24/2010-12/21/2010<No Rx>
    <NO NDC>          AUGMENTIN 200/5 50ML             30      30     5.00

     TOTAL                                                             $5.00
------------------------------------------------------------------------------
ERROR:239 - Prescription Number missing (2)
------------------------------------------------------------------------------
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

Figure 2-3: Error 239 is displayed

2.2 Table Maintenance Modifications

Changes have been made to some Table Maintenance options to allow prompts to be better understood.

2.2.1 Site Parameters Option Modification

Added help text to 3P Site Parameters field ISA08 VALUE. This field will populate ISA08. If blank, it will check Insurer fields X12 TRADING PARTNER ID and AO CONTROL NUMBER.

```
ISA08 VALUE: ?
     Choose from:
       C00400   C00400
       C00900   C00900
       04401    04401
       04402    04402
```

Figure 2-4: System provides information from the X12 TRADING PARTNER ID and AO CONTROL NUMBER fields

> **Note**: User manual v2.6 has Description/Action set to ISA08 VALUE.

2.2.2 Insurer File Modification

Added help text to both EMC SUBMITTER ID fields in the Add/Edit Insurer option. This field will populate the ISA06 element.

```
EMC SUBMITTER ID: ??

1-15 characters.  Will populate ISA06 of 837.  This is used if the EMC
SUBMITTER ID for the Visit Type isn't populated.  If both EMC SUBMITTER IDs
are blank, the Location Federal Tax No. will be used.
```

Figure 2-5: Help text

2.3 Modifications to the Electronic Media Claims (EMC)

The following section will explain the changes made to electronic billing and will guide the user in setting up the Clearinghouse functionality.

2.3.1 ASC X12 837 Professional Export Mode

A new export mode has been added to Third Party Billing to allow sites to submit electronic claims to payers that accept the 837 Professional version 5010 (#32) export mode. The user should see the export mode in the Claim Editor as well as other options that utilize the export mode.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,PAUL  [HRN:3948]                      Claim Number: 30932
......................... (CLAIM IDENTIFIERS) ............................

                [1] Clinic.............: URGENT CARE
                 [2] Visit Type.........: OUTPATIENT
                 [3] Bill Type..........: 131
                 [4] Billing From Date..: 04/11/2011
                 [5] Billing Thru Date..: 04/11/2011
                 [6] Super Bill #.......:
                 [7] Mode of Export.....: 837P (HCFA) 5010
                 [8] Visit Location.....: INDIAN HEALTH HOSPITAL

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

Figure 2-6: Claim Editor Page 1 screen showing 837P Version 5010 export mode

The following will detail the changes made as a result of adding the 837 Professional, version 5010 to Third Party Billing. Many of the options shows appear when the export mode is 837P (HCFA) 5010. Billing staff must be aware of the payer requirements as populating a new field will send the data to the payer.

2.3.1.1 Claim Editor, Page 3 Questions Changes

New questions have been added to Page 3 of the Claim Editor. This allows the user to define and update criteria for each claim that is created.

Many of the new questions added may not print on the paper CMS-1500 unless indicated below.

To Add/Edit Page 3, follow these steps:

1. At the Third Party Billing System "Select menu option" prompt, type **EDTP** and press the Enter key.
2. At the "Add/Edit Claim Menu option" prompt, type **EDCL** and press the Enter key. (User will need to key in a billable visit via a generated claim)
3. Jump to Page 3 by typing **J3**. Use the following table for Page 3 as a guide to Add/or Edit.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT  [HRN:1456]                    Claim Number: 32397
............................ (QUESTIONS) ..............................

[1] Release of Information..: NO
[2] Assignment of Benefits..: YES   From: 02/24/2011
[3] Accident Related........: NO
[4] Employment Related......: NO
[5] Emergency Room Required.:
[6] Special Program.........: NO
[7] Outside Lab Charges.....:
[8] Date of First Symptom...:
[9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17)  :
[12] Case No. (External ID)..:
[13] Resubmission(Control) No:
[14] PRO Approval Number.....:
[15] HCFA-1500B Block 19.....:
[16] Supervising Prov.(FL19).:     I.D. Number:       Date Last Seen:
[17] Date of Last X-Ray......:
[18] Prior Authorization #...:
[19] Homebound Indicator.....:
[20] Hospice Employed Prov...:
[21] Delayed Reason Code.....:
[22] Reference Lab CLIA#.....: 12T1234567  THE REFERENCE LAB INC.
[23] In-House CLIA#..........: 12A3456789
[24] Hearing/Vision Prescription Date:
[25] Start/End Disability Dates:
[26] Assumed/Relinquished Care Dates:
[27] Property/Casualty Date of 1st Contact:
[28] Patient Paid Amount:
[29] Vision Condition Info:
```

```
[29] Spinal Manipulation Cond Code Ind:
------------------------------------------------------------------------------
Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//
```

Figure 2-7: Table for Page 3

Release of Information Question

Added help text to Release of Information, to Page3 in the claim editor.

