RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 30
April 2020

Office of Information Technology
Division 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.

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

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

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1.0 Introduction

1.1 Summary of Changes

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

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

1.1.1 Patch 30

1. Change Request 8338 – HEAT 287500

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

2. Change Request 8717 – HEAT 277665

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

3. Change Request 8868 – HEAT 308002

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

4. Change Request 8870 – HEAT 308891

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

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

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

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

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

7. Change Request 8939 – HEAT 310003

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

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

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

9. Change Request 9115 – HEAT 341586

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

10. Change Request 9263 – NO HEAT TICKET

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

11. Change Request 9457 – HEAT 352796

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

12. Change Request 9872 – NO HEAT TICKET

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

13. Change Request 10215 – HEAT 392914

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

14. Change Request 10400 – HEAT 326962

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

15. Change Request 11053 – HEAT 470230

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

16. Change Request 11171 – HEAT 479351

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

2.0 Patch 30

2.1 Claim Editor

2.1.1 Units and Charge Fields Expanded

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

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

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

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

     REVN                                                UNIT             TOTAL
     CODE      HCPCS - AMBULANCE SERVICES               CHARGE    QTY    CHARGE
     ==== ========================================== ======== ======= ==========
[1]  CHARGE DATE: 02/22/2020
      540 A0021-RH-25-27 Outside state ambulance      500.00  1.585       792.50
                serv
                                                                  ==============
                                                                         $792.50

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

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

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

```
                    ***** 837P (HCFA) 5010 CHARGE SUMMARY *****

Active Insurer: NEW MEXICO BC/BS INC

* - Indicates time (minutes) instead of units

                                                Corr
 Charge Date     POS TOS  Description           Diag         Charge       Qty
-------------------------------------------------------------------------------
12-12-19 12-12-19 22  2  12001                 1,2             518.54    1.035
12-12-19 12-12-19 22  1  99215-25-27-57      1,2,4,5           761.13    1.589
12-12-19 12-12-19 22  4  74022-76               2             503.53    2.258
12-12-19 12-12-19 22  7  00140                  2             100.00       60*
12-12-19 12-12-19 22     R&B                                    39.73    1.589
12-12-19 12-12-19 22  1  J7030                  4             106.56     3.33
12-12-19 12-12-19 22  9  90807                  5              26.45    1.058
                                                           -----------
          TOTAL CHARGE                                      2,055.94
```

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

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

Active Insurer: NEW MEXICO MEDICAID

                             Revn                  Total
            Description      Code       Units      Charges
-------------------------------------------------------------------------------
AMBULANCE           |        0540       3.435         1,255.00
                                                    -------------
          TOTAL CHARGE        0001                      1,255.00
```

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

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

```
LX*1~
SV3*AD:D1351:25:26:27*65.60****1.058*****1~
TOO*JP*R~
REF*6R*000000006179330001~
```

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

```
LX*1~
SV2*0540*HC:A0021:RH:25:27*792.50*UN*1.585~
DTP*472*D8*20191122~
REF*6R*000000006129470001~
LX*2~
SV2*0540*HC:A0130:HE:25:27*462.50*UN*1.85~
DTP*472*D8*20191122~
REF*6R*000000006129470002~
```

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

```
LX*1~
SV1*HC:12001*518.54*UN*1.035***1:2~
DTP*472*D8*20191212~
REF*6R*000000006174210001~
LX*2~
SV1*HC:99212*39.73*UN*1.589~
DTP*472*D8*20191212~
REF*6R*000000006174250001~
LX*3~
```

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

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

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

                             2017 DEMO HOSPITAL

                            STATEMENT OF SERVICES


    DATE   : 03/25/2020                     PATIENT,DEMO
    CHART #: 111111                         550 HOMESTEAD DRIVE
    REF #  : 123456A                        ANYTOWN, NM  87000

-------------------------------------------------------------------------------
===============================================================================
|PATIENT NAME: PATIENT,DEMO           |SERVICE DATE: 12/12/2019   |PAGE: 001|
-------------------------------------------------------------------------------
|VISIT TYPE: OUTPATIENT               |ATTENDING PHYSICIAN: DOCTOR,DEMO|
===============================================================================
|SERVICE |SERVICE  |                                    |       |             |
|DATE    |CODE     |DESCRIPTION                         |  QTY  |   AMOUNT    |
|--------|---------|------------------------------------|-------|-------------|
|12/12/19|    12001|RPR S/N/AX/GEN/TRNK 2.5CM/<         | 1.035 |       518.54|
|12/12/19|      510|CLINIC                              | 1.589 |        39.73|
|12/12/19|    99215|OFFICE/OUTPATIENT VISIT EST         | 1.589 |       761.13|
|12/12/19|    74022|X-RAY EXAM SERIES ABDOMEN           | 2.258 |       503.53|
|12/12/19|    00140|ANESTH PROCEDURES ON EYE            |     1 |       100.00|
|12/12/19|    J7030|Normal saline solution infus        |  3.33 |       106.56|
|12/12/19|    90807|PSYTX OFF 45-50 MIN W/E&M           | 1.058 |        26.45|
|        |         |                                    |       |=============|
|        |         |                        TOTAL CHARGES|       |     2,055.94|
|        |         |                                    |       |             |
|        |         |                                    |       |             |
|        |         |                                    |       |             |
|        |         |                                    |       |             |
|        |         |                                    |       |             |
|        |         |                                    |       |             |
|        |         |                                    |       |             |
|        |         |                                    |       |             |
-------------------------------------------------------------------------------
Your coverage on file is:
1. NEW MEXICO BC/BS INC                                      Eff: 01/01/2018
2. MHBP                                                      Eff: 01/01/2019
```

```
 ------------------------------------------------------------------------------
 |Your insurance has been billed (03/25/2020)                                  |
 ------------------------------------------------------------------------------
 Payments or inquiries may be sent to:            2017 DEMO HOSPITAL
                                                  5300 HOMESTEAD NE
                                                  ALBUQUERQUE, NM  87110

                                                  5052481111
```

