



RESOURCE AND PATIENT MANAGEMENT SYSTEM

# **Third Party Billing**

(ABM)

## **Addendum to User Manual**

Version 2.6 Patch 31  
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## Preface

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

References to “Change Requests,” “HEAT,” and “Service Now” (or SNOW) will be seen throughout the document. A Change Request is a request for modifications in any part of the service and refers to the detailed information about the change, including the reason for the change, the priority, and the type of change. HEAT and Service Now is the software used to document and track issues reported from the end-user. The issue is prioritized for development by the Technical Advisory Group (TAG).

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 31 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 and processes regarding billing.

#### 1.1.1 Patch 31

1. Change Request 8833 – HEAT157329 – Reported by Karuk Tribal Health

Corrections have been made to the ADA-2012 and the ADA-2019 paper claim forms to print the correct policy holder information in the *Other Coverage* section (Boxes 4 through 11) when the patient has multiple insurers. When the primary insurer is billed, the secondary policy information will print in *Other Coverage*. When the secondary insurer is billed, the primary policy information will print in *Other Coverage*. When the tertiary insurer is billed, the secondary policy information will print in *Other Coverage*.

2. Change Request 8848 – HEAT296936 – Reported by Whiteriver Indian Hospital

Changes were made to the 837 claim formats to use the Date of Birth of the policy holder from the Railroad Retirement Eligible file. The claims were using the Date of Birth from the patient file and not the eligibility file.

The Gender field will also be used from the eligibility file for Medicare, Medicaid and Railroad Retirement and not from the Patient file.

The Other Subscriber Name in Loop 2330A will now be used from the eligibility file the insurer is stored in. Prior to this patch, the system was displaying the Other Subscriber from the active insurer on the bill.

The Patient Name and Patient Date of Birth have been updated on both the UB-04 (FL8b and FL10) and the CMS-1500 (Version 02/12) (FL2 and FL3) to print from the Patient file all the time, not from the Medicaid Eligible or the Medicare Eligible files.

3. Change Request 8851 – HEAT182553 – Reported by Karuk Tribal Health and Lake County Tribal Health

The California Area sites reported that a newborn covered under Medi-Cal may use the mother's information as the policy holder for initial eligibility. This would require the mother of the newborn to be added as the policy holder for the patient's Medicaid eligibility. A change was made so that if the RELATIONSHIP TO INSURED field is populated in the Medicaid Eligible file, the claim forms will use the policy holder which may not be the patient. This affects Loops 2000C and 2010CA in the electronic 837 file format.

4. Change Request 8881 – HEAT330106 – Reported by Yakama Health Center

A change was made to Page 3 of the Claim Editor to allow the entry of Referring Provider to populate certain fields if the provider contains an entry in the New Person file in RPMS. Duplicate CMS-1500, Form Locator 17 fields existed on Page 3 and were used for both the paper and electronic claim formats. The duplicate questions have been merged together.

5. Change Request 8903 – HEAT273949 – Reported by Yellowhawk Health Center

Updated the Claim Generator to make Service Category Telecommunications (Code: T) unbillable. Changes were also made to allow Telecommunications to be billable in Site Parameters with OIT assistance. If billable, the system will require this type of visit to be reviewed and completed in the Coding Queue prior to the Claim Generator creating the claim.

6. Change Request 8944 – HEAT322631 – Reported by Browning Indian Hospital

Multiple corrections have been made to Coordination of Benefits (COB) billing within the Claim Editor and on the electronic claim forms to include:

- Updated the transaction display in the COB Page (Page A) of the Claim Editor to only reflect the transactions of the previously billed payer rather than all processed payers if billing the tertiary (or higher sequenced) insurer.
- Fixed the display of transactions to not merge together on the bill which would incorrectly report the prior payment/adjustment amounts for each billed payer.
- Corrected an error that would halt the user out of the system if the same Standard Adjustment Reason (SAR) code was used by different payers when approving a tertiary or higher COB sequenced type of claim.

7. Change Request 10027, 10064 and 10381 – HEAT375548, HEAT382452, and HEAT413046 – Reported by multiple facilities

Updated the Place of Service codes with the latest code set in the 3P Codes file.

8. Change Request 10044 – HEAT292652 – Reported by Sells Indian Hospital

Updated Page 3 of the Claim Editor to display the following warnings/errors:

- 17 – Admission Type Unspecified
- 18 – Admission Source Unspecified
- 21 – Patient (Discharge) Status Unspecified

Prior to Patch 31, the system would not display the errors/warnings especially if the visit occurred at an outside location for services where the inpatient physician services were to be billed on a UB-04 at an outside hospital location. The errors/warnings would only display on Page 7 – Inpatient Data but this fix allows the errors to display on Page 3 – Questions.

9. Change Request 10340 – HEAT403358 – Reported by Northern Navajo Medical Center

A form locator modification has been made to the paper UB-04, Form Locator 54 (Prior Payments) to correctly align the prior payment amount. Prior to Patch 31, the amount was off by one character.

10. Change Request 10341 – HEAT404592 – Reported by Lake County Tribal Health and by the Office of Resource, Access and Partnership (ORAP)

New Pended Claim Status reasons have been added to the Claim Editor. One new reason has been added for business offices waiting on COVID-19 guidance for billing.

11. Change Request 10351 – HEAT378627 – Reported by Claremore Indian Hospital and Pawnee Indian Health Center

Form locator modifications have been made to the paper ADA-2012 and ADA-2019, Form Locator 50 and 55 (License Number) to remove the printing of the of dash (-) between the State code and the license number. The fields were also expanded to print 12 characters in Form Locator 50 and in Form Locator 55.

12. Change Request 10374 – HEAT178385, HEAT347723, HEAT367419, and HEAT383907 – Reported by multiple facilities

Multiple modifications have been made to accommodate electronic billing to payers, specifically, secondary and tertiary billing.

- Added the AMT\*EAF Remaining Patient Liability which will contain the sum of deductibles and copays/coinsurances for each prior billed payer.
- Added the CAS\*CO segment to the 837 Institutional claim format. This segment reports the adjustments processed by the prior payer. Prior to this patch, the 837 files were only reporting the CAS\*OA segment which indicated that an Other Adjustment was being reported.

- Updated Claim Adjustment Reason Codes (CARC) or the Standard Adjustment Reason (SAR) code to correctly classify reason codes belonging to the Contract Obligations (CO) category within the Claim Adjustment Group Code element on the 837 electronic claim formats.
- Corrected the Claim Adjustment Group Code that reports the adjustments made when billing Medicare after the Tribal Self-Insured plan. The Part A adjustment was being reported incorrectly.

13. Change Request 10421 – HEAT420572 – Reported by Zuni Indian Hospital

Correction to the error where the user was being exited from the system where an immunization lot batch number was added into the Claim Editor that contained the letter ‘E’ at the beginning of the lot number. The system was interpreting the ‘E’ as scientific notation and exiting the user with the following error:

```
<MAXNUM>43+25^ABMERGR6.
```

14. Change Request 10857 – HEAT448687, HEAT444380, HEAT445896, HEAT455608 and HEAT456711 – Reported by multiple facilities

Problems that were reported by users in the field regarding how CPT codes were displaying in the Claim Editor and other menu options have been addressed.

