



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 29
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Office of Information Technology
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Preface

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

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

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

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1.0 Introduction

1.1 Summary of Changes

Patch 29 provides enhancements and minor corrections to Version 2.6 of the Third Party Billing application. This patch is not cumulative of prior released patches. Please refer to those patch addendums for additional information.

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

1.1.1 Patch 29

Change Request 10404 – HEAT 407313

Updates were made to allow for having a Clinical Laboratory Improvement Amendments (CLIA) number automatically populate on claims that have an export mode of 837P (HCFA) 5010. This functionality requires that a CLIA number be specified in Site Parameter Maintenance and an insurer and CPT/HCPCS (Current Procedural Terminology/ Healthcare Common Procedural Coding System) code(s) be specified in the TLCP option. This set-up will trigger a CLIA number to populate on charges in the EDCL option and in the 837P (HCFA) 5010 export file.

Change Request 10410 – HEAT 139591, 375312

Changes were made to allow for billing non-covered charges to Medicare so that a denial can be received and used for billing another payer. When individual charges are identified as being non-covered by using a GY modifier, or when an entire claim is identified as being non-covered by using Condition Code 21, the non-covered dollar amounts will populate in the 837I (UB) 5010 and on the UB-04.

Change Request 10669 – No HEAT Ticket

A change was made to several reports and table maintenance options to ensure that users will only see one entry for CPT/HCPCS codes that contain duplicate entries in the CPT file. The code that displays will be the Active entry, but the report will pull data for the duplicate codes as well and will display data for all entries. This will ensure that all the data for duplicate CPT codes is captured and displayed.

Change Request 10686 – No HEAT Ticket

A change was made to the claim generator for visits that have a SERVICE CATEGORY of Ambulatory to ensure that the CPT code entered on the visit is the same CPT code that populates on the claim. Prior to patch 29, the claim generator used the CPT code to determine which entry to use on a claim, but this was causing incorrect codes to populate in some scenarios. To correct this, the claim generator will now use the CPT code's Internal Entry Number (IEN).

Change Request 10696 – No HEAT Ticket

A field was added to 3P Parameters and to the 3P Export Mode file to allow for specifying a maximum bill amount when approving claims. If a maximum bill amount is specified and a claim's bill amount is greater than that dollar amount, a warning message will display in the EDCL option and the user will have to answer an additional prompt to approve the claim.

Change Request 10825 – HEAT 430922

A correction was made to the UB-04 to ensure that the Admission Type (box 14) and Admission Source (box 15) populate with one digit, rather than being populated with a leading zero. This change applies to all payers except for Arizona Medicaid when the AO Control Number is 99999 and the Visit Type is 998. In that scenario, box 15 will be blank.

Change Request 10834 – HEAT 442038

A correction was made to the EDFE option to allow for entering Medical CPT codes that have an Internal Entry Number (IEN) that is outside of the 90000–99999 Medical CPT code range. An example of this would be CPT code 90832 having an IEN of 100742. IEN 100742 is outside of the 90000–99999 range. Prior to patch 29, the EDFE option would not have allowed that CPT code. Now it will.

Change Request 10836 – HEAT 445295, 461988

A correction was made to the EXPR and REPR options to ensure that paper claims print and reprint with the correct payer information and in the correct order. Prior to patch 29, when paper claims were printed or reprinted and one of the claims in the print batch had a secondary insurer, the wrong insurer would populate in the claim header for every subsequent claim. Included with this change request is a correction to the EDCL option to ensure that page 4 is updated with the correct provider information when the active insurer on a claim is changed.

Change Request 10844 – HEAT 443663

A correction was made to the UB-04 to ensure that the correct revenue code populates in box 42 for insurers that have an Insurer Type of Medicaid. Prior to patch 29, the revenue code for Medicaid insurers was populating with 0001 regardless of which revenue code was approved on the claim.

Change Request 10850 – HEAT 447196

A correction was made for California Medicaid to ensure that boxes 44, 46, and 47 are correctly populated on the UB-04. Prior to patch 29, these boxes were blank when billing itemized charges to California Medicaid with a Bill Type 731, a Visit Type other than 142, and Place of Service other than 51–55.

Change Request 10860 – HEAT 471782

A correction was made to the LSFEE option to prevent a subscript error when printing a fee schedule that contains a HCPCS code ending with an ‘F’, such as 9007F. This correction applies to the claim generator as well and will ensure that visits containing a HCPCS code ending with an ‘F’ do not cause the claim generator to stop running.

Change Request 10875 – HEAT 423321

Corrections were made to the CMS-1500 (02/12) to ensure that the patient’s insurance information is correctly populated when Medicare Part B is being billed as the secondary payer.