```
[1] Was RELEASE OF INFORMATION obtained? N// ??
Is a Signed Statement for Release of Information on File
```

Figure 2-8: Help text displays

Assignment of Benefits

Version 5010 provides a W option if the patient refuses to sign. This value, if selected, will be sent to the payer.

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

Desired FIELDS:  (1-28): 1-28// 2
     Select one of the following:

      Y         YES
      N         NO
      W         Patient refuses to assign benefits

[2] Was ASSIGNMENT OF BENEFITS Obtained: Y//
```

Figure 2-9: The W option

Start/End Disability Dates

A new question has been added to Page 3 for version 5010 837 Professional that prompts for the Start and/or End Disability dates. This may be used to report dates for Workmen's Compensation claims. *Warning #238–Only one disability date populated* will appear if only one of the Start or End date entries has been added.

```
 [24] Start/End Disability Dates:

If both dates aren't populated a "Warning 238" will populate.
WARNING:238 - Only one disability date populated.
```

Figure 2-10: Warning text displays

Assumed/Relinquished Care Dates

A new question has been added that allows the biller to indicate an assumed or relinquished care date for providers that share postoperative care where the global period must be reported by each provider of care.

```
[26] Assumed/Relinquished Care Dates:

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


Desired FIELDS:  (1-28): 1-28// 26
[26] Assumed Care Date:
[26] Relinquished Care Date:
```

Figure 2-11: Prompts for Assumed Care Date and Relinquished Care Date

Property/Casualty Date of First Contact

This new question is used to indicate the date of the patient's first contact with this provider for the condition being reported. The Implementation Guide indicates this question is used mainly used for Third Party Liability/Workmen's Compensation claims.

```
[27] Property/Casualty Date of 1st Contact:

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


Desired FIELDS:  (1-28): 1-28// 27
[27] Property/Casualty Date of 1st Contact:
```

Figure 2-12: Entering the date of first contact

Delayed Reason Code

The Delayed Reason codes have been updated with the addition of Natural Disaster. You will be able to view the new Delayed Reason Codes.

```
[21] Delayed Reason Code: ??

   Choose from:
   10        ADMINISTRATION DELAY IN THE PRIOR APPROVAL PROCESS
   11        OTHER
   15        NATURAL DISASTER
   01        PROOF OF ELIGIBILITY UNKNOWN OR UNAVALABLE
   02        LITIGATION
   03        AUTHORIZATION DELAYS
   04        DELAY IN CERTIFYING PROVIDER
   05        DELAY IN SUPPLYING BILLING FORM
   06        DELAY IN DELIVERY OF CUSTOM-MADE APPLIANCES
   07        THIRD PARTY PROCESSING DELAY
   08        DELAY IN ELIGIBILITY DETERMINATION
   09        ORIGINAL CLAIM REJECTED DENIED UNRELATED TO LIMITATION RULES
```

Figure 2-13: Delayed Reason Codes display

Patient Paid Amount

This new question is used only if required by the payer to report a patient paid amount.

```
[28] Patient Paid Amount:

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

Desired FIELDS:  (1-28): 1-28// 28
[28] Patient Paid Amount: 20.40
```

Figure 2-14: Patient Paid Amount displays

Hearing/Vision Prescription Date

This new prompt is used to report the prescription date for hearing devices or vision frames and lenses when it is being billed and is required by the payer.

```
[23] Hearing/Vision Prescription Date:
```

Figure 2-15: The “Hearing/Vision Prescription Date” prompt

Vision Condition Information

This new prompt will appear when clinic is Optometry and aids in billing for Optometry services. Vision condition Info, Vision Cert. Condition Indicator, and Vision Condition Indicators are prompted but not required unless indicated by the payer.

```
[29] Vision Condition Info: ??

     Choose from:
       E1       SPECTACLE LENSES
       E2       CONTACT LENSES
       E3       SPECTACLE FRAMES
[28] Vision Condition Info: E2  CONTACT LENSES

 Vision Certification Condition Indicator: ??

     Choose from:
       Y        YES
       N        NO
 Vision Certification Condition Indicator: Y  YES
Select VISION CONDITION INDICATORS: ??
        You may enter a new VISION CONDITION INDICATORS, if you wish
   Choose from:
   L1    GEN STANDARD 20 DEGREE OR .5 DIOPTER SPHERE OR
          CYLINDER CHANGE MET
   L2    REPLACE DUE TO LOSS/THEFT
   L3    REPLACE DUE TO BREAKAGE/DAMAGE
   L4    REPLACE DUE TO PATIENT PREFERENCE
   L5    REPLACE DUE TO MEDICAL REASON

Select VISION CONDITION INDICATORS: L3  (L3   REPLACE DUE TO
BREAKAGE/DAMAGE)
```

Figure 2-16: Vision Condition information displays

Spinal Manipulation Condition Code Indicator Question

This prompt will only display if clinic is Chiropractic and is used to report one or more condition indicators for the Chiropractic services.

```
[29] Spinal Manipulation Cond Code Ind:

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

Desired FIELDS:  (1-29): 1-29// 29
[29] Spinal Manipulation Cond Code Ind: ??

     Choose from:
       A        ACUTE CONDITION
       C        CHRONIC CONDITION
       D        NON-ACUTE
       E        NON-LIFE THREATENING
       F        ROUTINE
       G        SYMPTOMATIC
       M        ACUTE MANIFESTATION OF A CHRONIC CONDITION
```

Figure 2-17: The “Spinal Manipulation Cond Code Ind” prompt

2.3.1.2 Claim Editor, Page 3A–Ambulance Changes

A new prompt has been added to Page 3A–Ambulance of the Claim Editor labeled Patient Count. The count is used to identify the number of patients transported, if more than one was transported. This is not a required field but must be used if required to be populated by the payer.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: Demo, Patient   [HRN:1456]                     Claim Number: 32383
..................... (AMBULANCE QUESTIONS) ............................