Some of the reported issues that have been fixed include:

- The user would occasionally see a CPT description of NO SUCH ENTRY while editing a claim. This was due to how the entry was stored in the CPT file during the CPT updates. This issue has been corrected.
- Corrected the Surgical Page (Page 8B) in the Claim Editor to allow the entry of active CPT codes rather than allowing inactive codes to be selected.
- Corrected the View CPT Fee (VWFE) option to allow the user to view all fee entries for a selected CPT code. The issue mainly affected the 9068\* codes and would display two question marks (??) to the user. If the user typed two question marks (??) at the “CPT” prompt the system was not displaying the correct charge. This has been corrected.
- Corrected the Fee Schedule Maintenance (EDFE) option to allow the HCPCS code to update the HCPCS Fees category. Prior to Patch 31, the system would allow certain HCPCS to update in the Medical Fees Category.
- Updated the Inquire to CPT (IQCP) option to display the CPT internal entry number (IEN) when inquiring about a CPT code.

15. Change Request 11063 – HEAT466377 – Reported by Winslow Indian Health Care Center

Corrections have been made to Page A - Coordination of Benefits Page (COB) in the Claim Editor to correctly report payment and adjustment transactions for patients that are being billed under the main parent facility but do not have a chart at that facility. The scenario behind this is that patient was seen at an outside location that is not an official registering facility so the patient does not have a chart number to append to the bill number. This was causing confusion for the claim in looking up prior payments or adjustments.

#### 16. Change Request 11077

A fix has been provided to the Print Fee Schedule Listing (LSFE) where a fee that was uploaded with a Professional and a Technical fee but no Global fee entry was exiting the user from the system with the following error: <SUBSCR>RANGE+44^ABMFEAPI. The option was not displaying the CPT Short Description all the time and has been corrected.

This fix also corrected the View CPT Fee (VWFE) option where the system was exiting the user if the Global fee was missing from the fee table. The user was exited with the following error: <UNDEF>S+15^DIC3.

#### 17. Change Request 11216

Modified the Import Foreign Fee Schedule (FIFE) option to store the correct version of the CPT code when populating the fee schedule. Prior to Patch 31, the system would store the first entry it would locate, which may not be an active or valid code. This resulted in the system not populating the Claim Editor with a CPT entry or with the correct CPT code.

#### 18. Change Request 11218

Updated the Print Patient Statement (REPT) option to display the short description of the CPT code on the printed statement. The same short description will also be sent to the Accounts Receivable system to update the Bill File. This issue was caused by multiple entries of the same CPT code and the system was only picking the description for the first entry found, regardless of the status of the CPT or if it were an invalid code.

This fix also includes the printing of the short description for Category III CPT codes.

#### 19. Change Request 11223

A correction to the CPT API call was added. If the CPT code was stored in the CPT file multiple times, or when the CPT is passed and there is an IEN that is the same as the CPT, the Claim Editor was not receiving the correct CPT entry.

#### 20. Change Request 11226

The Print CPT Procedure File (LSCP) option was updated to print more accurate data when the user does not add sufficient exclusion parameters to print the report. The erroneous data on the report was due to the user typing <spacebar><enter> at either the Start with CPT Code or Finish with CPT Code prompts. This caused a '-1' to print in the report header and the data to not be consistent on the printed report.

#### 21. Change Request 11624

A fix was added to the Claim Editor that would exit the user from the system if the user was adding or editing a CPT code entry that contained one or more entries in the CPT File. The logic to check for the CPT code entry updated to prevent the following error from occurring: <SUBSCR>VLTCP+8^ICPTCOD.

#### 22. Change Request 11832

A Change Request was created to aid in billing for COVID-19 related services. These changes are meant to help the billing technician identify the type of visits and to allow the Claim Generator to properly process certain telehealth services.

- Updated Page 0 – Claim Summary in the Claim Editor to include the PCC Visit data on the bottom left portion of the screen. This also resulted in the display of data in the Page 3-Questions portion to shift to the upper right section of the screen.
- Visits that have been coded with a Service Category of Telemedicine (Code: M) will have the Admission Type populate with a value of '2' (Urgent) and the Admission Source populate with a value of '1' (Non-Health Care Facility Point of Origin). Prior to this patch, the system would leave the aforementioned fields blank.
- A new field was added to the 3P Visit Type file labeled Hospital Location. This field is to be used in conjunction with the Clinic Stop value stored in the Visit Type file to allow for more accurate claim generation. When populated, the new field will be used by the Claim Generator to determine the Visit Type of the claim. With this patch it will now try to match the Hospital Location and Clinic for the visit type. If it cannot find a match that way, it will try matching on just the Hospital Location. If a match is not found, it will check for the clinic stop code. The Visit Type must be added into the Insurer file and will use the first match it finds by checking the visit types in numerical order.

#### 23. Change Request 11834 – Reported by multiple facilities

Changes have been made to the Pending Claims Status Report (PCRSP) to allow for the display of data by the date the claim was pended. This is new functionality for the report. Additional logic changes have been made to improve the processing time it takes to print the report.

## 2.0 Patch 31

### 2.1 COVID-19 Billing Modifications

Changes have been made to accommodate for more telehealth services the I/T/Us are providing. Telehealth services range from drive through services, telephone-only visits, and Audio/Visual-type visits.

The challenge for the biller is to determine the type of visit that needs to be billed, such as billing for an E-Visit, Telephone Call, Audio/Visual, etc. The updates to the application should help the biller determine the Visit Type used to classify the claim.

#### 2.1.1 Telecommunications Service Category

Prior to Patch 31, the Claim Generator in Third Party Billing would generate claims for the Telecommunications (Code: T) Service Category without being reviewed by coding. Visits would also generate even if the Coding Que status was not present. The installation of Patch 31 will stop the generation of the Telecommunication visits and will set existing claims to an **Unbillable** claims status.

**Note:** Telephone visits such as appointment reminders and non-visit related services are not considered workload reportable and are not billable. These visits are coded using the Telecommunication (T) Service Category. Consult with your coding staff for additional guidance.

Sites that have been using Telecommunications should consider using an appropriate Service Category to classify the visit. A temporary option has been added to Third Party Billing and is accessible via FileMan which allows the visit to process through the Coding Que. The visit must be reviewed and completed prior to the Claim Generator creating a claim in Third Party Billing. Contact the IT Service Desk by using the tiered system of support for assistance with setting up this temporary option.

#### 2.1.2 Admission Type and Admission Source

Services that generated a claim and were billed on a UB-04 or 837 Institutional format for Telemedicine (Code: M) was not populating the Admission Type or the Admission Source. Patch 31 updates the claim to populate the Admission Type using 2 – Urgent as the Type and updates the Admission Source with 1 – Non-healthcare facility point of origin.

Although this change will aide in defaulting the Admission Type and Admission Source, the billing technician will need to ensure these codes are valid for the services provided.

### 2.1.3 Hospital Location in the Visit Type File

The Hospital Location has been added as a field in the 3P Visit Type file. This new option allows the billing manager to set up a Visit Type with a scheduled clinic entry. Adding the scheduled clinic along with populating the Visit Type into the Insurer File allows the Claim Generator to generate the claim automatically to the Visit Type the clinic was added to. This change will help to better categorize the claims generated on the Brief Claim Listing (BRRP).

An example of a scheduled visit would be:

Table 2-1: Example of Scheduled Visits and Results of Claim Generation

| Clinic (Scheduling Package) | Clinic Stop Code     | Service Category | Visit Type            | If added to the Insurer File, claim generates with | If not added to the Insurer File, claim generates with |
|-----------------------------|----------------------|------------------|-----------------------|--|--|
| Virtual Check-In            | General (01)         | Telemedicine (M) | Virtual Check-in      | Virtual Check-In                                   | Outpatient   |
| E-Visit BH                  | Online Services (D7) | Telemedicine (M) | Mental Health E-Visit | Mental Health E-Visit                              | Outpatient   |

To update the Hospital Location (or Scheduled Clinic) within the Visit Type, add the entry to the 3P Visit Type file in Table Maintenance (**3PB > TMTP > VITM**).