Change Request 10876 – HEAT 376087

Corrections were made to the 837D (ADA) 5010 and the ADA-2012 to ensure that the Operative Site populates correctly. If the Operative Site on an approved claim consists of one number, a leading zero will be added when populating the 837D and the ADA-2012. If the Operative Site on an approved claim consists of one letter, a leading space will be added when populating the ADA-2012.

Change Request 10888 – HEAT 436147, 442002

Changes were made for California Medicaid to ensure that a revenue code and the number of units are populated on each line item for the 837I (UB) 5010 and the UB-04 when billing an all-inclusive charge with at least one informational charge. When the claim is exported or printed, the revenue code on the all-inclusive charge will be applied to the informational charge(s). Included in this change request is a correction to display anesthesia units as minutes on the EDCL charge summary screen for all payers.

Change Request 10910 – HEAT 455093

A correction was made to prevent a programming error in the claim generator when the “ADD ZERO FEES” prompt is set to Yes in the insurer file and a claim is created for a visit that does not contain an E&M code (the visit only contains a HCPCS code, for example). This correction also ensures that the Quantity entered on a visit in PCC is what populates for the Units on the TPB claim, and if the Quantity is left blank in PCC, the claim will be populated with 1 Unit.

2.0 Patch 29

2.1 Claim Editor Warning for Upper Bill Limit

A field was added to the Site Parameter Maintenance (SITM) option and to the 3P Export Mode file to allow for specifying a maximum bill amount when approving claims. If a maximum bill amount is specified and a claim's bill amount is greater than that dollar amount, a warning message will display in the Edit Claim Data (EDCL) option and the user will have to answer an additional prompt to approve the claim.

The new field in SITM is called UPPER LIMIT FOR BILL APPROVAL. If populated, it will apply to all export modes. Leaving this field blank or populating it with a zero will have no effect on claim approval.

```

+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p29          |
+-----+-----+
|          Site Parameter Maintenance          |
|          2016 DEMO HOSPITAL          |
+-----+-----+
User: SUPER,USER                      18-JUL-2019 11:48 AM

EMC File Preference.....: HOST FILE//
DEFAULT EMC PATH.....: c:\pub\//
Facility to Receive Payments....: 2016 DEMO HOSPITAL
//
Printable Name of Payment Site..: DEMO HOSPITAL//
Current Default Fee Schedule....: 4//
Create Bills for all Patients...: NO//
Require that Queing be Forced...: NO//
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.....: 11//
Bill Number Suffix (fac-code)...: DH//
Append HRN to Bill Number.....: YES//
Upper Limit for Bill Approval...: 7500

```

Figure 2-1: New field in Site Parameters to indicate upper bill limit

The new field in the 3P EXPORT file is called UPPER LIMIT and, if populated, will apply only to the specified export mode. An amount populated in the 3P EXPORT file will override an amount populated in SITM. Leaving this field blank or populating it with a zero will have no effect on claim approval.

Note: The 3P EXPORT file can only be accessed using the FileMan Enter or Edit Entries option. Always use extreme caution when making any changes in FileMan.

```

VA FileMan 22.0

Select OPTION: ENTER OR EDIT FILE ENTRIES

INPUT TO WHAT FILE: 3P CLAIM DATA// 3P EXPORT MODE      (32 entries)
EDIT WHICH FIELD: ALL//

Select 3P EXPORT MODE FORMAT: CMS-1500 (02/12)          OMB No. 0938-1197
FORMAT: CMS-1500 (02/12)//
LEFT MARGIN:
TOP MARGIN:
EXPORT ROUTINE: ABMDF35//
ALIGNMENT ROUTINE: ABMDF35X//
DENTAL SCREEN: NOT DENTAL RELATED//
DESCRIPTION: OMB No. 0938-1197//
QUESTIONS: 1,2,3,4B,5,7,9,10,15,20,22,26,28,34,35,36,38,19,41,43,44
              Replace
STATUS:
CHARGE SUMMARY ROUTINE: ABMDES3//
ONLY APPLIES TO:
CONTAINS MULTIPLE BILLS:
UPPER LIMIT: 5000
    
```

Figure 2-2: New field in the 3P EXPORT MODE file

If a dollar amount is populated in SITM and a claim’s bill amount is greater than the amount specified, a warning will display on the Charge Summary screen in the EDCL option and the user will have to answer an additional prompt to approve the claim.

```

=====
SUMMARY
=====
Active Insurer: HIGHMARK BCBS

Form          Charges          Previous          Write-offs          Non-cvd          Bill
-----          -----          -----          -----          -----          -----
CMS-1500 (02/12)  7,650.00          0.00          0.00          0.00          7,650.00
=====          =====          =====          =====          =====          =====
              7,650.00          0.00          0.00          0.00          7,650.00

WARNING: The amount billed exceeds the UPPER BILL AMOUNT ($7,500.00) set
in the SITM option

Do you acknowledge the amount? N// YES

Do You Wish to APPROVE this Claim for Billing? YES

Transferring Data....

Bill Number 123456A Created. (Export Mode: CMS-1500 (02/12))
    
```

Figure 2-3: Warning message and additional prompt displayed for exceeding SITM bill limit

If a dollar amount is populated in the 3P EXPORT MODE file and a claim's bill amount for that export mode is greater than the amount specified, a warning will display on the Charge Summary screen in EDCL and the user will have to answer an additional prompt to approve the claim.