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

2.1.2 Diagnosis Code Display

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

```
-----------------------------        V POV       -----------------------------
POV: 518.81                             PATIENT NAME:
  VISIT: FEB 15, 2011@12:03             PROVIDER NARRATIVE: RESP FAILURE
  FIRST/REVISIT: REVISIT                PRIMARY/SECONDARY: PRIMARY
  PRESENT ON ADMISSION?: YES
  ICD NARRATIVE (c): ACUTE RESPIRATORY FAILURE
POV: 415.12                             PATIENT NAME:
  VISIT: FEB 15, 2011@12:03             PROVIDER NARRATIVE: PE
  FIRST/REVISIT: REVISIT                PRIMARY/SECONDARY: SECONDARY
  PRESENT ON ADMISSION?: YES
  ICD NARRATIVE (c): SEPTIC PULMONARY EMBOLSM
```

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

2.1.3 New 3P ERROR Codes

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

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

  This code will display on page 4 of the claim editor when the claim is missing an attending and/or rendering provider.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 4  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,DEMO  [HRN:111111]                      Claim Number: 123456
.............................. (PROVIDER DATA) ..............................

                PROVIDER                NPI                DISCIPLINE
        ========================  ============  ==============================
```

```
--------------------------------------------------------------------------------
  ERROR:092 - ATTENDING PROVIDER UNSPECIFIED
  ERROR:244 - No Providers on claim
  ERROR:256 - ATTENDING AND/OR RENDERING PROVIDER MISSING
--------------------------------------------------------------------------------
```

Figure 2-9: Example of code 256 displayed on page 4 of the claim editor

- **Code 257** was added to the 3P ERROR CODE file to alert users when a Discharge Status has been selected that contains the word 'expired' for claims that have an export mode of 837I or UB-04. Code 257 will display the following: Discharge Status contains 'Expired'. By default, this code will be reflected as a warning upon patch installation but may be changed to an error, if desired.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,DEMO  [HRN:111111]                      Claim Number: 123458
.............................. (QUESTIONS) ..............................

 [1] Release of Information..: YES
 [2] Assignment of Benefits..: YES
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.:
 [6] Special Program.........: NO
 [7] Blood Furnished.(pints).: NO
 [8] Referring Phys. (FL17)  :
 [9] Case No. (External ID)..:
[10] PRO Approval Number.....:
[11] Type of Admission.......:  2  URGENT
[12] Source of Admission.....:  2  CLINIC OR PHYSICIAN'S OFFICE
[13] Discharge Status........: 20  EXPIRED (DID NOT RECOVER)
[14] Admitting Diagnosis.....: E11.9  Type 2 diabetes mellitus without complicat
ions
[15] Prior Authorization #...:
[16] Delayed Reason Code.....:
--------------------------------------------------------------------------------
WARNING:257 - Discharge Status contains 'Expired'
--------------------------------------------------------------------------------
```

Figure 2-10: Example of error code 257 displayed on page 3 for Expired Discharge Status

2.1.4 Default Removed from Discharge Status

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

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

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,DEMO  [HRN:111111]                      Claim Number: 123456
```

```
.............................. (QUESTIONS) ..............................