See Appendix B for a matrix to help with setting up the scheduled clinic to link to the visit type.

## 2.2 Claim Editor

### 2.2.1 Page 0 – Claim Summary Page

Changes have been made to the Claim Editor, Page 0 – Claim Summary Page, to display PCC Visit Data. The purpose of these changes is the allow the billing technician the ability to see where the patient was checked in to. The scheduled clinic is what displays as the Hospital Location and may provide clues as to the type of visit the patient was seen for.

```

~~~~~ PAGE 0 ~~~~~
Patient: COFFEE,LEON [HRN:113116] Claim Number: 402657
..... (CLAIM SUMMARY) .....
Pg-1 (Claim Identifiers) | Pg-3 (Questions)
Location..: 2017 DEMO | Release Info: YES Assign Benef: YES
Clinic....: URGENT CARE |
Visit Type: OUTPATIENT |
Bill From: 07-07-2020 Thru: 07-07-2020 | Pg-4 (Providers)
Pg-2 (Billing Entity) | Attn: COOPER,STEVEN
UNITED HEALTH CARE | ACTIVE |
GILSBAR, INC | PENDING | Pg-5A (Diagnosis)
    
```

|  |          |                                |
|--|----------|--------------------------------|
| RAILROAD RETIREMENT                        | PENDING  | 1) FEVER                       |
| PCC Visit Data                             |          |                                |
| Prim Visit: 07/07/2020@08:45               | Count: 1 |                                |
| Srv Cat: T Hsp Loc: DR ATKINS TELEPHONE    |          | Pg-8 (CPT Procedures)          |
| Last Visit: 07/10/2020@08:45               | Loc: MHS | 1) OFFICE/OUTPATIENT VISIT EST |
| Srv Cat: T Cl:80 Hsp Loc: CHART REVIE      |          |                                |
| WARNING:250 - DOS after ICD Indicator Date |          |                                |

Figure 2-1: PCC Visit Data display

The PCC visit data includes:

- The primary visit date and time the visit occurred (labeled *Prim Visit*)
- The visit counts associated with the visit (labeled *Count*),  
Visit counts are meant to indicate how many PCC visits make up the data in the claim and may be beneficial for inpatient claims.
- The Service Category (labeled *Srv Cat*), and  
The Service Category classifies the type of visit that occurred. Refer to the IHS Standard Codebook under OIT SCB Table for a complete list of Service Categories:  
[https://www.ihs.gov/scb/index.cfm?module=W\\_SVC\\_CATEGORY&option=list&num=66&newquery=1](https://www.ihs.gov/scb/index.cfm?module=W_SVC_CATEGORY&option=list&num=66&newquery=1)
- The Hospital Location of the encounter (labeled *Hsp Loc*)  
The Hospital Location references the scheduled clinic the patient was checked in to. It may also indicate the ward location the patient was admitted to for inpatient services.

This data is generally populated in the PCC Visit file and is required to populate on Page 0 of the Claim Editor. This means that a manually added claim will not contain PCC Visit data and will display the following message:

|  |  |
|--|--|
| PCC Visit Data                         |  |
| No PCC data associated with this claim |  |

Figure 2-2: PCC Visit Data display showing the Visit status for a manual claim

The information for the patient's last visit will also display. This means that the visit prior to this visit is what the billing technician will see and includes:

- the last visit date along with the time of visit,
- the location of encounter,
- the service category, and
- the hospital location.

## 2.2.2 Page 3 – Questions

### 2.2.2.1 Form Locator 17 – Referring, Ordering, Supervisory Physician

The Referring Physician field on page 3 of the claim editor has been modified to read *Referring Phys. (FL17)*. Prior to patch 31, there were two questions (??) for the Referring Provider. These two questions have been merged into one. A lookup into the New Person File will be performed and if there is a New Person entry the NPI will be automatically retrieved. If a match is not made, the field will be treated as free text storing data entered by the user.

```
[11] Referring Phys. (FL17) :
```

Figure 2-3: Referring Physician Field from Page 3 of the Claim Editor – Current Field Used

The properties for this field require the provider's name to include the last name followed by a comma and a minimum of the first initial. If more than one entry is found, the user will be allowed to choose from the entries found. There is help text available by typing a question mark (?) to assist the user with how the field works.

```
Enter name in LASTNAME,FIRSTNAME FORMAT; it must contain the last name, a comma, and at least the first initial; a look up into the New Person file will be attempted; if no match it will store what is typed
```

Figure 2-4: Help Text with the Referring Provider on Page 3 of the Claim Editor

The prompts a user will receive on page 3 is dependent on how the NPI USAGE is populated in the insurer file.

```
[20] Ord/Ref/Sup Phys (FL17) .:
```

Figure 2-5: Old Referring Physician Field from Page 3 of the Claim Editor - Removed

An additional change was made to the Referring Provider if an entry has been added to Page 3 and Page 4 where both pages reference the same Referring Provider entry. The entry from Page 3 will be used first. If no entry exists on Page 3, then the entry from Page 4 will be used.

### 2.2.2.2 Admission Type, Admission Source and Discharge Status Codes

The Claim Editor has been updated with the following error codes:

- Error Codes 17 (Admission Type Unspecified),
- 18 (Admission Source Unspecified), and
- 21 (Patient Discharge Status Unspecified)

These are existing errors/warnings in the system but patch 31 has updated the display on Page 3-Questions. This is meant for those facilities that bill for services that are being billed for a patient that is in an inpatient status at a different facility than where the services are rendered. This is only applicable to billing for professional services on either a UB-04 or an 837I mode of export.

The CORRECTIVE ACTION for each error code has been updated to start with [J]ump to either Questions Page (3) or Inpatient Data Page (7) so the user will know how to correct the error.

```

~~~~~ PAGE 1 ~~~~~
Patient: BUNNY,BLUE [HRN:127259] Claim Number: 402598
..... (CLAIM IDENTIFIERS) .....

[1] Clinic.....: INTERNAL MEDICINE
[2] Visit Type.....: PROFESSIONAL COMPONENT
[3] Bill Type.....: 111
[4] Billing From Date..: 05/11/2020
[5] Billing Thru Date..: 05/12/2020
[6] Super Bill #.....:
[7] Mode of Export.....: 837I (UB) 5010
[8] Visit Location.....: UNIVERSITY MEDICAL CENTER PHOENIX

```

Figure 2-6: Inpatient pro fee on 837I

```

~~~~~ PAGE 3 ~~~~~
Patient: BUNNY,BLUE [HRN:127259] Claim Number: 402598
..... (QUESTIONS) .....