SUMMARY						
=====						
Active Insurer: BLUE CROSS/BLUE SHIELD						
Form	Charges	Previous Payments	Write-offs	Non-cvd	Bill Amount	
-----	-----	-----	-----	-----	-----	
CMS-1500 (02/12)	7,650.00	0.00	0.00	0.00	7,650.00	
	=====	=====	=====	=====	=====	
	7,650.00	0.00	0.00	0.00	7,650.00	
WARNING: The amount billed exceeds the UPPER BILL AMOUNT (\$5,000.00) set for Export Mode CMS-1500 (02/12)						
Do you acknowledge the amount? N// YES						
Do You Wish to APPROVE this Claim for Billing? YES						
Transferring Data....						
Bill Number 987654A Created. (Export Mode: CMS-1500 (02/12))						

Figure 2-4: Warning message and additional prompt display for exceeding 3P EXPORT MODE bill limit

2.2 CLIA Numbers and the 837 Professional Export Mode

Several changes were made to the functionality that allows for having a CLIA number automatically populate on individual line items in the Edit Claim Data (EDCL) option as well as in the 837P (HCFA) 5010 export file. This functionality is not entirely new, but there have been some updates in patch 29 that are dependent on the following:

- Having a CLIA number populated in 3P Parameters, in addition to
- Having the TLCP option set up with insurers and CPT/HCPCS codes that require a CLIA number.

Once that setup is complete, a CLIA number will automatically populate on claims that have a status of Flagged as Billable and an export mode of 837P (HCFA) 5010. If the CLIA number is not deleted from page 3 of the claim editor and is not deleted from the line item(s), it will populate in the REF*F4 segment of the 837P (HCFA) 5010 export file.

Before setting up the TLCP option, review the Site Parameter Maintenance (SITM) option to ensure that a CLIA number is populated. Please note that a CLIA number is unique to each laboratory. The CLIA number used in the following examples was created for demonstration purposes and does not reflect an entry you should use at your facility.

```

+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p29          |
+          Site Parameter Maintenance                      +
|          2016 DEMO HOSPITAL                              |
+-----+-----+
User: SUPER,USER                                24-JUL-2019 8:56 AM

EMC File Preference.....: HOST FILE//
DEFAULT EMC PATH.....:
Facility to Receive Payments....:
Printable Name of Payment Site..:
Current Default Fee Schedule....:
Create Bills for all Patients...:
Require that Queing be Forced...:
Display Long ICD/CPT Description:
Backbilling Limit (months).....:
Block 31 (HCFA 1500) print.....:
UB-92 SIGNATURE.....:
Place of Service Code.....:
Bill Number Suffix (fac-code)...:
Append HRN to Bill Number.....:
Upper Limit for Bill Approval...:
Allow for CPT Modifiers Prompt..:
Set Prof. Comp. Automatically...:
Default Version of HCFA-1500....:
Default Form for Dental Billing.:
VA STATION NUMBER:
VA CONTRACT NUMBER:
Select DEFAULT UNBILLABLE CLINICS:
Select DFLT INVALID PRV DISCIPLINES:
Select DISPLAY UNBILLABLE INSURER(S):
UB-92 Form Locator 38:
IN-HOUSE DEFAULT CLIA#: 99D9999999//

```

Figure 2-5: CLIA number field in SITM option

Next, review and set up the TLCP option. This option was modified to allow for specifying CPT/HCPCS codes that require a CLIA number. In addition, to make the TLCP option name more meaningful, it was changed from Lab CPT/HCPCS Requiring Test Results to Lab CPT/HCPCS Requiring Test Results & CLIA. The help text that displays upon entering the TLCP option has also been updated to reflect the changes in patch 29.

```

+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p29          |
+          Lab CPT/HCPCS Requiring Test Results & CLIA      +
|          2016 DEMO HOSPITAL                              |
+-----+-----+
User: SUPER,USER                                24-JUL-2019 10:10 AM

```

```
An insurer and a list of CPT/HCPCS codes will be prompted for.
Any codes entered for that insurer can be set up to require:
- Results for the lab being performed
- A CLIA number to be included on the claim
This information, when present on a claim, will populate in the
837P electronic export file.
```

Figure 2-6: TLCP menu option name change and updated help text

Enter the insurer name that requires a CLIA number. If any CPT/HCPCS codes have previously been entered for the insurer, you will see a summary of what was specified for those CPT/HCPCS codes (lab results required and CLIA# required).

