



Revenue Operations Manual



Part 4

Billing

Version 2

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Department of Health & Human Services
Indian Health Service
Business Office

Part 4. Billing

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1. Overview of Billing

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1.1 About the Revenue Operations Manual

The Indian Health Service (IHS) Revenue Operations Manual (ROM) provides a system-wide reference resource for all Indian Health Service (Federal), Tribal, and Urban (I/T/U) facilities across the United States. The manual will provide guidance for any questions related to business operation procedures and processes.

This manual is an important reference document for the entire Revenue Operations staff, enabling them to perform in a consistent, standardized manner.

Each part and chapter of the manual is designed to address a specific area, department, or function. A part may also contain one or more appendices of topic-related reference materials.

Because the focus of this document is for the business office, there will be links throughout the manual to other business functions (Purchased Referred Care, Accounts Receivable, etc.) to provide detail on the function's processes.

Updates to the manual based on new information from the business office or insurer need to be reviewed by the Revenue Operations team prior to being placed into the ROM. After approval of content and wording, the information should be added to the correct part or chapter and should be dated.

Information that is no longer relevant should be deleted or highlighted with a date when the information will no longer be valid. This update process is important for insuring that the manual does not become outdated.

1.1.1 ROM Objectives

- Provide standardized guidelines for the Business Office related functions of IHS facilities.
- Capture accurate coding for all procedures and services to maximize reimbursement for each facility.
- Provide on-line, via the IHS Intranet, reference material subdivided by department and function that is accessible to all facilities.
- Share innovative concepts and creative approaches to Business Office functions across all the Area offices and facilities.
- Promote a more collaborative internal working environment throughout all IHS.
- Foster and promote continuous quality improvement standards, which when implemented and monitored on a day-to-day basis, will ensure the highest standard of quality service at each Business Office operation.

The manual is divided into the following five (5) parts:

Part	Title/Contents
1	Administrative Roles and Responsibilities <ul style="list-style-type: none">• Overview of Revenue Operations• IHS Laws, Regulations, and Policies• Business Office Management• Business Office Staff• Business Office Quality Process Improvement• Compliance
2	Patient Registration <ul style="list-style-type: none">• Overview of Patient Registration• Patient Eligibility, Rights, and Grievances• Direct Care and Purchased/Referred Care (PRC)• Registration, Discharge, and Transfer• Third Party Coverage• Scheduling Appointments• Benefit Coordination
3	Coding <ul style="list-style-type: none">• Overview of Coding• Health Record Documentation• Coding Best Practices• Data Capture Entry
4	Billing <ul style="list-style-type: none">• Overview of Billing• Paper Versus Electronic Claims Processing• Billing Medicare• Billing Medicaid• Billing Private Insurance• Third Party Liability Billing• Billing Private Dental Insurance• Billing Pharmacy• Secondary Billing Process• Billing Veterans Administration (VA)• Billing for Commissioned Officers and Their Dependents (BMP)

Part	Title/Contents
5	Accounts Management <ul style="list-style-type: none"> • Overview of Accounts Management • Receipt Methodologies and Processes • Batching (Recording Revenue) • Remittance Advices and Explanation of Benefits • Posting (Processing Payments and Adjustments) • Managing Patient Accounts • Denial Management • Debt Management • Overview of Reconciliation – File, Accounts Receivable, and Cash Management • Account Management Reports

This manual also contains an **Acronym** dictionary and a **Glossary**.

1.1.2 Facility Expectations

Each facility will be able to obtain from the IHS Revenue Operations Manual the following:

- How to use and implement the various guidelines;
- What information needs to be consistently captured at the time of registration;
- What documentation is needed from the facility staff for the health record;
- Verification and application of the correct code. How to accurately complete billing claim forms;
- How to create a bill for various insurers;
- How to establish electronic billing and auto-posting interchanges with insurers;
- How to understand Explanation of Benefits (EOB) and Remittance Advices;
- How to follow-up on outstanding accounts in a consistent, organized manner; and,
- Understand the requirements, frequency, and importance of external compliance audits.

1.1.3 Accessing the Revenue Operations Manual

The *Revenue Operations Manual* is available for viewing, and printing at this website:

<https://www.ihs.gov/BusinessOffice/rom/>

Having the manual available from a website allows more timely updates.

1.2 **Billing Authorities**

Indian Health Care Improvement Act (P.L. 94-437) allows for the *right of recovery* of the reasonable charges billed to a patient's health insurance and other third party resources. Title IV of the Indian Health Care Improvement Act, as amended, authorizes Indian Health Services facilities to bill and receive payment from Medicaid and Medicare and Children's Health Insurance Program on behalf of the patient. Public Law 100-713 of the Indian Health Care Improvement Act Amendments of 1998 allows IHS to bill and seek payments from private insurance companies and has affirmed the IHS has the statutory right of recovery.