[1] Release of Information..: YES From: 07/06/2019
[2] Assignment of Benefits..: YES From: 07/06/2019
[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.....:
[12] Source of Admission.....:
[13] Discharge Status.....:
[14] Admitting Diagnosis.....:
[15] Prior Authorization #...:
[16] Delayed Reason Code.....:

-----
WARNING:017 - ADMISSION TYPE UNSPECIFIED
WARNING:018 - ADMISSION SOURCE UNSPECIFIED
ERROR:021 - PATIENT (DISCHARGE) STATUS UNSPECIFIED
-----

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

```

Figure 2-7: Error messages on Page 3 of the Claim Editor

```

Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired): 17

```

```

(WARNING:17 ADMISSION TYPE UNSPECIFIED)
-----
Corrective Action: [J]ump to either Questions Page (3) or Inpatient Data Page
                   (7) and [E]dit the Admission Type field so that it is
                   specified.

```

Figure 2-8: Corrective Action for error code 17

```

Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired): 18

(WARNING:18 ADMISSION SOURCE UNSPECIFIED)
-----
Corrective Action: [J]ump to either Questions Page (3) or Inpatient Data Page
                   (7) and [E]dit the Admission Source field so that it is
                   specified.

```

Figure 2-9: Corrective Action for error code 18

```

Enter ERROR/WARNING NUMBER for CORRECTIVE ACTION (if Desired): 21

(ERROR:21 PATIENT (DISCHARGE) STATUS UNSPECIFIED)
-----
Corrective Action: [J]ump to either Questions Page (3) or Inpatient Data Page
                   (7) and [E]dit the Discharge Status field so that it is
                   specified.

```

Figure 2-10: Corrective Action for error code 21

## 2.3 Coordination of Benefits (COB) Billing

Changes have been made to billing for secondary, tertiary, and higher COB-status claims.

### 2.3.1 Sorting Transactions by Payer for Proper Reporting

When billing electronically to other payers (secondary, tertiary, etc.), the Coordination of Benefits page (Page A) displays. The purpose of this page is to allow the billing technician the ability to review the payments and adjustments from the previously billed insurers. The user also has the ability to match the adjustment codes to the proper Claim Adjustment Reason Code (CARC) or Standard Adjustment Reason (SAR) code.

Prior to Patch 31, the system would combine all prior paid or adjusted amounts. This correction displays transactions from the last insurer billed only. For example, if billing a tertiary insurer, the prior payment/adjustment in the portion of the COB page will reflect the payment/adjustments from the secondary insurer. This allows the correct amount to approve to the tertiary payer. The Current Bill Amount should reflect a total of the amounts under Deductible and Co-pay/ins amounts, if applicable.

```

~~~~~ PAGE A ~~~~~
Patient: FALLS,NIAGARA [no HRN] Claim Number: 402628
..... (PRIOR PAYMENTS/ADJUSTMENTS) .....

```

|   |               |                              |                               |
|---|---------------|------------------------------|-------------------------------|
| <b>Payment Amount....:</b> (  | <b>50.00)</b> | ORIGINAL BILL AMOUNT:        | 289.00                        |
| Deductible Amount.:   | 0.00          | Current Charges.....:        | 289.00                        |
| <b>Co-pay/ins Amount.:</b>  | <b>105.00</b> | <b>Current Bill Amount.:</b> | <b>105.00</b>                 |
| Write Off.....:   | 0.00          |                              |                               |
| <b>Non-Covered Amount:</b>  | <b>84.00</b>  |                              |                               |
| Penalty Amount....:   | 0.00          |                              |                               |
| Group Allowance.:   | 0.00          |                              |                               |
| Refund.....:  | 0.00          |                              |                               |
| Payment Credits...:   | 0.00          |                              |                               |
| [1] INSURER: NEW MEXICO BC/BS INC PRIORITY ORDER: 1 STATUS: COMPLETED   |               |                              |                               |
| PAYMENT: ( 50.00)   |               |                              |                               |
| ADJUSTMENT:   | 25.00         | [4] NON PAYMENT              | [425] Pmt Adj-MPN [P25]       |
| ADJUSTMENT:   | 30.00         | [4] NON PAYMENT              | [426] Pmt Adj-VPN [P26]       |
| ADJUSTMENT:   | 60.00         | [13] DEDUCTIBLE              | [29] Deductible [1]           |
| ADJUSTMENT:   | 70.00         | [14] CO-PAY                  | [27] Co-payment [3]           |
| ADJUSTMENT:   | 25.00         | [4] NON PAYMENT              | [696] Non Covered Charge [96] |
| ADJUSTMENT:   | 29.00         | [14] CO-PAY                  | [602] Coinsurance Amount [2]  |
| [2] INSURER: MHBP PRIORITY ORDER: 2 STATUS: COMPLETED                   |               |                              |                               |
| PAYMENT: ( 50.00)   |               |                              |                               |
| ADJUSTMENT:   | 40.00         | [4] NON PAYMENT              | [122] Services Not Cover [46] |
| ADJUSTMENT:   | 60.00         | [14] CO-PAY                  | [27] Co-payment [3]           |
| ADJUSTMENT:   | 45.00         | [14] CO-PAY                  | [602] Coinsurance Amount [2]  |
| ADJUSTMENT:   | 44.00         | [4] NON PAYMENT              | [645] Chgs exceed fee sc [45] |
| [3] INSURER: GEHA PRIORITY ORDER: 3 STATUS: ACTIVE                      |               |                              |                               |
| COVERAGE TYPE: MEDICAL  |               |                              |                               |
| -----   |               |                              |                               |
| **Use the EDIT option to populate the Standard Adjustment Reason Code** |               |                              |                               |

Figure 2-11: Sample of Coordination of Benefits Page

The same adjustment type code will not combine amounts if that adjustment code was used for the primary and the secondary insurers. This means that if a CO-PAYMENT (SAR #3) was used for Medicare (primary) for \$25.00 and used for Aetna (secondary) for \$10.00, the system was trying to combine the adjustment to reflect \$35.00 and was exiting the user from the system with an error. This error has been corrected.

### 2.3.2 AMT Segment: Remaining Patient Liability

The 837 files have been updated to include the AMT\*EAF segment in Loop 2320. This segment reflects the Remaining Patient Liability when billing a non-primary insurer. This segment is a total dollar amount of deductibles plus the total amount of co-pays and co-insurance for each insurer.

```
SBR*S**148*****CI~
NM1*IL*1*AIRMAN*SHELBY****MI*MHBP3334~
NM1*PR*2*MHBP*****PI*99999~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*FALLS*NIAGARA~
N3*555 WATERFALL LANE~
N4*ALBUQUERQUE*NM*87125~
DMG*D8*19700130*F~
CLM*402628B-SC-148554*289.00***13:A:1**A*Y*Y~
```

```

DTP*434*RD8*20200503-20200503~
CL1*2*1*01~
REF*EA*148554~
HI*ABK:R05~
NMI*71*1*FEENEY*PENELOPE****XX*1184624744~
PRV*AT*PXC*208D0000X~
REF*OB*NM-34058~
NMI*77*2*2017 SATELLITE CLINIC****XX*851234567~
N4**NM~
SBR*P*19*105*****BL~
CAS*OA*96*25*1~
CAS*PR*1*60*1*3*70*1*2*29*1~
CAS*CO*P25*25*1*P26*30*1~
AMT*D*50~
AMT*EAF*159~

```

Figure 2-12: Sample 837I File with EAF segment

### 2.3.3 CAS Segment: Adjustment Reason Reporting

The reporting of the Claim Adjustment Reason Codes (CARC), otherwise known as Standard Adjustment Reason (SAR) codes will now be reported to reflect the proper Claim Adjustment Group Code. Prior to Patch 31, the 837 files would report the following adjustment codes as Other Adjustment (OA) in the CAS – Claim Level Adjustments segment:

- SAR 45 (4/645) Charges exceed fee schedule/max allow or contracted/legislated fee arrangement.
- SAR 139 (4/739) Contracted funding agreement-Subscriber employed by the provider of services.
- SAR 249 (4/989) Clm identified as a readmission
- SAR 279 (4/329) Services not provided by Preferred network providers
- SAR 281 (4/331) Deductible waived per contractual agreement
- SAR P16 (4/416) Medical Provider not auth'd/certified to provide trmt to injured workers
- SAR P24 (4/424) Payment adjusted based on Preferred Provider Organization (PPO)
- SAR P25 (4/425) Payment adjusted based on Medical Provider Network (MPN)
- SAR P26 (4/426) Payment adjusted based on Voluntary Provider Network (VPN)

Once Patch 31 is installed, the claims that contain these adjustments will be reported as Contract Obligations (CO).

```

CLM*402624B-DH-133552*509.00***22:B:1*Y*A*Y*Y~
REF*EA*133552~
HI*ABK:J069~
NMI*82*1*COOPER*STEVEN****XX*1528005857~
PRV*PE*PXC*207RC0000X~

```

```

SBR*P*18**UNKNOWN*****BL~
CAS*1*42*74*1~
CAS*PR*1*50*1*3*100*1~
CAS*CO*45*30*1*139*30*1*249*30*1*281*30*1*P16*30*1*P24*30*1~
AMT*D*75~
AMT*EAF*150~

```

Figure 2-13: 837 File with CAS\*CO segment populated

This change also allowed the CAS\*CO segment to appear on the 837 Institutional claim file.