Enter a CPT code or a HCPCS code. You may enter a Laboratory CPT code (80000-89999), any HCPCS code (A–Z), or CPT 36415. CPT code 36415 is classified as a Surgical code, so it will populate on page 3B of the claim editor. If you need to submit lab results and/or a CLIA number with CPT 36415, you will need to delete the charge from page 8B and add it to page 8E.

To have the claim editor prompt for test results on page 8E, type YES at the “RESULTS REQ'D FOR THIS INSURER” prompt. This is not new in patch 29. However, the prompt has been modified in patch 29 to be more meaningful.

To have a CLIA number automatically populate on a CPT/HCPCS code in the claim editor, type YES at the “SEND CLIA NUMBER WITH THIS CODE” prompt. Leaving this prompt blank will set the prompt to NO. This completes the setup.

```
Select INSURER:   BC/BS OF KS INC      KANSAS      66629
                ...OK? Yes//      (Yes)

Current  Results  CLIA
Codes   Req'd?   Req'd?
36415   NO        YES

Enter CPT/HCPCS codes: 81001      URINALYSIS AUTO W/SCOPE
                        URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE,
                        HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY,
                        UROBILINOGEN, ANY

CPT/HCPCS code: 81001//

                RESULTS REQ'D FOR THIS INSURER: Y  YES
                SEND CLIA NUMBER WITH THIS CODE: Y  YES

Enter CPT/HCPCS codes:
```

Figure 2-7: TLCP updates and set-up example

For users who have the at (@) symbol assigned for FileMan Access, the TLCP display will look a little different. Those users will see an additional column displaying the IEN for each CPT/HCPCS code that has been specified for the insurer.

Current Codes	Results Req'd?	CLIA Req'd?	CPT IEN
36415	NO	YES	36415
81001	YES	YES	81001

Figure 2-8: TLCP display for users with FileMan @ access

Once the setup is complete, your site’s CLIA number will populate on the specified CPT/HCPCS codes for claims that are in a status of Flagged as Billable and have an export mode of 837P (HCFA) 5010.

```

~~~~~ PAGE 8E ~~~~~
Patient: DEMO,PATIENT [HRN:12345] Claim Number: 987654
Mode of Export: 837P (HCFA) 5010
..... (LABORATORY SERVICES) .....

      REVN                                UNIT          TOTAL
      CODE          CPT - LABORATORY SERVICES    CHARGE QTY    CHARGE
=====
[1] CHARGE DATE: 07/17/2019
    0300 81001 URINALYSIS AUTO W/SCOPE                20.00  1      20.00
                                                =====
                                                $20.00

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

[1] 81001
Select 1st MODIFIER:

          DIAGNOSES
      Seq   ICD
      Num   Code          Diagnosis Description
=====
       1   N39.0   Urinary tract infection, site not specified

UNITS: 1//

PLACE OF SERVICE: 22//
IN-HOUSE CLIA#: 17D1020998//

Enter LABORATORY Results:
TYPE OF TEST RESULT:
TEST RESULT:
TEST RESULT:
TEST DATE:

UNIT CHARGE: 20.00//
Select SERVICE LINE PROVIDER:
    
```

Figure 2-9: CLIA# populated in the EDCL option

If the CLIA number on page 3 of the claim editor is the same as the CLIA number on a line item, or if the CLIA number is only populated on page 3, the CLIA number will be applied to the entire claim in the 837P export file.

```
CLM*987654A-DH-112233*307.92***22:B:1*Y*A*Y*Y~
REF*X4*17D1020998~
REF*EA*143226~
HI*ABK:I158*ABF:G43811~
NM1*82*1*COOPER*STEVEN*****XX*1528005857~
PRV*PE*PXC*207RC0000X~
```

Figure 2-10: CLIA number when applied to an entire claim in the 837P

If the CLIA number on page 3 is deleted, or if the CLIA number on page 3 is different from the CLIA number on a specific CPT/HCPCS code, the CLIA number will populate in the 837P only for that specific CPT/HCPCS code.