   [01] Point of Pickup........:


        [02] Modifier.........:
   [03] Destination............: INDIAN HEALTH HOSPITAL
                                 PO BOX 30990
                                 ALBUQUERQUE, NEW MEXICO  87125-0990
        [04] Modifier.........:

   [05] Mileage (Covered)......:
   [06] Mileage (Non-Covered)..:
   [07] Medical Necessity Ind..:
   [08] Patient Weight (lbs)...:
   [09] Patient Count..........: 3

Transfers Only:
   [10] Type of Transport......:
   [11] Transported To/For.....:

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

```
Desired FIELDS:  (1-11): 1-11// 9

AMBULANCE PATIENT COUNT: 3// ??
Req'd when more than one patient is transported in the same vehicle for
Ambulance or non-emergency transportation services.
```

Figure 2-18: Page 3A displays

2.3.1.3 New Claim Editor Page, Page 3B–TPL/WC Questions

A new page has been added to the Claim Editor that allows the user to enter additional Workmen's Compensation or Third Party Liability data if billed via the Third Party Billing system. Page 3B only appears if the active insurer on the claim contains an insurer type of W for Workmen's Comp or T for Third Party Liability.

Additional questions will display for Property and Casualty Claim Number, as well as the Patient Identifier and Patient number.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3B  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: GREEN,APPLE  [HRN:6670]                        Claim Number: 32380
.......... (THIRD PARTY LIABILITY/WORKER'S COMP QUESTIONS) ..............

[1] Property and Casualty Claim Number:
        Patient Identifier/Number:
[2] Date Last Worked:
[3] Date Authorized to Return to Work:

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

Figure 2-19: Page 3B displays

2.3.1.4 Claim Editor, Page 8H–Miscellaneous Services Changes

Additional fields have been added to Page 8H of the Claim Editor. These fields are used to report Development, Modernization, and Enhancement (DME) rental and/or supplied information if required by the payer to report.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8H  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: GREEN,FLOWER  [HRN:3369]                         Claim Number: 32381
Mode of Export: CMS-1500 (08/05)
......................... (MISC. SERVICES) ..............................

REVN                                                      UNIT       TOTAL
CODE         HCPCS - MISC. SERVICES                     CHARGE QTY  CHARGE
==== ========================================  ====== === =========
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A

===============  ADD MODE - MISC. SERVICES  ===============
Select Misc. Services (HCPCS Code): K0885
( )
MTLU found no usable words.

The following word was not used in this search:
```

```
     K0

Attempting FILEMAN lookup...    PWC GP4 STD MULT POW OPT CAP
       Power wheelchair, group 4 standard, multiple power option, captains
chair, patient weight capacity up to and including 300 pounds
         ...OK? Yes//   (Yes)

Select 1st MODIFIER:

                     DIAGNOSES
Seq   ICD9
Num   Code               Diagnosis Description
===  ======   ========================================
        1   460.     ACUTE NASOPHARYNGITIS

   Misc. Services SERVICE FROM DATE/TIME: 12/24/2010
         //   (DEC 24, 2010)

   Misc. Services SERVICE TO DATE/TIME: 12/24/2010
         //   (DEC 24, 2010)
   Misc. Services UNITS: 1
   Misc. Services QTY/LENGTH MEDICAL NECESSITY: 30
   Misc. Services MONETARY AMT/DME RENTAL PRICE: 25
   Misc. Services MONETARY AMT/DME PURCH. PRICE: 250
   Misc. Services FRQ CODE/RENTAL UNIT PRICE IND:??
     Choose from:
       1        WEEKLY
       4        MONTHLY
       6        DAILY
   Misc. Services FRQ CODE/RENTAL UNIT PRICE IND: 1  WEEKLY
   Misc. Services UNIT CHARGE: 250
   Misc. Services PLACE OF SERVICE: 22//        OUTPATIENT HOSPITAL


Misc. Services UNIT CHARGE: 100.00
Select SERVICE LINE PROVIDER:
```

Figure 2-20: Page 8H displays

The new fields will only appear if the active insurer has the DME flag set within the Visit Type of the Insurer File.

```
DME Contractor?.....: YES// ??

     Choose from:
       Y        YES
       N        NO
```

Figure 2-21: DME Contractor options

2.3.1.5 Claim Editor, Page 9A–Occurrence Codes Changes

A Modification has been added to Occurrence Codes on Page 9A of the Claim Editor: Last Menstrual Period. If populated, then segment DTP*484 will populate on the 837 Professional V5010 claim.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: GREEN,FLOWER  [HRN:3369]                       Claim Number: 32381
......................... (OCCURRENCE CODES) ............................

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

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

===============  ADD MODE - OCCURRENCE CODES  ===============
Select Occurance Code: 10       LAST MENSTRUAL PERIOD

   Occurance Code OCCURANCE DATE: 1.1.10  (JAN 01, 2010)
```

Figure 2-22: Page 9A displays

2.3.1.6 Claim Editor, Page 9G–Claim Attachments Changes

Additional Codes Added to Page 9G of the Claim Editor. Code FT File Transfer was also added to report the type of transmission.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9G  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,VINCENT  [HRN:1456]                       Claim Number: 32398
......................... (CLAIM ATTACHMENTS) ............................

REPORT TYPE          TRNS TYPE          CONTROL NUMBER
==================== ================== ============================

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

===============  ADD MODE - CLAIM ATTACHMENTS  ===============
Select Claim Attachment: ??