### 2.3.4 Tribal Self-Insured

Billing to Medicare for a Tribal Self-Insured (TSI) plan required certain segments to populate according to guidance provided by Novitas Solutions, Tribal Self-Funded Claims guidance (<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005807>).

Part A Guidance:

- GRP field, enter CO. If the tribal self-funded remittance is available, the appropriate group code should be used. If not, they should use CO.
- CARC field, enter 45. If the tribal self-funded remittance is available, enter the appropriate CARC(s) from the remit. Otherwise, if no remittance is available, use CARC 45.

Part B Guidance:

- Loop 2320 or Loop 2430 (one or the other but not both) - Claim Adjustment Segment (CAS) codes
  - Segment: CAS01      Entry: ‘OA’
  - Segment: CAS02      Entry: ‘96’
  - Segment: CAS03      Entry: ‘Total Billed Amount’

Patch 31 applies the correct Claim Adjustment Group Code of CO for Part A claims and OA for Part B claims which allows for Medicare’s processing of the Tribal Self-Insured claim.

## 2.4 Table Updates

### 2.4.1 Place of Service Codes

The following place of service codes have been updated. These codes are updated in Site Parameters (**3PB > TMTP > SITM**) where a default Place of Service code is required.

Table 2-2: CMS-1500 Place of Service Code List – New Entries

| Place of Service Code | Description  |
|-----------------------|--|
| 01                    | Pharmacy   |
| 04                    | Homeless Shelter                                   |
| 09                    | Prison/Correctional Facility                       |
| 13                    | Assisted Living Facility                           |
| 14                    | Group Home   |
| 16                    | Temporary Lodging                                  |
| 17                    | Walk-In Retail Health Clinic                       |
| 18                    | Place of Employment-Worksite                       |
| 20                    | Urgent Care Facility                               |
| 49                    | Independent Clinic                                 |
| 57                    | Non-Residential Substance Abuse Treatment Facility |
| 58                    | Non-Residential Opioid Treatment Facility          |

The system also allows the Place of Service code to override the default value on the CMS-1500 claim form.

The complete Place of Service Codes list is available at:  
[https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set).

## 2.5 Electronic and Paper Claim Form Updates

### 2.5.1 Eligibility and Demographics

Updates to the claim formats have been made in this patch. These updates affect the data that prints on the paper claim form and the electronic claim formats. These changes can also have an effect on reprinted or re-exported claims. Pay careful attention to the following fields and how these changes affect claims processing by the payer.

#### 2.5.1.1 Patient's Name and Date of Birth

Updated the UB-04 and the CMS-1500 paper claim forms to print the patient's name and the date of birth from the Patient File and not the Medicare Eligible or Medicaid Eligible file. This affects Form Locator 8B and Form Locator 10 on the UB-04.

|                       |  |                       |  |                                    |  |  |  |
|-----------------------|--|-----------------------|--|------------------------------------|--|--|--|
| 2017 DEMO HOSPITAL    |  | 2017 DEMO HOSPITAL    |  | 3a PAT. CNTRL # 402637B-DH-124100  |  | 4 TYPE OF BILL                                       |  |
| 5300 HOMESTEAD RD NE  |  | 5300 HOMESTEAD NE     |  | b. MED. REC. # 124100              |  | 131  |  |
| ALBUQUERQUE, NM 87110 |  | ALBUQUERQUE, NM 87110 |  | 5 FED. TAX NO. 383892542           |  | 6 STATEMENT COVERS PERIOD FROM 060120 THROUGH 060120 |  |
| 5052481111            |  |                       |  |                                    |  |  |  |
| 8 PATIENT NAME a      |  |                       |  | 9 PATIENT ADDRESS a                |  |  |  |
| b HERO, SUPER         |  |                       |  | b ALBUQUERQUE                      |  |  |  |
| 10 BIRTHDATE          |  | 11 SEX                |  | 12 DATE                            |  | 13 HR  |  |
| 11241940              |  | M                     |  | 06012008                           |  | 2  |  |
| 31 OCCURRENCE DATE    |  | 32 CODE               |  | 33 OCCURRENCE DATE                 |  | 34 CODE  |  |
|                       |  |                       |  |                                    |  |  |  |
| 35 OCCURRENCE DATE    |  | 36 CODE               |  | 37 OCCURRENCE DATE                 |  | 38 CODE  |  |
|                       |  |                       |  |                                    |  |  |  |
| 19 MEDICARE           |  |                       |  | 39 CODE                            |  |  |  |
| P.O. BOX 660155       |  |                       |  | 40 CODE                            |  |  |  |
| DALLAS, TX 75266-0155 |  |                       |  | 41 CODE                            |  |  |  |
|                       |  |                       |  | 42 CODE                            |  |  |  |
| 42 REV. CD. 0510      |  | 43 DESCRIPTION CLINIC |  | 44 HCPCS / RATE / HIPPS CODE 99212 |  | 45 SERV. DATE 060120                                 |  |
|                       |  |                       |  |                                    |  | 46 SERV. UNITS 1                                     |  |
|                       |  |                       |  |                                    |  | 47 TOTAL CHARGES 14200                               |  |
|                       |  |                       |  |                                    |  | 48 NON-COVERED CHARGES                               |  |
|                       |  |                       |  |                                    |  | 49   |  |

Figure 2-14: UB-04 Claim with FL 8 Displaying the Patient's Name from Page 1 of the Registration Editor

This also affects Form Locator 2 and Form Locator 3 on the CMS-1500.



To: UNITED HEALTH CARE-HMO PLAN  
P.O. BOX 15645  
LAS VEGAS, NV 89114-5645

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Page 1 of 1

|  |  |  |
|--|--|--|
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> |  | 1a. INSURED'S ID, NUMBER (For Program in Item 1)<br>CR8868                 |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br>HERO, SUPER   |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br>HERO, PRESTON |
| 3. PATIENT'S BIRTH DATE<br>MM   DD   YY<br>11   24   1940  |  | 7. INSURED'S ADDRESS (No., Street)<br>715 FREEDOM DRIVE                    |
| 5. PATIENT'S ADDRESS (No., Street)<br>715 FREEDOM DRIVE  |  | 8. RESERVED FOR NUCC USE   |
| 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>   |  | CITY<br>ALBUQUERQUE  |
| CITY<br>ALBUQUERQUE  |  | STATE<br>NM  |
| STATE<br>NM  |  | ZIP CODE<br>87125  |
| ZIP CODE<br>87125  |  | TELEPHONE (Include Area Code)<br>( )                                       |
| TELEPHONE (Include Area Code)<br>( )   |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER                                  |

Figure 2-15: CMS-1500 with Box 2 displaying the Patient's Name and Box 3 displaying the Patient's Date of Birth from Page 1 of the Registration Editor

### 2.5.1.2 Other Subscriber's Name

The Other Subscriber's Name is used to identify the policy holder if the policy holder is not the same as the patient on the claim form.

The Other Subscriber Name in loop 2330A has been corrected to show the name from the insurer being billed and not from the active insurer on the bill. This was causing the wrong subscriber name to display on the electronic file.