```
SV1*HC:81001*20.00*UN*1***2~
DTP*472*D8*20190717~
REF*6R*000000006128370002~
REF*X4*17D1020998~
LX*5~
```

Figure 2-11: CLIA number when applied to a specific charge in the 837P

2.3 Medicare Non-Covered Charges

Several changes were made to allow for billing non-covered charges to Medicare so that a denial can be received and used for billing another payer. When individual charges are identified as being non-covered by using a GY modifier, or when an entire claim is identified as being non-covered by using Condition Code 21, those non-covered dollar amounts will populate in the 837I (UB) 5010 and on the UB-04.

The changes for this patch were mainly developed for Medicare Part A billing (such as FQHC billing) where the site will itemize to Medicare; however, these changes also apply to non-covered claims being billed at the All-Inclusive rate.

The following has been published by National Government Services (NGS) for billing Medicare with Condition code 21:

[NGS Medicare Condition Code 21](https://www.ngsmedicare.com/ngs/poc/ngsmedicare?1dmy&urile=wcm%3apath%3a%2FNGSMedicareContentNEW%2FNGSMedicareNEW%2FTraining%2FJob+Aids+Manuals%2FBilling+Medicare+for+a+Denial+-+Condition+Code+21&LOB=FQHC&LOC=Georgia&ngsLOC=Georgia&ngsLOB=FQHC&jurisdiction)

(<https://www.ngsmedicare.com/ngs/poc/ngsmedicare?1dmy&urile=wcm%3apath%3a%2FNGSMedicareContentNEW%2FNGSMedicareNEW%2FTraining%2FJob+Aids+Manuals%2FBilling+Medicare+for+a+Denial+-+Condition+Code+21&LOB=FQHC&LOC=Georgia&ngsLOC=Georgia&ngsLOB=FQHC&jurisdiction>)

2.3.1 Non-Covered Charges Billed with Covered Charges

When one or more non-covered charges are billed on the same claim with covered charges, add modifier GY (Statutorily Excluded) to the non-covered charges using the Edit Claim Data (EDCL) option and ensure that the mode of export is set to 837I (UB) 5010 or UB-04.

For the 837I, the CLM02 segment will populate with the total dollar amount of all charges. The SV202 will populate the GY modifier, the SV203 will populate the charge amount, and the SV207 will populate the non-covered amount, which will be the same as the charge amount.

```
CLM*123456A-DH-1234*1379.00***13:A:1**A*N*I~
```

Figure 2-12: Total claim amount in CLM02

```
SV2*0960*HC:17106:GY*751.00*UN*1**751.00~
```

Figure 2-13: SV2 segments populated for non-covered charges

For the UB-04, the GY modifier will print next to the CPT/HCPCS code in box 44. The dollar amount in box 47 will be zero, and the dollar amount in box 48 will be the non-covered charge amount. The total dollar amounts on line 23 will add up accordingly.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0270	CLINIC	A4211	041219	1	5000		1
2 0324	CLINIC	71035	041219	1	16400		2
3 0960	CLINIC	17106GY	041219	1	000	75100	3

Figure 2-14: Non-covered charges on UB-04 by line item

23	PAGE	OF	CREATION DATE	TOTALS	21400	75100	23
50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	

Figure 2-15: Covered/non-covered totals on UB-04

2.3.2 Entire Claim Is Non-Covered

To mark an entire claim as non-covered, do the following:

1. Add Condition Code 21 (Billing for Denial Notice) to page 9C in the EDCL option
2. Ensure that the mode of export is set to 837I (UB) 5010 or UB-04
3. The third position of the bill type must end in zero (0). Two examples of this are bill types 770 and 130.

For the 837I, all dollar amounts will be populated just like any other itemized claim. However, having Condition Code 21 on the claim triggers an HI segment to populate in Loop 2300 with BG indicating that the next piece of information will be a Condition Code. This indicates to Medicare that the entire claim is non-covered.

```
CLM*102311A-DH-143*300.16***77:A:0**A*N*I~
DTP*434*RD8*20190628-20190628~
REF*EA*143~
```

```
HI*ABK:I158~
HI*BG:21~
```

Figure 2-16: HI01-1 segment in the 837I populated with Condition Code 21

For the UB-04, box 47 will be populated with zeros for each line item and box 48 will be populated with the non-covered charge amounts. The total dollar amounts on line 23 will add up accordingly.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0300	LABORATORY OR (LAB)	81001	062819	1	000	516	1
2 0960	PRO FEE	99214	062819	1	000	26400	2
3							3
4							4

Figure 2-17: All charges non-covered on the UB-04

23	PAGE	OF	CREATION DATE	TOTALS	000	30016

Figure 2-18: Non-covered total charge amounts on the UB-04

2.4 Medicare Part B Secondary Claims

Corrections were made to the CMS-1500 (02/12) to ensure that the patient's insurance information correctly populates when Medicare Part B is being billed as the secondary payer on an approved claim. Depending on what is populated in Patient Registration at the time a CMS-1500 (02/12) is printed for a patient, the following information will print on the claim. This is also dependent on a tertiary payer being present and billable.

- Box 2 – Patient's name, not the patient's Medicare name
- Box 4 – Policy holder's name for primary payer
- Box 7 – Policy holder's address and phone number for primary payer
- Box 9 – Policy holder's name for tertiary payer, or blank for none
- Box 9a – Policy number and group number for tertiary payer, or blank for none
- Box 9d – Plan name for tertiary payer, or blank for none
- Box 11 – Policy number for primary payer or member number, if a member number exists
- Box 11a – Policy holder's date of birth and sex for primary payer
- Box 11b – Policy holder's employer for primary payer
- Box 11c – Primary payer name
- Box 11d – Will be blank

1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
DEMO.MISSY		DEMO,MISTER
3. PATIENT'S BIRTH DATE		6. PATIENT RELATIONSHIP TO INSURED
MM DD YY 04 01 1955 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)
555 RESIDENCE PLACE		455 RESIDENCE PLACE
CITY STATE ALBUQUERQUE NM		CITY STATE ALBUQUERQUE NM
8. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		UHC998877
DEMO.MISSY B		10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)
1122334455		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State)
c. RESERVED FOR NUCC USE		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
NEW MEXICO MEDICAID		10d. RESERVED FOR LOCAL USE
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a and 9d.</i>

Figure 2-19: CMS-1500 (02/12) for a patient with billable tertiary coverage

2.5 Anesthesia Units on Summary Screens

A correction was made in the EDCL option to ensure that anesthesia units populate on the Charge Summary screen and on the Charge Print Order Screen. Prior to patch 29, the Units column on the Charge Summary screen was blank for anesthesia charges, and the Units column on the Charge Print Summary Screen displayed a zero for anesthesia charges.

The Units column on the Charge Summary screen will now populate with the anesthesia minutes. Help text was added to the Charge Summary screen to indicate that the number displayed for anesthesia units reflects time in minutes.