   Choose from:
   10        Continued Treatment
   11        Chemical Analysis
   13        Certified Test Report
   15        Justification for Admission
   21        Recovery Plan
   03        Report Justifying Treatment Beyond Utilization Guidelines
   04        Drugs Administered
   05        Treatment Diagnosis
   06        Initial Assessment
   07        Functional Goals
   08        Plan of Treatment
   09        Progress Report
   A3        Allergies/Sensitivities Document
   A4        Autopsy Report
   AM        Ambulance Certification
   BR        Benchmark Testing Results
   BS        Baseline
   BT        Blanket Test Results
   CB        Chiropractic Justification
   CK        Consent Form(s)
   D2        Drug Profile Document
   DB        Durable Medical Equipment Prescription
   DJ        Discharge Monitoring Report
```

```
   HC        Health Certificate
   HR        Health Clinic Records
   I5        Immunization Record
   IR        State School Immunization Records
   LA        Laboratory Results
   M1        Medical Record Attachment
   OC        Oxygen Content Averaging Report
   OD        Orders and Treatments Document
   OE        Objective Physical Examination (including vital signs)
Document
   OX        Oxygen Therapy Certification
   P4        Pathology Report
   P5        Patient Medical History Document
   PE        Parenteral or Enteral Certification
   PQ        Paramedical Results
   PY        Physician's Report
   RX        Renewable Oxygen Content Averaging Report
   SG        Symptoms Document
   V5        Death Notification
   XP        Photographs

Select Claim Attachment: 10       Continued Treatment

   CLAIM ATTACHMENTS Transmission Code: ??

     Choose from:
       FT       FILE TRANSFER
  CLAIM ATTACHMENTS Transmission Code: FT  FILE TRANSFER
```

Figure 2-23: Page 9G displays

2.3.1.7 Claim Editor, Page 9E–Special Program Codes Changes

Warning Code 237 has been added to Page 9E, if using the 5010 format. The following codes are specific to the 837P version 5010:

- 02 PHYSICALLY HANDICAPPED CHILDREN'S PROGRAM
- 03 SPECIAL FEDERAL FUNDING
- 05 DISABILITY
- 09 Second Opinion or Surgery

The use of codes other than the codes listed above will display Warning 237–Special Program code not supported by 837 5010 format.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9E  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,VINCENT  [HRN:1456]                      Claim Number: 32377
....................... (SPECIAL PROGRAM CODES) ........................

PRGM
CODE               SPECIAL PROGRAM DESCRIPTION
====    ============================================================
[1]    06     PVV/MEDICARE 100% PAYMENT PROGRAM
-------------------------------------------------------------------------
WARNING:237 - Special Program code not supported by 837 5010 format
```

```
------------------------------------------------------------------------------

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

Figure 2-24: Page 9E displays

2.3.2 Electronic Media Claims Setup

ABM→TMTP→ECTM

A new option has been added to the Table Maintenance Menu labeled Electronic Claims Setup. This option requires no key and has been created to make future Electronic Claims Setup.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.6p6          |
          +                Table Maintenance Menu                   +
          |                INDIAN HEALTH HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    11-MAY-2011 1:21 PM

   FETM   Fee Schedule Menu ...
   CPTM   CPT File Menu ...
   PRTM   Provider Menu ...
   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
   RLTM   Add/Edit Reference Lab Locations
   SSTM   Initialize New Facility
   TMRP   Manager Reports ...
   TLCP   Lab CPT/HCPCS Requiring Test Results
   ECTM   Electronic Claims Setup ...

Select Table Maintenance Menu Option: ECTM   Electronic Claims Setup ...
```

Figure 2-25: Example of the Table Maintenance Menu showing the Electronic Claims option

Within the Electronic Claims Setup Menu, the following options are available.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.6p6          |
          +               Electronic Claims Setup                   +
          |                INDIAN HEALTH HOSPITAL                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: LUJAN,ADRIAN M                    11-MAY-2011 1:25 PM
```

```
   SGTM   837 Segment Override
   CHEC   Clearinghouse Setup
   CHRP   Clearinghouse Report

Select Electronic Claims Setup Option:
```

Figure 2-26: Electronic Claims Setup options

2.3.2.1 837 Segment Override

ABM→TMTP→ECTM→SGTM

This option will allow the user to override select loops/segments/elements of the 837 or not send a whole segment. The option also enables users to customize insurer and visit type information on all the 837 version 5010 electronic formats. This information is site-, insurer-, and form-specific.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |         THIRD PARTY BILLING SYSTEM - VER 2.6p6          |
           +                  837 Segment Override                   +
           |                 INDIAN HEALTH HOSPITAL                  |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: LUJAN,ADRIAN M                    11-MAY-2011 1:34 PM

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

     Select one of the following:

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

Select Loop: 4  2010AA

     Select one of the following:

          S         Send
          N         Don't Send

Select: s  Send

     Select one of the following:

          1         NM1
          2         REF

Select Segment: 2  REF

     Select one of the following:
```

```
          1         REF01
          2         REF02

Select Element: 2  REF02
  Are you adding 'FM32 2010AA REF02 9999' as
    a new 837 SEGMENT OVERRIDE (the 1ST for this 3P INSURER)? No// YES
(Yes)
DATA VALUE: 239138923
EDIT ANOTHER SEGMENT?? N//
```

Figure 2-27: 837 Segment Override

To customize insurer and visit type information on all the 837s, follow these steps:

1. At Select Electronic Claims set up Menu Option, type **SGTM** and press the Enter key.
2. At "Select 3P Insurer," type the name of the insurer to edit.
3. At "Select 3P Export Mode Format," type the name or number of the form to edit.
4. At "Enter Visit type, or leave blank for all," type the number or name of the visit type which the user wants to restrict this change. Multiple visit type entries may be added but the user will need to keep entering this menu option to do so.
    a. The system prompts you to verify the selection (if a specific visit type was selected).
    b. To make this override change on all claims for the specified insurer and form, regardless of visit type, press Enter to leave this prompt blank.
5. At "Are you adding 'FM32 HEADER ISA15 9999' as a new 837 SEGMENT OVERRIDE (the 1ST for this 3P INSURER)?" type **Yes** or **No**.
    a. **Yes** to add a new value or edit the data in the specified segment.
    b. **No** allows you to exit without saving or adding.