In 2012, the Veterans Administration and the Indian Health Service signed a Memorandum of Understanding (MOU) to reimburse Indian Health Service and Tribal Health Programs health care facilities for direct care services provided to eligible American Indian/Alaska Native (AI/AN) Veterans.

1.3 **Billing Policy Statement**

The goal of the Business Office is to optimize collections efficiently and effectively from all third party resources in accordance with the rules and regulations of the Centers for Medicare/Medicaid (CMS) and IHS and Third Party Accounts Management and Internal Controls policy.

To have a successful claims management process, all functions of the revenue cycle must work together and perform their responsibilities accurately, cooperatively and timely. All necessary steps will be taken to ensure that follow-up on every third party account is adequately and appropriately performed in a timely manner. All facilities recognize that collecting third party revenue is a cooperative organizational effort.

1.4 **Billing Guidelines**

- When the rates are updated within the system, users must make sure any approved claims are exported prior to the updates being implemented.
- All fee schedules need to be reviewed and updated annually. A Custom Fee Analyzer may be purchased and used as a guide for reviewing the fee schedule for the facility.

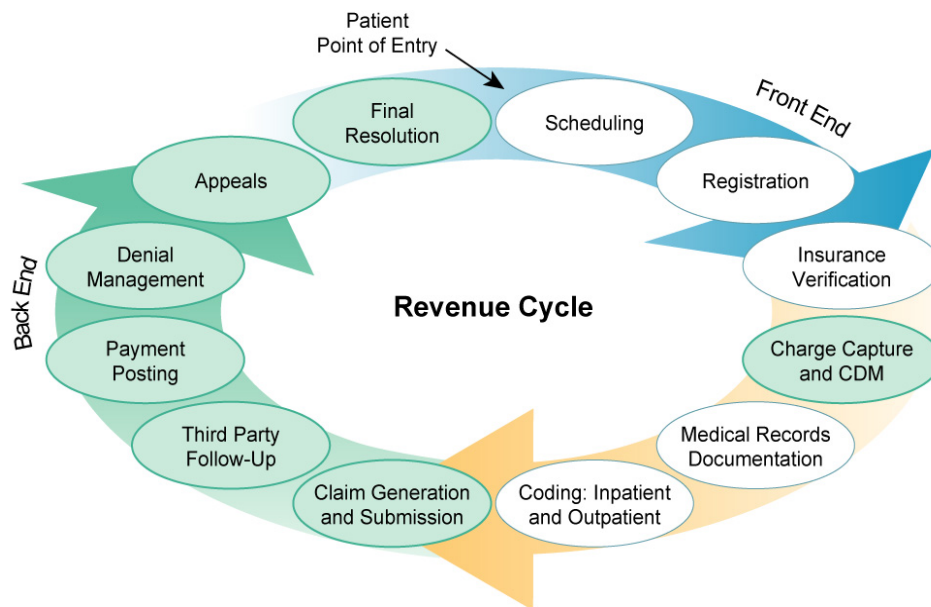
The Analyzer begins with a detailed process on how to review the facility's fees. It is recommended that once a fee schedule is established by the facility that it is used for all payers. To review codes other than outpatient, use either the Healthcare Common Procedure Coding System (HCPCS) or Dental Analyzer.

- All necessary diagnoses and procedure codes affecting the current treatment of the patient must be included in the Electronic Health Record (EHR) visit, as well as on the claim forms.
- The coders will code the applicable billing and procedure codes and enter all codes into the Resource and Patient Management System (RPMS) EHR or equivalent medical software system according to the provider documentation. Codes should be supported by appropriate tests and procedures.
- The coder will then release the visit from the coding queue, and the visit will drop into the Third Party Billing package overnight.
- The biller will validate the coding, ensuring all codes are correctly billed, and create the claim. Once the claim is approved, the biller will ensure claim is forwarded to the payer for processing. If there are errors or omissions, the biller will return the visit to the coding staff for revisions.
- A biller should never modify documentation by a provider. Provider documentation is the legal record and cannot be altered. The coding staff must be notified of revisions that require provider intervention for additional follow up. If there are deficiencies within the visit record, the provider must correct the documentation in the visit file and the biller must make appropriate corrections to the claim.
- All claims require a relationship between the procedure and diagnosis codes, and the provider documentation.
- Current Physician Terminology (CPT), HCPCS, and/or the American Dental Association (ADA) codes are required by most insurers depending on the type of service. Procedure codes need to be routinely checked or validated against the diagnostic codes to assure reimbursement is made only for those procedures that are “medically necessary” for the treatment of the stated diagnosis. Both the coder and the biller, should validate the CPT codes for accuracy.
- Claims are processed to the insurer according to the terms set forth in the patient’s benefit plan. After receiving the claim, the plan may:
 - Verify the patient’s eligibility
 - Verify whether the services provided are covered under the patient’s plan
 - Verify services meet plan requirements
 - Verify pre-certification, or pre-authorization is required and/or obtained when needed.