```

***** 837I (UB) 5010 CHARGE SUMMARY *****

Active Insurer: BC/BS OF MN
* - Indicates time (minutes) instead of units

Description                               Revn Code   Units   Total Charges
-----
LAB |                               0300     2       24.00
ANESTHESIA |                               0370    25*     523.00
CLINIC |                               0510     1       220.00
-----
TOTAL CHARGE                               0001                                440.00
    
```

Figure 2-20: Charge Summary Screen displays anesthesia units as minutes

The Units column on the Charge Print Order Screen will also populate with the anesthesia minutes. This screen displays immediately after the Charge Summary Screen, but only if it has been set up to do so for the claim's visit type in the 3P Insurer file.

```

* * * CHARGE PRINT ORDER SCREEN * * *

Complete list of charges on claim for BC/BS OF MN:

Revenue      Serv      Total
Code Description  PG Code      DOS      Units  Charges
-----
1. 300 LAB          8F 87490      07/02/19 2    $ 24.00
2. 370 ANESTHESIA   8 00100      07/02/19 25*   $ 523.00
3. 510 CLINIC      8A 99349      07/02/19 1    $ 220.00

NOTE: all lines must be included in the printing order and separated by commas.
      (i.e., 2,1,4,3)
Select printing order: 3,2,1
    
```

Figure 2-21: Charge Print Order Screen displays anesthesia units as minutes

2.6 Dental Operative Site

Corrections were made to the 837D (ADA) 5010 and the ADA-2012 to ensure that the Operative Site populates correctly. If the Operative Site on an approved claim consists of one number, a leading zero will be added to the TOO02 segment of the 837D and to box 27 of the ADA-2012. If the Operative Site on an approved claim consists of one letter, a leading space will be added to box 27 of the ADA-2012.

```

SV3*AD:D1351*62.00*****1~
TOO*JP*06~
REF*6R*000000006131330001~
LX*2~
SV3*AD:D1351*62.00*****1~
TOO*JP*E~
REF*6R*000000006131330002~
    
```

Figure 2-22: TOO02 segment of the 837D

RECORD OF SERVICES PROVIDED										
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	06/01/2019			06		D1351	A	1	SEALANT - PER TOOTH	\$62.00
2	06/01/2019			E		D1351	A	1	SEALANT - PER TOOTH	\$62.00
3										

Figure 2-23: Box 27 of the ADA-2012

2.7 California Medicaid

Changes were made for the O/P Medi-Cal payer (California Medicaid) to ensure that a revenue code and the number of units populate on each line item for the 837I (UB) 5010 and the UB-04 when billing an all-inclusive charge with at least one informational charge. When the claim is exported or printed, the revenue code on the all-inclusive charge will be applied to the informational charge(s). These changes were added to comply with the October 1, 2017 Medi-Cal claim form modifications referenced in the following:

[Medi-Cal FQHC/RHC/IHS/MOA Code Conversion](https://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaaqa_fqhc-rhc-and-ihs-moa_code_conversions.asp)

(https://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaaqa_fqhc-rhc-and-ihs-moa_code_conversions.asp)

To use this functionality, the following set-up must be completed in the 3P Insurer file (TMTP > INTM > EDIN):

- AO Control Number must contain 61044
- All Inclusive Mode is set to Yes
- Visit Type
 - Procedure Coding is set to CPT
 - A fee schedule is specified that contains T1015 at the all-inclusive rate with all other fees set to zero. This means a “Zero-Fee Schedule” was uploaded.
 - Add Zero Fees is set to Yes
 - Mode of Export is set to 837I (UB) 5010 or UB-04
 - Itemized UB is set to Yes
 - Display Print Order Screen in Claim Editor is set to Yes
 - Default Revenue Code and Default Revenue Description fields are populated
 - Default CPT Code field is blank
 - A default all-inclusive dollar amount is not specified

The examples below in Figure 2-24 and Figure 2-25 are snippets of what the setup should look like. Some of the fields in these examples will be populated differently at each facility, such as the Visit Type, Fee Schedule number, Revenue Code, and Revenue Code Description. All other data must be populated or left blank, as listed above.