Keep in mind that all additions or edits are immediately added to the 837 format edited. Only users that have experience with the 837 Implementation Guides are recommended to use this option.

2.3.2.2 Clearinghouse Setup

ABM→TMPT→ECTM→CHEC

The Clearinghouse Setup will allow the user to setup a clearinghouse within RPMS so claims for multiple insurers can go into one electronic claim batch file for transmission to the electronic payer or clearinghouse.

There are many uses for this option.

- Example 1: The user is located in New Mexico and bills to Blue Cross/Blue Shield (BC/CS) of New Mexico (NM), BC/BS of Illinois (IL), BC/BS of Arizona (AZ) and BC/BS of Utah (UT). BC/BS may require the user to submit all out-of-state BCBS to BC/BS of NM. The clearinghouse option in the Resource and Patient Management System (RPMS) may be used to generate one file to BC/BS of NM rather than the user submitting four different files.
- Example 2: The user submits claims to Private Insurance plans via a clearinghouse. The clearinghouse option in RPMS will allow the user to set up the external clearinghouse to have one file created and submitted to the external clearinghouse for submission to the payer.

To set up the Clearinghouse Setup, follow these steps:

1. At Clearinghouse Setup, type the clearinghouse name and press Enter. A search will be performed for other clearinghouse names. If there is no match it will continue to Add New Clearinghouse.
2. At the "Are you adding 'clearing house name' as a new 3P RECEIVER (the 3RD)" prompt, enter:
   a. **Yes** if you wish to proceed.
   b. **NO** if you wish to exit. If you exit without creating the clearinghouse, the system will not create entry.
3. At "PAYER ID (ISA06/GS02)," type in the clearinghouse identifier that will populate ISA06/GS02 and press Enter. This field is a free-text field.
4. At "Select Insurer," type the insurer name that will be linked to the clearinghouse.
5. At "INSURERS PAYER ID(CLEARINGHOUSE)" prompt, type the ID name which will be identified by the clearinghouse.
6. At the "INSURERS" prompt, the insurer name and default will display what was added at "Select Insurer".
7. At the "PAYER ID (CLEARINGHOUSE):" prompt, the payer ID clearinghouse default will display what was added at "INSURERS PAYER ID(CLEARINGHOUSE)".
8. The "Select Insurer" will allow the user to add additional insurers to the clearinghouse.

```
+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
|         THIRD PARTY BILLING SYSTEM - VER 2.6p6          |
+                  Clearinghouse Setup                    +
|                INDIAN HEALTH HOSPITAL                   |
+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
User: VALENCIA,TINA                    4-MAY-2011 9:18 AM
```

```
Enter the clearinghouse name: ALBUQUERQUE CLEARINGHOUSENarrative contained
no useable words.
Search was unsuccessful.


Since the KEYWORD LOOKUP failed lets try a NON-KEYWORD LOOKUP...

     ALBUQUERQUE CLEARINGHOUSE
  Are you adding 'ALBUQUERQUE CLEARINGHOUSE' as
    a new 3P RECEIVER (the 6TH)? No// Y  (Yes)
CLEARINGHOUSE: ALBUQUERQUE CLEARINGHOUSE  Replace

Setting up Header Data...

PAYER ID (ISA06/GS02): ALB0012

Select Insurer: BCBS OF ALB( BLUE CROSS/CROSSBONES/CROSSE SHIELD )

The following words were not used in this search: BC/BS OF ALABAM


INSURERS PAYER ID (CLEARINGHOUSE): BCBS/ALB
INSURERS: BC/BS OF ALABAMA//
PAYER ID (CLEARINGHOUSE): BCBS/ALB//
Select Insurer:
```

Figure 2-28: The “Select Insurer” prompt

> **Note**: When adding insurers, group them accordingly. If the file is too large, it may not transmit due to multiple insurers’ setup in the clearinghouse file.

2.3.2.3 Clearinghouse Report

ABM→TMTP→ECTM→CHRP

This option reports all entries from the Clearinghouse Setup. It will display all entries and their associated data and gives the user a view of all the Clearinghouse data and the specific insurers which are setup for that clearinghouse.

To run the report,

- At the “Output DEVICE: HOME//” prompt, HOME is the default. You can queue report to print on a terminal or a printer.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.6p6          |
          +                  Clearinghouse Report                   +
          |                 INDIAN HEALTH HOSPITAL                  |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: VALENCIA,TINA                      4-MAY-2011 11:22 AM

This report will print all Clearinghouse entries and their associated
```

```
insurers, as well as any fields that have been populated for that
Clearinghouse.