- The All-Inclusive Rates (AIR), which are published in the Federal Register annually, are applicable to reimbursement methodologies primarily under the Medicare and Medicaid programs. However, the All-Inclusive Rates are utilized in reimbursement methodologies for services reimbursed under the VA-IHS Reimbursement Agreement and the Federal Medical Care Recovery Act (FMCRA). It is important to understand the detailed payment methodologies by third party payer and the circumstances in which the All-Inclusive Rate may be claimed and reimbursed.
- Billing staff must be familiar with the requirements, benefits, and exclusions for each insurer. Accounts Receivable must work closely with billing to follow-up on all rejected, unpaid, or denied claims within the stipulated timeframe for each insurer.

1.4.1 Guidelines to Improve Reimbursement

The organizational flow of information and accurate documentation and coding is crucial to processing third party claims.



To prevent a disruption in the revenue cycle and to ensure smooth claims processing, the business process needs to review such areas as:

- Coding integrity
- Identification of incomplete claims and timely follow up
- Ensuring documentation is sufficient and adequately reflects the service(s) provided
- Communication with the payer

- Ensuring all services are billed for the visit, as required by the payer
- Compliance with timely claim filing requirements

The overall reimbursement process is a series of sequential independent steps, starting with the patient's visit to the facility. The steps involve:

- Assuring that all patients are registered for scheduled or walk-in appointments.
- Obtaining and updating accurate and detailed insurance and demographic information during the registration process.
- Accurately documenting the service, examination, and patient care by all providers (physician, mid-level practitioner, nurse, ancillary staff or others).
- Capturing and coding correctly all reportable and billable services.
- Billing all billable services that are not only reimbursable by the insurance company but also supported by documentation.
- Reconciling claim payments to assure correct payment. Researching all rejections and appealing rejected claims that should have been paid.

1.5 **Capturing all Reportable and Billable Services**

It is important to assure that providers document all services and procedures in the clinical record and enter the applicable codes into the EHR or the RPMS Patient Care Component (PCC) application. To accomplish this, the Business Office should:

- Devote adequate time to learn more about billing and coding for services, to acquire enough knowledge to identify all reportable services, procedures, and even supplies.
- Keep current with all the updates from the insurers, for example, Medicare Learning Network (MLN), Medicare Administrative Contractor (MAC) Web Updates, CMS newsletter, Medicaid Newsletters, and other private insurers.
- Conduct peer review and implement tracking mechanism to identify all rejections or denials. This would include registration, coding, data entry, provider documentation, billing and accounts receivable. This determines if identifiable errors should be reduced or corrected in the future.

- Make sure the providers document all the services and procedures. This information should be entered into the EHR or equivalent medical software by the provider or thoroughly documented on the superbill or in PCC. Documentation should include the Evaluation and Management (E&M) level of service, diagnosis, date of services, procedure, patient name, location, and any other pertinent demographic and reporting information.
- Educate providers with both current and anticipated billing changes, and errors in documentation causing denials
- Understand billing requirements for bundling and unbundling of services. Ensure entire team has the same understanding; i.e., providers, coding staff, billing staff, Accounts Receivable (A/R) staff.
- Provide training regarding fraud, waste, abuse, and inappropriate billing practices.
- Examine coding options such as whether to use CPT or HCPCS Level II or Level III codes for procedures and services. Carriers or insurer payer policies may dictate what procedure codes or combination of codes to submit.
- For a date of service when multiple surgical procedures are involved, sequence each procedure. The first procedure should be the primary reason for the surgery, and other surgical procedures become secondary. After sequencing, then add the appropriate modifier.
- Link all diagnosis codes or symptoms to the relevant procedures or services. Linking addresses the medical necessity question, supports the services provided, and relates the reason for each service.
- Understand or analyze reports associated with the billing process such as Explanation of Benefits (EOB), Electronic Remittance Advice (ERA), RPMS reports, MAC top-ten error reports, and Return to Provider (RTP) reports.
- Report all software issues promptly to the supervisor who then reports to the software vendor.

1.6 About the CMS-1450 / UB-04 Form

The CMS-1450 form, more commonly known as UB-04 (previously known as the UB-92), serves the needs of many payers. Not all of the data elements need to be completed for every payer.

Data elements in the CMS uniform electronic billing specifications are consistent with the CMS-1450 form data set to the extent that one processing system can handle both. Definitions are also identical. However, due to the space constraints on the form, the electronic record contains more characters for some items than the corresponding items on the paper claim form

The revenue coding system for both Form CMS-1450 and the electronic specifications are identical.