```

Contact Person.....:
Federal Tax ID#.....:
AO Control Number...: 61044//
Insurer Status.....: BILLABLE//
All Inclusive Mode.: YES//
For All Inclusive print the NDC:
    
```

Figure 2-24: Required fields in the 3P Insurer file

```

Visit      Mode of      Mult Fee      ----- Flat Rate -----
Type - Description      Export      Form Sched      Start      Stop      Rate
=====
131  OUTPATIENT      837I (UB) 5010 NO      20      01/01/2018 12/31/2018 427.00

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

Billable (Y/N/E).....: YES//
Reporting purposes only:
Do you want to replace with another insurer/visit type?
Start Billing Date (create no claims with visit date before)...:
Procedure Coding.....: CPT//
Fee Schedule.....: 20//
Add Zero Fees?...: YES//
Multiple Forms?.....:
Payer Assigned Provider Number.....: XCMM00004//
EMC Submitter ID #...:
EMC Reference ID.....:
Auto Approve?.....: NO//
Mode of Export.....: 837I (UB) 5010//
Billing Prv Taxonomy:
Relationship Code?:
Itemized UB?.....: YES//
UB-04 Form Locator 38:
ICD PX on Claim?:
Print meds on 2 lines?:
UB-04 Block 44 Blank?:
Display Print Order Screen in Claim Editor?: YES//
RX# IN FL44?.....:
Contract Code Req'd? N// O
Service Facility Location:
SUBPART NPI:
DME Contractor?.....:
Revenue Code.....: 510//
Revenue Description.: OUTPATIENT CLINIC//
Bill Type.....: 131//
CPT Code.....:
    
```

Figure 2-25: Required fields in Visit Type

Claims generated for the specified Visit Type will need to be edited in the EDCL option as usual. When the claim is approved, the Charge Print Order Screen will display. The order in which charges populate in the 837I or on the UB-04 must be specified here.

```

          * * * CHARGE PRINT ORDER SCREEN * * *

Complete list of charges on claim for O/P MEDI-CAL 9:
    
```

Revenue Code	Description	Serv PG Code	DOS	Units	Total Charges
1. 300	LAB	8F 87490	07/02/19	2	\$ 0.00
2. 370	ANESTHESIA	8 00100	07/02/19	60*	\$ 0.00
3. 510	CLINIC	8H T1015	07/02/19	1	\$ 220.00
4. 720	DELIVERY R	8H T1015	07/02/19	1	\$ 220.00
5. 960	PRO FEE	8B 10120	07/02/19	2	\$ 0.00
6. 960	PRO FEE	8A 99349	07/02/19	1	\$ 0.00

NOTE: all lines must be included in the printing order and separated by commas.
(i.e., 2,1,4,3)

Select printing order: 3,5,2,4,6,1

Figure 2-26: Charge Print Order Screen in EDCL option

If the charge print order has been correctly specified (all-inclusive charges followed by informational charges) the claim output for the 837I and the UB-04 will be as follows:

- All-inclusive charge will print first and will use the revenue code that was approved on the claim.
- Informational charge will print next and will use the revenue code of the all-inclusive charge.
- Additional all-inclusive charge, if present, will print next and will use the revenue code that was approved on the claim.
- Additional informational charges, if present, will print next and will use the revenue code of the second all-inclusive charge.

```

SV2*0510*HC:T1015*220.00*UN*1~
DTP*472*D8*20190702~
REF*6R*000000006129430001~
LX*2~
SV2*0510*HC:10120**UN*2~
DTP*472*D8*20190702~
REF*6R*000000006129210001~
LX*3~
SV2*0510*HC:00100**UN*1~
DTP*472*D8*20190702~
REF*6R*000000006129390001~
LX*4~
SV2*0720*HC:T1015*220.00*UN*1~
DTP*472*D8*20190702~
REF*6R*000000006129430002~
LX*5~
SV2*0720*HC:99349**UN*1~
DTP*472*D8*20190702~
REF*6R*000000006129270001~
LX*6~

```