Output DEVICE: HOME//   Virtual


================================================================================
CLEARINGHOUSE LISTING for ALL BILLING SOURCES  MAY 4,2011@11:22:55   Page 1
Billing Location: INDIAN HOSP
================================================================================
Clearinghouse
Insurer                    Payer ID  EXP     AO CONTROL#        EMC SUB ID
--------------------------------------------------------------------------------
CLEARING HOUSE TEST   PAYER ID:
   BC/BS OF ARIZONA INC         BCBS OF AZ        538554
   BC/BS OF OKLAHOMA            12345
   BCBS OF NEW MEXICO (FEP)     BSBSNM FEP
   BCBS OF NEW MEXICO           BCBS OF NM

EMDEON   PAYER ID:
   NEW MEXICO MEDICAID          NM MEDICAID       NMMAD              P074
   ARIZONA MEDICAID             AZ MEDICAID       99999              486595
   PRESBYTERIAN SALUD           PRES SALUD
   LOVELACE SALUD               LUV SALUD
   CIMARRON SALUD               CIM SALUD

(REPORT COMPLETE):
```

Figure 2-29: Running the Clearinghouse Report

2.4 New Report: Facility EHR Incentive Report

ABMM→RPTP→MURP→FEIR

A new report has been added to the Third Party Billing System under the Meaningful Use Reports option. The report can be run by Fiscal Year or a user-defined date range and is used to provide a count of both IP and OP covered visits that have been paid. This may assist the user in determining how their facility may qualify for the Meaningful Use Incentive.

This report does not provide statistics that determine Meaningful Use eligibility in the Medicare or Medicaid Incentive Program.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |         THIRD PARTY BILLING SYSTEM - VER 2.6p6          |
          +             Facility EHR Incentive Report               +
          |                  INDIAN HEALTH CENTER                   |
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          User: RENDER,SHONDA                      4-APR-2011 12:58 PM

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

```
     Select one of the following:

          F         FISCAL YEAR
          D         DATE RANGE

Run report by FISCAL YEAR or DATE RANGE: FISCAL YEAR//

Select REPORT DATE Fiscal year:  (1960-2100): 2011// 2010


     Select one of the following:

          S         SUMMARY
          D         DETAIL
          B         BOTH

SUMMARY, DETAIL, or BOTH: SUMMARY// BOTH

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

Enter DEVICE: HOME//   Virtual
```

Figure 2-30: The Facility EHR Incentive Report

Use the following to print the report:

1. At the Reports Menu option, type **RPTP** and press Enter.
2. At the "Meaningful Use Reports" prompt, type **MURP** and press Enter.
3. At the "Facility EHR Incentive Report" prompt, type **FEIR** and press Enter.
4. At the "Entry of Date Range" prompt, type in the **Fiscal Year or Date Range** and press Enter.
   a. If Date Range is selected, a Start and End date of the report must be entered.
5. Regardless of the type of date selected, you will be prompted to enter one of three selections for the output of the report. You must select from Summary, Detail, or Both.
   - The Summary provides a summary report and is recommended to be displayed on the screen or printed to a printer.
   - The Detail will print a detailed report that allows you to view what makes up the summary report. This report contains specific visits and can be used to validate the summary report. It is recommended to print this to the Host File Server (HFS) because it could be a large file.

- Both will print both a Summary and Detailed report. It is recommended to print this report to the HFS because it could be a large file.

6. After selecting the report type, the system will prompt for the device. Select the printing device and press Enter. When printing the Detail and Both, the Enter Path prompt will display with a default path. Press Enter to accept the displayed pathname, or type the name of the path where the file will be stored. You may need to confirm with your RPMS administrator that the correct permissions have been assigned to this directory in order to generate a report here.

   At "Enter File Name" prompt, label the file you are creating by typing in a file name. It is helpful to create a filename that will be meaningful to you when searching the directory for the file. It is also recommended to type **.txt** at the end of the filename. This will allow the file to be opened as a text file.

7. The report has completed when DONE is displayed. The file can then be retrieved from the directory (from the path indicated above), saved onto your computer, and imported into an Excel spreadsheet.

```
==========================================================================
FACILITY EHR INCENTIVE REPORT               APR 4,2011@12:58:17   Page 1
For FISCAL YEAR: 2010
Billing Location: INDIAN HOSP
==========================================================================
                                                      # Discharges
--------------------------------------------------------------------------
                              -- M E D I C A R E --
# Paid MEDICARE IP Discharges                                            1
# Paid MEDICARE IP Profees (No Inpt Bill)                                1
# Paid MEDICARE IP Bed Days                                             31
# Paid MEDICARE IP Bed Days Profees (No Inpt Bill)                      30
# Paid MEDICARE OP All-Inclusive                                         0
# Paid MEDICARE OP Profees (No Outpt Bill)                               0
# Paid MEDICARE OP Itemized                                              0

                              -- M E D I C A I D --
# Paid MEDICAID IP Discharges                                            0
# Paid MEDICAID IP Profees (No Inpt Bill)                                0
# Paid MEDICAID IP Bed Days                                              0
# Paid MEDICAID IP Bed Days Profees (No Inpt Bill)                       0
# Paid MEDICAID OP All-Inclusive                                         0
# Paid MEDICAID OP Profees (No Outpt Bill)                               0
# Paid MEDICAID OP Itemized                                              0

                    -- P R I V A T E  I N S U R A N C E --
# Paid PRIVATE IP Discharges                                             0
# Paid PRIVATE IP Profees (No Inpt Bill)                                 0
# Paid PRIVATE IP Bed Days                                               0
# Paid PRIVATE IP Bed Days Profees (No Inpt Bill)                        0
# Paid PRIVATE OP All-Inclusive                                          0
# Paid PRIVATE OP Profees (No Outpt Bill)                                0
# Paid PRIVATE OP Itemized                                               1