 [1] Release of Information..: YES
 [2] Assignment of Benefits..: YES
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.:
 [6] Special Program.........: NO
 [7] Blood Furnished.(pints).: NO
 [8] Referring Phys. (FL17)  :
 [9] Case No. (External ID)..:
[10] PRO Approval Number.....:
[11] Type of Admission.......:  2  URGENT
[12] Source of Admission.....:  2  CLINIC OR PHYSICIAN'S OFFICE
[13] Discharge Status........:
[14] Admitting Diagnosis.....: E11.9  Type 2 diabetes mellitus without complicat
ions
[15] Prior Authorization #...:
[16] Delayed Reason Code.....:
------------------------------------------------------------------------------
  ERROR:021 - PATIENT (DISCHARGE) STATUS UNSPECIFIED
------------------------------------------------------------------------
```

Figure 2-11: Example of Error Code 021 displayed on page 3 when Discharge Status is blank

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

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

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

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

Figure 2-12: Page 3 View option for a Hospitalization claim

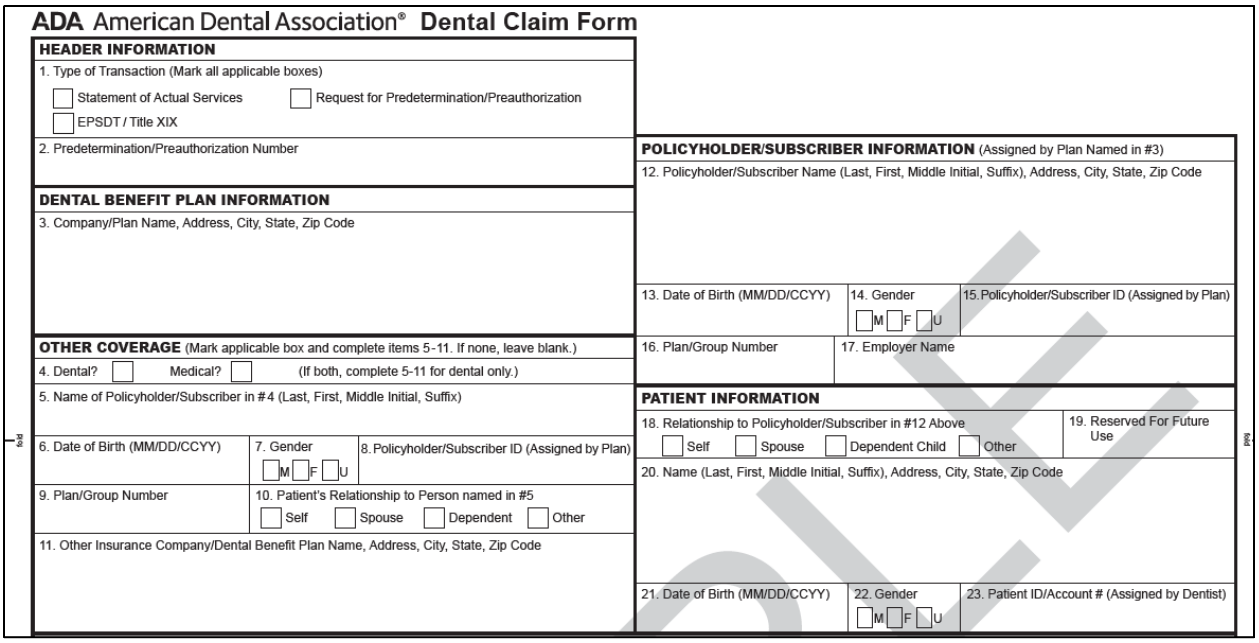
For emergency medicine claims, users will see the V EMERGENCY VISIT RECORD file. This file contains the DISPOSITION OF CARE, if populated on the visit in PCC.

```
--------------------------V EMERGENCY VISIT RECORD--------------------------
FORM ID: IHS-114 ER                     PATIENT NAME: DEMO,PATIENT
  VISIT: DEC 10, 2019@10:00             INITIAL ACUITY: URGENT (3)
  MEANS OF ARRIVAL: AMBULANCE           ENTERED ER BY: AMBULATORY
  DISPOSITION OF CARE: ADMIT            CONDITION ON DEPARTURE: WALKED OUT
-------------------------------------------------------------------------------
```

Figure 2-13: Page 3 view option on an emergency medicine claim

2.2 ADA-2019

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


ADA American Dental Association® Dental Claim Form

HEADER INFORMATION
1. Type of Transaction (Mark all applicable boxes)
Statement of Actual Services
Request for Predetermination/Preauthorization
EPSDT / Title XIX
2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)
4. Dental? Medical? (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender M F U
8. Policyholder/Subscriber ID (Assigned by Plan)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender M F U
15. Policyholder/Subscriber ID (Assigned by Plan)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION
18. Relationship to Policyholder/Subscriber in #12 Above Self Spouse Dependent Child Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender M F U
23. Patient ID/Account # (Assigned by Dentist)

Figure 2-14: Example of ADA-2019 boxes 7, 14, and 22

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

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p30          |
           +                     Reprint Bill                        +
           |                  2017 DEMO HOSPITAL                     |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,SUPER                    22-JAN-2020 4:19 PM

Re-Print Bills for:

     Select one of the following:

          1         SELECTIVE BILL(S)
          2         ALL BILLS FOR AN EXPORT BATCH
```

```
          3         UNPAID BILLS

Select Desired Option: 1  SELECTIVE BILL(S)

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

Select 2nd BILL to Re-Print:

     Select one of the following:

          29        ADA-2006
          34        ADA-2012
          36        ADA-2019

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

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

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

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p30          |
           +                 Form Locator Override                   +
           |                   2017 DEMO HOSPITAL                    |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,SUPER                       7-APR-2020 6:44 PM

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

Select 3P EXPORT MODE FORMAT: ??

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

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

     Select one of the following:

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

```
Select Form Locator:
```

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

Acronym List

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

Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS IT Service Desk.

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