```
SV2*0720*HC:87490**UN*2~
DTP*472*D8*20190702~
REF*6R*000000006129370001~
```

Figure 2-27: 837I claim output with two all-inclusive rate charges

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0510	OUTPATIENT CLINIC	T1015	070219	1	22000		1
2 0510		10120	070219	1	000		2
3 0510		00100	070219	1	000		3
4 0720	OUTPATIENT CLINIC	T1015	070219	1	22000		4
5 0720		99349	070219	1	000		5
6 0720		87490	070219	1	000		6

Figure 2-28: UB-04 claim output with two all-inclusive rate charges

2.8 CPT/HCPCS Modifications

The way that the CPT file is updated has changed over the past several years. This change eventually led to duplicate entries in the CPT file, which also led to some issues in Third Party Billing. Patch 29 changes the way Third Party Billing uses the CPT file to address some of these issues. For the most part, users will not see these changes because they happen behind the scenes. The most obvious change will be seen in several Table Maintenance options and in the EXCLUSION PARAMETERS for several Report Menu options.

Prior to patch 29, if a site's CPT file contained duplicate entries for a CPT/HCPCS code and that code was entered in certain Table Maintenance or Report Menu options, numerous entries for the code would display for users to select. Users had no way of knowing which entry to select. Now, in patch 29, when a duplicate CPT/HCPCS code is selected, the system will only display the Active entry.

The Table Maintenance menu options affected are as follows:

- Print CPT Procedure File (TMTP > CPTM > LSCP)
- Inquire to CPT File (TMTP > CPTM > IQCP)
- CPT File Maintenance (TMTP > CPTM > MNCP)
- NOC NEC Required for 5010 submissions (TMTP > NARR)

The Reports Menu options affected are as follows:

- Employee Productivity Report (RPTP > PRRP)
- Bills Listing (RPTP > BLRP)
- Statistical Billed-Payment Report (RPTP > STRP)
- Billing Activity for a Specific Patient (RPTP > PTRP)
- Listing of Billed Primary Diagnosis (RPTP > DXRP)
- Listing of Billed Procedures (RPTP > PXRPP)

Prior to patch 29, when a duplicate CPT/HCPCS code was entered in any of those options, every entry for that CPT/HCPCS code displayed.

```

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

Select one of the following:

1          LOCATION
2          BILLING ENTITY
3          DATE RANGE
4          APPROVING OFFICIAL
5          PROVIDER
6          ELIGIBILITY STATUS
7          DIAGNOSIS RANGE
8          CPT RANGE
9          REPORT TYPE

Select ONE or MORE of the above EXCLUSION PARAMETERS: 8  CPT RANGE

ENTRY of CPT PROCEDURE RANGE:
=====
Low CPT Code: 99349
1  99349  HOME VISIT EST PATIENT
      HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH
REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A
2  99349  HOME VISIT EST PATIENT
      HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH
REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A
3  99349  HOME VISIT EST PATIENT
      HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH
REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A
4  99349  HOME VISIT EST PATIENT
      HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH
REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A
5  99349  HOME VISIT EST PATIENT
      HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH
REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5:

```

Figure 2-29: Duplicate CPT codes displayed prior to patch 29

Patch 29 will only display the Active entry from the CPT file. For the Reports Menu options, if there is any data to be reported for a duplicate CPT/HCPCS code that is Inactive, that data will be combined with the data for the Active entry and displayed on the report as one entry.

```

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

Select one of the following:

1          LOCATION
2          BILLING ENTITY
3          DATE RANGE

```

```
4      APPROVING OFFICIAL
5      PROVIDER
6      ELIGIBILITY STATUS
7      DIAGNOSIS RANGE
8      CPT RANGE
9      REPORT TYPE

Select ONE or MORE of the above EXCLUSION PARAMETERS: 8  CPT RANGE

ENTRY of CPT PROCEDURE RANGE:
=====
Low CPT Code: 99349
High CPT Code: 99349
```

Figure 2-30: Active entry being displayed in patch 29

Acronym List

Acronym	Meaning
3P	Third Party
ADA	American Dental Association
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid
CPT	Current Procedural Terminology
E&M	Evaluation and Management
EDCL	Edit Claim Data
EDFE	Fee Schedule Maintenance
EDTP	Add/Edit Claim Menu
EXPR	Print Approved Bills
FI	Fiscal Intermediary
HCFA	Health Care Financing Administration
HCPCS	Healthcare Common Procedural Coding
IEN	Internal Entry Number
LSFE	Print Fee Schedule Listing
MAC	Medicare Administrative Contractor (replaces "FI")
REPR	Reprint Bill
RPMS	Resource and Patient Management System
SITM	Site Parameter Maintenance
TLCP	Lab CPT/HCPCS Requiring Test Results & CLIA
TMTM	Table Maintenance Menu
TPB	Third Party Billing
UB	Uniform Billing

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