                        -- K I D S C A R E / C H I P --
```

```
# Paid KIDSCARE/CHIP IP Discharges                                    0
# Paid KIDSCARE/CHIP IP Profees (No Inpt Bill)                        0
# Paid KIDSCARE/CHIP IP Bed Days                                      0
# Paid KIDSCARE/CHIP IP Bed Days Profees (No Inpt Bill)               0
# Paid KIDSCARE/CHIP OP All-Inclusive                                 0
# Paid KIDSCARE/CHIP OP Profees (No Outpt Bill)                       0
# Paid KIDSCARE/CHIP OP Itemized                                      0

                                -- O T H E R --
# Paid OTHER IP Discharges                                            0
# Paid OTHER IP Profees (No Inpt Bill)                                0
# Paid OTHER IP Bed Days                                              0
# Paid OTHER IP Bed Days Profees (No Inpt Bill)                       0
# Paid OTHER OP All-Inclusive                                         0
# Paid OTHER OP Profees (No Outpt Bill)                               0
# Paid OTHER OP Itemized                                              0

(SUMMARY REPORT COMPLETE):

Enter RETURN to continue or '^' to exit:

Will now write detail to file

Enter Path: c:\rpms\//
Enter File Name: shonda.txt

Creating file...DONE
```

Figure 2-31: The Summary Report

2.4.1 Report Logic

To compile the data, the report will search through 3P Bills, looking for visits with either a SERVICE TO DATE or a DISCHARGE DATE within the user-defined date range. Each bill found within the specified date range will check to see if any payment has been posted in A/R for this bill. Only bills with a Transaction Type of PAYMENT or an Adjustment Type of PAYMENT CREDIT will be included on this report. Every visit for one patient will only be counted once, even if there are multiple bills that have been generated and paid.

The summary report will display a count of discharges for each insurer category (refer to definitions below), and a count of Inpatient Bed Days. The insurer categories are defined as below:

Medicare Insurer Types R-Medicare FI, MD-Medicare Part D, MH-Medicare HMO

Medicaid: Includes Insurer Type D-Medicaid FI

Private Insurance: Insurer types H for HMO, P for Private, F for Fraternal Organization

Medicare Insurer Types R-Medicare FI, MD-Medicare Part D, MH-Medicare HMO

Kidscare/Chip: Insure type K-Kidscare (SCHIP)

Other: Insurer Types W-Workmens Comp, C-Champus, N-Non Beneficiary, I-Indian Beneficiary, T-Third Party Liability, G-Guarantor

Within each insurer category, the bills will be subdivided with the following service categories being grouped by:

Inpatient	Outpatient	Ignored for this report
Hospitalization	Ambulatory	Chart Review
In Hospital	Day Surgery	Telecommuncations
	Nursing Home	Not Found
	Observation	Daily Hospitalization Data
		Ancillary Package Daily Data

Specific checks are done for instances where there are multiple bills associated with one visit so that visits fall into the counts in a particular order. The bills are checked in the following order. Once a criterion is met, it stops checking for that bill.

The criteria are as follows:

- If the service category is Hospitalization or In Hospital, the bill type is 11#, and the visit type is 111, it is an Inpatient Discharge.
- If the service category is Hospitalization or In Hospital, the bill type is 11#, and the visit type is 999, it is an Inpatient Pro Fee.
- If the service category is *neither* Hospitalization and In Hospital, the bill type is 13# or 85# or 73#, the visit type is 131, and an all-inclusive rate is set up for that DOS, count as Outpatient All-Inclusive Rate.
- If the service category is *neither* Hospitalization and In Hospital, the bill type is 13# or 85# or 73#, the visit type is 131, and no all-inclusive rate is set up for that DOS, count as Outpatient Itemized.
- If the service category is *neither* Hospitalization and In Hospital, the bill type is 13# or 85# or 73#, and the visit type is 999, count as Outpatient Pro Fee.
- If the service category is Hospitalization or In Hospital, and the bill type is *not* 11#, count as an Inpatient Pro Fee.

- If an all-inclusive rate is set up for that DOS, count as Outpatient All-Inclusive Rate.
- If it gets to here, assume it is Outpatient Itemized.