### 2.5.1.3 Policy Holder Date of Birth

When creating an 837 file for Railroad Retirement claims, the system was using the patient's date of birth from Page 1 of the Registration Editor. Patch 31 updated the claim form to use the correct date of birth from the Railroad Retirement Eligible file, or Page 4 in the Registration Editor. If no date of birth exists for the policy holder, the patient's date of birth will be used on the claim form.

### 2.5.1.4 Policy Holder's Gender

For Medicare, Railroad Retirement, and Medicaid claims, the system was using the gender from the patient's sex field on Page 1 of the Registration Editor. With this update, the system will now start using the gender from the correct eligibility file on Page 4 of the Registration Editor.

### 2.5.1.5 Relationship to Insured

The system will start looking at the *Relationship to Insured* field on the Medicaid Page to determine if the subscriber will be used as the policy holder for Medicaid coverage. This is used for certain payers, such as Medi-Cal, which requires the patient's mother to be used as a policy holder when enrolling a newborn for eligibility. Once the mother's eligibility has been entered, the system will use the mother's policy holder information and not the patient's for coverage on the claim form. Prior to patch 31, the system was using the patient's demographic data as the policy holder information.

This change affects Loop 2000C and Loop 2010CA on the 837 file.

## 2.5.2 Dental Paper Forms (ADA-2012 and ADA-2019)

### 2.5.2.1 Other Coverage Fields

The *OTHER COVERAGE* section of the ADA-2012 and the ADA-2019 paper claim forms has been corrected to print the following:

- When billing the primary insurer, the *secondary coverage* will print in the *Other Coverage* fields.
- When billing the secondary insurer, the *primary coverage* will print in the *Oher Coverage* fields.
- When billing the tertiary insurer, the *secondary coverage* will print in the *Other Coverage* fields.

The *Other Coverage* fields refer to Form Locator 4 to Form Locator 11 on both the ADA-2012 and the ADA-2019 claim forms:

| <b>OTHER COVERAGE</b> (Mark applicable box and complete items 5-11. If none, leave blank.)                      |   |  |
|---|---|--|
| 4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (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<br><input type="checkbox"/> M <input type="checkbox"/> F  | 8. Policyholder/Subscriber ID (SSN or ID#) |
| 9. Plan/Group Number  | 10. Patient's Relationship to Person named in #5<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other |  |
| 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code                            |   |  |

Figure 2-16: ADA-2012, Other Coverage fields

| <b>OTHER COVERAGE</b> (Mark applicable box and complete items 5-11. If none, leave blank.)                      |   |  |
|---|---|--|
| 4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (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<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U   | 8. Policyholder/Subscriber ID (Assigned by Plan) |
| 9. Plan/Group Number  | 10. Patient's Relationship to Person named in #5<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other |  |
| 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code                            |   |  |

Figure 2-17: ADA-2019, Other Coverage fields

### 2.5.2.2 Dentist's License Number

The License Number fields (Form Locator 50 and Form Locator 55) have been expanded to print additional characters. The format of the provider's license number reflected the state along with the provider's license number. A dash (-) was used to separate the state from number:

DENTALPROVIDER, MARTIN

License Number: CA-1001001001

Patch 31 modifies the display of the number to remove the dash, print 12 characters in Form Locator 50 and Form Locator 55. This will allow the license number to print:

DENTALPROVIDER, MARTIN      License Number: CA1001001001

## 2.6 Reports

### 2.6.1 Pending Claims Status Report

ABM > RPTP > PCR

#### 2.6.1.1 New Pending Status Reasons

The following status' have been added into the 3P Claim Pending Status file and are available for immediate use:

- 26 – Pending provider documentation completion
- 27 – Pending prior authorization/treatment plan documentation
- 28 – Guidelines pending – Public Health Emergency

#### 2.6.1.2 Pending Report Modifications

The 3P Claim file stores all claim data and has been updated to capture the date and time a claim is placed in a status of pending. Claims that are placed in a status of pending following the installation of Patch 31 will have the actual date and time when the claim was put in a status of pending. This data will be available via FileMan by performing an Inquire into the 3P Claim Data file. Claims placed in a status of pending prior to patch 31 will have the date the claim was last edited as the pended date.

The Pending Claims Report has also been updated to include a parameter for the pended date range. When this parameter is used, the report will only include claims placed in a pending status during the date range specified.

```

Select ONE or MORE of the above EXCLUSION PARAMETERS: 3  DATE RANGE

  Select one of the following:

      1      Pended Date
      2      Visit Date

Select TYPE of DATE Desired: 1  Pended Date

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

Enter STARTING PENDED DATE for the Report:  ?

This response must be a date.

Enter STARTING PENDED DATE for the Report:  5/1/2020  (MAY 01, 2020)

Enter ENDING DATE for the Report:  5/15/2020  (MAY 15, 2020)
    
```

Figure 2-18: Report selection criteria for the Pended Claim Date

Minor modifications have been made to the Pending report to prevent the wrapping of lines on the report. The descriptions have also been replaced by the number of the pending status. A key will print at the end of the report that notifies the user of the type of pending reasons used.

```

=====
PENDING CLAIMS STATUS LISTING                               JUN 29,2020@17:48:01  Page 1
for ALL BILLING SOURCES with PENDED DATES from 06/29/2020 to 06/29/2020
Billing Location: 2017 DEMO
=====
Patient           HRN      Claim  Visit  Clinic      Reason
Number  Date
-----
Visit Location: 2017 DEMO HOSPITAL

Status Updater: PINTO-YAZZIE,ANGELA
Visit Type: OUTPATIENT

Active Insurer: NEW MEXICO MEDICAID
JALAPENO,ARIEL   116258  402641  06/01/2020  INTERNAL MED 7-Verify Eligibility
-----
Subtotal: 1

Visit Type: DENTAL

Active Insurer: NEW MEXICO BC/BS INC
BUNNY,BLUE       127259  402617  05/15/2020  DENTAL      9-Cannot locate Medi

Active Insurer: UNITED HEALTH CARE
COFFEE,LEON     113116  402615  04/19/2020  DENTAL      5-Missing POV
-----
Subtotal: 2

Total: 3
    
```

```
REASONS:  
  5-Missing POV  
  7-Verify Eligibility  
  9-Cannot locate Medical Record to verify Services  
  
E N D   O F   R E P O R T
```

Figure 2-19: Pending Claims Status Report

## Appendix A OIT Standard Codebook: Service Categories

| <b>Code</b> | <b>Service Category</b>      |
|-------------|------------------------------|
| A           | AMBULATORY                   |
| C           | CHART REVIEW                 |
| D           | DAILY HOSPITALIZATION DATA   |
| E           | EVENT (HISTORICAL)           |
| H           | HOSPITALIZATION              |
| I           | IN HOSPITAL                  |
| M           | TELEMEDICINE                 |
| N           | NOT FOUND                    |
| O           | OBSERVATION                  |
| R           | NURSING HOME                 |
| S           | DAY SURGERY                  |
| T           | TELECOMMUNICATIONS           |
| X           | ANCILLARY PACKAGE DAILY DATA |

## Appendix B Visit Type Set Up

The purpose of this exercise is to review and determine if any changes to the Visit Types are needed in Third Party Billing. This is important, especially if the parameters have not been reviewed in a while.

Patch 31 introduced the ability to allow the Claim Generator to generate claims by using the Hospital Location from the Scheduling and ADT (Admission/Discharge and Transfer) applications. Doing this allows the claims to generate with a specific Visit Type.