The detail report will display the bills found to generate the counts from the summary. The detail report output is a delimited file and will include the insurer category, the inpatient/outpatient subcategories, insurer and insurer type, as well as visit location.

When looking at the detail you may see bills with a $0 in the payment column. In this case, there was a payment made but it was then reversed for some reason, causing the amount paid to be $0. It was still included (at this time anyway) to show that a payment was posted at some point.

Payments and payments credits are both considered payments for this report.

The report will find all locations associated with the location the report is being run from, and pull data for all reports (so if it is a multidivision system, it will pull data for all divisions). If the divisions are set up separately in accounts receivable (A/R), then the report will need to be run for each A/R division.

Appendix A: Detailed Facility EHR Incentive Report

Printing the detailed Facility EHR Incentive report provides the following sample data. The report may be imported into an Excel spreadsheet using the caret (^) as the delimiter.

FACILITY EHR INCENTIVE REPORT MAY 11,2011@13:01:34

For FISCAL YEAR: 2011

Billing Location: INDIAN HOSP

INSURER CATEGORY	IP/OP CATEGORY	INSURER	INSURER TYPE	BILL NUMBER	ADMIT DT	DISCHG DT	AMOUNT BILLED	PAYMENT	COVD DAYS	N-COVD DAYS	VISIT	VISIT LOCATION
MEDICARE	IP CHGS	MEDICARE	MEDICARE FI	30834B-IH-5064	2/1/2011	2/3/2011	10,830.21	15,483.00	3	0	02/01/2011@10:45	INDIAN HEALTH HOSPITAL
MEDICARE	IP DISCHGS	MEDICARE	MEDICARE FI	30909A-IH-5064	2/8/2011	2/12/2011	8,184.00	12,049.56	4	0	02/08/2011@15:40	INDIAN HEALTH HOSPITAL
MEDICARE	OP CHGS	MEDICARE	MEDICARE FI	30842A-IH-5064	1/12/2011	1/12/2011	166	120	1	0	01/12/2011@13:00	INDIAN HEALTH HOSPITAL
MEDICARE	OP CHGS	MEDICARE	MEDICARE FI	30852A-IH-5064	1/10/2011	1/10/2011	80	36.8	1	0	01/10/2011@13:30	INDIAN HEALTH HOSPITAL
MEDICARE	OP CHGS	MEDICARE	MEDICARE FI	30927A-IH-5064	3/19/2011	3/19/2011	62	36.8	1	0	03/19/2011@15:40	INDIAN HEALTH HOSPITAL
MEDICAID	IP DISCHGS	NEW MEXICO MEDICAID	MEDICAID FI	30839A-IH-5064	12/15/2010	12/17/2010	3,452.00	3,452.00	2	0	12/15/2010@17:56	INDIAN HEALTH HOSPITAL
MEDICAID	OP AIR	ARIZONA MEDICAID	MEDICAID FI	30824A-IH-5064	11/2/2010	11/2/2010	268	268	1	0	11/02/2010@16:00	INDIAN HEALTH HOSPITAL
MEDICAID	OP AIR	NEW MEXICO MEDICAID	MEDICAID FI	30837A-IH-5064	1/31/2011	1/31/2011	289	289	1	0	01/31/2011@15:00	INDIAN HEALTH HOSPITAL
PRIVATE	IP DISCHGS	BCBS OF NEW MEXICO	PRIVATE	30917A-IH-5064	2/15/2011	2/21/2011	18,011.00	15,655.83	6	0	02/15/2011@12:03	INDIAN HEALTH HOSPITAL
PRIVATE	IP DISCHGS	KEY INSURANCE PLANS	PRIVATE	30916A-IH-5064	11/18/2010	11/21/2010	6,817.40	5,113.05	3	0	11/18/2010@16:07	INDIAN HEALTH HOSPITAL
PRIVATE	OP ITEM	DELTA DENTAL OF NEW MEXICO INC	PRIVATE	30853A-IH-5064	1/1/2011	1/1/2011	265.66	197.22	1	0	01/01/2011@08:00	INDIAN HEALTH HOSPITAL
PRIVATE	OP ITEM	DELTA DENTAL OF NEW MEXICO INC	PRIVATE	30854A-IH-5064	11/22/2010	11/22/2010	41.07	12.56	1	0	11/22/2010@08:00	INDIAN HEALTH HOSPITAL
PRIVATE	OP ITEM	FIRST AMERICAN ADMINISTRATORS	PRIVATE	30828A-IH-5064	12/12/2010	12/12/2010	75	48	1	0	12/12/2010@14:00	INDIAN HEALTH HOSPITAL
PRIVATE	OP ITEM	LIGHTENING INSURANCE CO	PRIVATE	30903A-A	12/23/2010	12/23/2010	2,725.60	2,180.48	1	0	12/23/2010@13:40	AMBULANCE

FACILITY EHR INCENTIVE REPORT MAY 11,2011@13:01:34

For FISCAL YEAR: 2011

Billing Location: INDIAN HOSP

INSURER CATEGORY	IP/OP CATEGORY	INSURER	INSURER TYPE	BILL NUMBER	ADMIT DT	DISCHG DT	AMOUNT BILLED	PAYMENT	COVD DAYS	N-COVD DAYS	VISIT	VISIT LOCATION
PRIVATE	OP ITEM	MUTUAL OF OMAHA	PRIVATE	30822A-IH-5064	10/23/2010	10/23/2010	166	142	1	0	10/23/2010@15:00	INDIAN HEALTH HOSPITAL
PRIVATE	OP ITEM	SPIDERMAN INSURANCE	PRIVATE	30840A-IH-5064	12/13/2010	12/13/2010	62	42	1	0	12/13/2010@10:40	INDIAN HEALTH HOSPITAL
PRIVATE	OP ITEM	WASHINGTON DENTAL SERVICE	PRIVATE	30826A-IH-5064	11/16/2010	11/16/2010	421.98	379.78	1	0	11/16/2010@08:00	INDIAN HEALTH HOSPITAL
KIDSCARE/ CHIP	OP ITEM	BLUECHIP	CHIP (KIDSCARE)	30911A-IH-5064	2/9/2011	2/9/2011	231	231	1	0	02/09/2011@14:14	INDIAN HEALTH HOSPITAL
KIDSCARE/ CHIP	OP ITEM	BLUECHIP	CHIP (KIDSCARE)	30912A-IH-5064	3/4/2011	3/4/2011	1,015.00	1,015.00	1	0	03/04/2011@10:39	INDIAN HEALTH HOSPITAL
OTHER	IP DISCHGS	CHAMPUS	CHAMPUS	30838A-IH-5064	1/17/2011	1/20/2011	2,827.68	829.04	3	0	01/17/2011@14:00	INDIAN HEALTH HOSPITAL

Contact Information

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

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