### B.1 Generating the Visit Type Report

The first part of this exercise is to run a Visit Type listing along with the Clinic Stop codes that have been linked to each Visit Type. The screen shot shows how the report will need to generate. The user must have access to the FileMan options in the Accounts Receivable Manager Menu (**A/R > MAN > FM**) to be able to run this report.

In the FileMan Reports (FM) option:

1. Select **Sort and Print (STP)**.
2. At the “Package Name” prompt, type **ABM** to print from the Third Party Billing system.
3. At “Select File,” type **3P VISIT TYPE**.
4. At “Sort By,” press Enter.
5. At “Start with Name” prompt, press Enter.
6. At “First Print Field,” type **NUMBER**.
7. At “Then Print Field,” type **NAME**.
8. At “Then Print Field,” type **CLINIC**. When the Enter key is pressed, the word **(multiple)** will display indicating a sub-file is being accessed.
9. At the “Then Print Clinic Sub-Field” prompt, type **CLINIC**.
10. At “Then Print Clinic Sub-Field,” press Enter.
11. At the “Then Print Field,” press Enter.
12. At the “Device” prompt, run the report to paper or it may be printed to the screen.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28          |
+                   Sort & Print                   +
|                   INDIAN HEALTH HOSPITAL                   |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: DEMO,USER M          BUSINESS OFFICE          31-AUG-2020 2:27 PM

Select PACKAGE NAME: ABM  IHS 3P BILLING SYSTEM          ABM
Select FILE: 3P VISIT TYPE
SORT BY: NAME// <ENTER>
START WITH NAME: FIRST// <ENTER>
FIRST PRINT FIELD: NUMBER
THEN PRINT FIELD: NAME
THEN PRINT FIELD: CLINIC      (multiple)
    THEN PRINT CLINIC SUB-FIELD: CLINIC
    THEN PRINT CLINIC SUB-FIELD: <ENTER>
THEN PRINT FIELD: <ENTER>
DEVICE:
    
```

Figure B-1: FileMan Sort and Print Parameters

When the report generates, it will look similar to Figure B-2.

| 3P VISIT TYPE LIST |                             | AUG 31,2020 14:28          | PAGE 1 |
|--------------------|-----------------------------|----------------------------|--------|
| NUMBER             | NAME                        | CLINIC                     |        |
| 991                | ACCOMMODATIONS              |                            |        |
| 902                | AMBULANCE                   | AMBULANCE                  |        |
| 831                | AMBULATORY SURGERY          |                            |        |
| 121                | ANCILLARY (MCR PART B ONLY) |                            |        |
| 992                | ANESTHESIA                  |                            |        |
| 24                 | AUDIOLOGY                   | AUDIOLOGY                  |        |
| 15                 | CASE MGT ADULT/DEV DIS      | MENTAL HEALTH (PSYCHIATRY) |        |
| 16                 | CASE MGT CMI                | MENTAL HEALTH (PSYCHIATRY) |        |
| 14                 | CASE MGT EPSDT/DEV DIS      | MENTAL HEALTH (PSYCHIATRY) |        |
| 13                 | CASE MGT EPSDT/MED RISK     | MENTAL HEALTH (PSYCHIATRY) |        |
| 12                 | CASE MGT EPSDT/SEV EM DI    | MENTAL HEALTH (PSYCHIATRY) |        |
| 540                | CHEMICAL DEP                | ALCOHOL AND SUBSTANCE      |        |
| 501                | CHIROPRACTIC                | CHIROPRACTIC               |        |
| 201                | CROSSOVER (INPT)            |                            |        |
| 202                | CROSSOVER (OUTPT)           |                            |        |
| 204                | CROSSOVER (PROF)            |                            |        |
| 998                | DENTAL                      |                            |        |
| 504                | E-VISIT                     |                            |        |
| 450                | EMERGENCY ROOM              | EMERGENCY MEDICINE         |        |
| 2                  | EPSDT W/O REFERRAL          | WELL CHILD                 |        |
| 115                | EPSDT W/REFERRAL            |                            |        |
| 421                | FLU/PNEUMO/HEPB             |                            |        |
| 140                | IMMUNIZATION                |                            |        |
| 111                | INPATIENT                   |                            |        |
| 996                | LABORATORY                  |                            |        |
| 11                 | LISW GROUP COUNSEL          | MENTAL HEALTH (PSYCHIATRY) |        |
| 10                 | LISW INDIV COUNSEL          | MENTAL HEALTH (PSYCHIATRY) |        |
| 9                  | LISW PSYCH CONSULT          | MENTAL HEALTH (PSYCHIATRY) |        |
| 7                  | LISW PSYCH EVAL             | MENTAL HEALTH (PSYCHIATRY) |        |
| 8                  | LISW PSYCH RPT              | MENTAL HEALTH (PSYCHIATRY) |        |
| 400                | MANAGED CARE DIFF RATE      |                            |        |
| 142                | MEDI-CAL OTHER HEALTH VISIT |                            |        |
| 206                | MEDI/MEDI                   |                            |        |

|                |                              |   |
|----------------|------------------------------|---|
| 601            | MEDICAL RECORDS FEES         |   |
| 502            | MEDICAL SOCIAL SVCS          | MEDICAL SOCIAL SERVICES                         |
| 993            | MEDICAL SUPPLY               |   |
| 990            | MEDICAL/SURGICAL             |   |
| 203            | MENTAL HEALTH                | MENTAL HEALTH (PSYCHIATRY)<br>BEHAVIORAL HEALTH |
| 6              | MSTR LVL GRP COUNSEL         | MENTAL HEALTH (PSYCHIATRY)                      |
| 5              | MSTR LVL INDIV COUNSEL       | MENTAL HEALTH (PSYCHIATRY)                      |
| 133            | MULTIPLE VISITS              |   |
| 134            | NEEDS ADDL INFO              |   |
| 110            | NON COVERED                  |   |
| 22             | NUT ASSESS CHILD             |   |
| 23             | NUT ASSESS PREG              |   |
| 21             | NUT COUNSEL CHILD            |   |
| 114            | NUTRIT ASSESS PREGNANT WOMEN |   |
| 205            | OBSERVATION                  | OBSERVATION                                     |
| 994            | OPTOMETRY                    | OPTOMETRY                                       |
| 131            | OUTPATIENT                   |   |
| 997            | PHARMACY                     | PHARMACY<br>OTC MEDICATIONS                     |
| 420            | PHYSICAL THERAPY             | PHYSICAL THERAPY                                |
| 200            | PI PRIMARY                   |   |
| 999            | PROFESSIONAL COMPONENT       |   |
| 901            | Pharmacy POS                 |   |
| 995            | RADIOLOGY                    | RADIOLOGY<br>MAMMOGRAPHY                        |
| 181            | SWINGBED                     |   |
| 506            | TELEMED DISTANT              |   |
| 500            | TELEMED ORIGINATING          |   |
| 505            | TELEPHONE E&M SERVICE        | TELEPHONE CALL                                  |
| 600            | UNBILLED REIMBURSEMENT       |   |
| 503            | VIRTUAL CHECK-IN             | ONLINE SERVICES                                 |
| 50             | ZERO-PAY CLAIM               |   |
| CR - CONTINUE: |                              |   |

Figure B-2: Display of the Visit Type Report and Associated Clinic Codes

A few notes about the report:

- Most of the Visit Types can be edited with the exception of the following:
  - 111 Inpatient
  - 121 Ancillary (Mcr Part B Only)
  - 131 Outpatient
  - 831 Ambulatory Surgery
  - 998 Dental
  - 999 Professional Component

The reason the above cannot be edited is because these are the Visit Types that are defaulted to when the insurer file is not set up with any types. Do not worry about modifying any of these types.

- Some Visit Types have multiple Clinic Stop codes associated with one Visit Type. This just means that if the visit is coded with that clinic and the Visit Type is added to the insurer file of the active insurer, the system will use that Visit Type when it generates the claim.

|     |               |   |
|-----|---------------|---|
| 203 | MENTAL HEALTH | MENTAL HEALTH (PSYCHIATRY)<br>BEHAVIORAL HEALTH |
|-----|---------------|---|

Figure B-3: Display of a Visit Type with Multiple Clinic Stops

- Some Clinic Stop codes may be linked to more than one Visit Type. This is helpful to try to get the system to generate a claim using this Visit Type but the system will always use the first entry of the visit type it finds. Again, the Visit Type has to exist in the insurer file.

|    |                          |                            |
|----|--------------------------|----------------------------|
| 15 | CASE MGT ADULT/DEV DIS   | MENTAL HEALTH (PSYCHIATRY) |
| 16 | CASE MGT CMI             | MENTAL HEALTH (PSYCHIATRY) |
| 14 | CASE MGT EPSDT/DEV DIS   | MENTAL HEALTH (PSYCHIATRY) |
| 13 | CASE MGT EPSDT/MED RISK  | MENTAL HEALTH (PSYCHIATRY) |
| 12 | CASE MGT EPSDT/SEV EM DI | MENTAL HEALTH (PSYCHIATRY) |

Figure B-4: Display of Multiple Visit Types with One Linked Clinic Stop Code

With this example, if all the above Visit Types were added to the Insurer File, the Claim Generator would generate a claim using #15-Case Mgt Adjust/dev Dis.

## B.2 Creating the Matrix

This matrix is meant to assist in setting up the Visit Type file to link the Hospital Location (scheduled clinic) to the Visit Type.

Table B-1: Link the Hospital Location to the Visit Type

| Visit Type                 | Clinic Stop                   | Hospital Location             | Description   | Insurer          |
|----------------------------|-------------------------------|-------------------------------|---|------------------|
| 15-Case Mgt Adult/Dev Dis  | 14-Mental Health (Psychiatry) | Welby Psych Clinic            | Adult Case Management Clinic for Dr. Welby                        | Arizona Medicaid |
| 14-Case Mgt EPSDT/Deve Dis | 14-Mental Health (Psychiatry) | Reynolds PA Child Development | Children's Developmental Disability Clinic for Mary Reynolds, PA. | Arizona Medicaid |

Table B-1 shows where the Visit Types use the same Clinic Stop code, but each Hospital Location is different. If added to the insurer file, the system will generate each claim to the appropriate Visit Type.

## B.3 Blank Matrix

Use the following to create your own matrix to set up your payers



To link the Hospital Location to the Visit Type, update the Visit Type using the Visit Type Maintenance (VITM) option:

1. At “Select Visit Type” prompt, type a new entry to create a new Visit Type.
  - a. To modify an existing Visit Type, type the name or number of the Visit Type and press Enter.
2. The “Name” will display. Press Enter to bypass this entry. Do not change the Visit Type name unless the name needs to be corrected.
3. At “UB-92 Bill Type” prompt, press Enter.
4. At the “Select Clinic” entry, type a single question mark (?) and press Enter to review the entries stored in this field.
  - a. To add a new Clinic Stop code, type the name of the Clinic Stop code and press Enter. The system will ask if a new entry should be added. Type **Yes** and press Enter to add the code.
  - b. To remove a Clinic Stop code, type the Clinic Stop name and Enter. Type the @ symbol at the prompt and press Enter. The system will ask if the entry should be deleted. Type **Yes** and press Enter.

**Note:** Multiple Clinic Stop codes may be added depending on what the Visit Type is used for. For example, a MENTAL HEALTH Visit Type may be linked to C4-Behavioral Health and 14-Mental Health clinic codes.

5. At “Select Hospital Location” prompt, type the name of the Scheduled Clinic or Hospital Location to link to the Visit Type. The system will ask for confirmation of adding the entry. Type **Yes** to add the entry.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p31          |
+          Visit Type Maintenance                          +
|          2017 DEMO HOSPITAL                              |
+-----+-----+-----+-----+-----+-----+-----+-----+
User: USER, DEMO                                     13-OCT-2020 8:36 AM

Select VISIT TYPE: 15 CASE MGT ADULT/DEV DIS
NAME: CASE MGT ADULT/DEV DIS Replace
UB-92 BILL TYPE: OUTPATIENT//
Select CLINIC: MENTAL HEALTH (PSYCHIATRY)//
Select HOSPITAL LOCATION: WELBY PSCYH CLINIC (ADULT)
  Are you adding 'WELBY PSCYH CLINIC (ADULT)' as
    a new HOSPITAL LOCATION (the 1ST for this 3P VISIT TYPE)? No// YES (Yes)
Select HOSPITAL LOCATION:

```

Figure B-5: Adding the Hospital Location to the Visit Type File

## B.5 Adding to the Insurer File

In order for the claim to generate with the Visit Type the Hospital Location was linked to, the Visit Type must be added to the Insurer file. To do this, select the Visit Type at the “Select Visit Type” prompt. If the Visit Type already exists, do nothing. The Claim Generator will use this Visit Type to generate a claim.

| Visit Type | Description | Mode of Export | Mult Form | Fee Sched | ----- Start | Flat Rate Stop | ----- Rate |
|------------|-------------|----------------|-----------|-----------|-------------|----------------|------------|
| 131        | OUTPATIENT  | UB-04          |           | NO        | 01/01/2013  | 12/31/2013     | 330.00     |
|            |             |                |           |           | 01/01/2014  | 12/31/2014     | 342.00     |
|            |             |                |           |           | 01/01/2015  |                | 350.00     |
| 997        | PHARMACY    | 837I (UB)      | 5010      | NO        | 01/01/2013  | 12/31/2013     | 330.00     |
|            |             |                |           |           | 01/01/2014  | 12/31/2014     | 342.00     |
|            |             |                |           |           | 01/01/2015  |                | 350.00     |

Select VISIT TYPE...: 15 CASE MGT ADULT/DEV DIS  
 Are you adding 'CASE MGT ADULT/DEV DIS' as  
 a new VISIT TYPE (the 3RD for this 3P INSURER)? No// YES (Yes)  
 Billable (Y/N/E).....:

Figure B-6: Adding a Visit Type to the Insurer File

## Appendix C Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (ROB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site:

<https://home.ihs.gov/security/index.cfm>.

**Note:** Users must be logged on to the IHS D1 Intranet to access these documents.

The ROB listed in the following sections are specific to RPMS.

### C.1 All RPMS Users

In addition to these rules, each application may include additional ROB that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

#### C.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

### C.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

### C.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.

- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

### C.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

### C.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

### C.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

### C.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.

- Give a password out over the phone.

### C.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

### C.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

### C.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

### C.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.

- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

### C.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

### C.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

## C.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

## C.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.

- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords and delete or reassign related active and backup files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

## Acronym List

| Acronym | Term Meaning                                   |
|---------|--|
| 3P      | Third Party                                    |
| 837D    | X12 ANSI Electronic Version of the ADA         |
| 837I    | X12 ANSI Electronic Version of the UB-04       |
| 837P    | X12 ANSI Electronic Version of the CMS-1500    |
| ADA     | American Dental Association                    |
| CARC    | Claim Adjustment Reason Code                   |
| 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    | Health Care Financing Administration           |
| IHS     | Indian Health Service                          |
| I/T/U   | IHS/Tribal/Urban                               |
| 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         |
| SAR     | Standard Adjustment Reason                     |
| SURP    | Summarized (multi-line) Claim Listing          |
| TSI     | Tribal Self-Insured                            |
| 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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