For more information on the descriptions of the locator fields, reference the website below:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1718CP.pdf>

1.7 Use of Modifiers

Modifiers are used to modify payment of a procedure code, assist in determining appropriate coverage, or otherwise identify the detail on the claim. The use of modifiers ensures the appropriate reimbursement by the insurer.

Modifiers are entered in box 24 D on the CMS-1500 claim form or UB-04 (CMS 1450).

For more information on the most current list of modifiers, reference the current CPT or HCPCS Code book.

Note: The modifiers are updated on a yearly basis, and the tables are supplied to each RPMS site by the IHS Office of Information Technology (OIT). It is the responsibility of each Area IT to install the updated tables.

1.8 Place of Service

Place of Service is a two-digit indicator assigned by CMS to the various places where a medical service or procedure can be provided.

The following lists the current Place of Service codes as published by CMS:

- 01 – Pharmacy
- 02 – Telehealth
- 03 – School
- 04 – Homeless Shelter
- 05 – Indian Health Service Free-standing Facility
- 06 – Indian Health Service provider-based Facility
- 07 – Tribal 638 Free-standing Facility
- 08 – Tribal 638 Provider-based Facility
- 09 – Prison/Correctional Facility
- 11 – Office
- 12 – Home
- 13 – Assisted Living Facility
- 14 – Group Home
- 15 – Mobile Unit

- 19 - Off Campus-Outpatient Hospital
- 20 – Urgent Care Facility
- 21 – Inpatient Hospital
- 22 – Outpatient Hospital
- 23 – Emergency Room – Hospital
- 24 – Ambulatory Surgical Center
- 25 – Birthing Center
- 26 – Military Treatment
- 31 – Skilled Nursing Facility
- 32 – Nursing Facility
- 33 – Custodial Care Facility
- 34 – Hospice
- 41 – Ambulance – Land
- 42 – Ambulance – Air or Water
- 49 – Independent Clinic
- 50 – Federally Qualified Health Facility
- 51 – Inpatient Psychiatric Facility
- 52 – Psychiatric Facility Partial Hospitalization
- 53 – Community Mental Health Center
- 54 – Intermediate Care Facility/Mentally Retarded
- 55 – Residential Substance Abuse Treatment Facility
- 56 – Psychiatric Residential Treatment Center
- 57 – Non-residential Substance Abuse Treatment Facility
- 60 – Mass Immunization Center
- 61 – Comprehensive Inpatient Rehabilitation Facility
- 62 – Comprehensive Outpatient Rehabilitation Facility
- 65 – End-Stage Renal Disease Treatment Facility
- 71 – State or Local Public Health Clinic
- 72 – Rural Health Clinic
- 81 – Independent Laboratory
- 99 – Other Unlisted Facility

The place where a service is rendered can determine the reimbursement and coding conventions applied to the service codes.

If services are rendered in two locations in a given day, such as the clinic and the emergency room, the reimbursement may be reduced for the services provided or split into technical and professional components. For the latter, usually two separate bills are provided by the facility.

An updated codes list can be found at:

<http://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html>

1.9 “Incident To” Services

“Incident To” services are defined as services commonly furnished in a physician’s office, which are:

- Incident to the professional services of a physician or a non-physician provider’s employee.
- Limited to situations in which there is direct physician/non-physician personal supervision.

This applies to auxiliary personnel employed by the physician/non-physician, which includes but is not limited to, nurses, technicians, therapists, non-physician practitioners, and others.

Verify with each payer’s covered services policy, whether the “Incident To” rule applies.

To have the same service covered as “incident to” the services of a physician, it must be performed under the direct personal supervision of the physician as an integral part of the physician’s personal in-clinic service. This does not mean that for each visit the patient must also see the physician. It does mean there must have been a direct, personal, professional service furnished by the physician/non-physician to initiate the course of treatment. This relationship must be documented in the visit. There must also be subsequent services by the physician/non-physician of a frequency that reflects his/her continuing active participation in, and management of, the course of treatment.

There are five things that are required to qualify for “incident to”:

- 1) The physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist must be an employee of the physician or of the entity which also employs the physician.
- 2) The physician has to have initially seen the patient.
- 3) The physician has to have direct supervision; the physician has to be within the facility, but not necessarily in the same room and must be available to render assistance and direction if necessary.
- 4) The physician must have an active participation in the on-going care of the patient.
- 5) Documentation within the record must state the physician was consulted or agreed to the treatment plan or course of action.

1.10 Fee Schedule Updates

As with all insurers, the correct CPT codes should be coded at the facility, but the billing process should be done according to payer guidelines. All fees should be updated annually. All fees when updated should be randomly, manually verified to the surrounding area to ensure consistency in billing.

Along with these updates, Room & Board (R&B) need to be updated. Room & Board rates can be updated by querying private sector facilities in the local area. Complete a comparison and document as indicated in the following example.

Revenue Code Description	Facility #1	Facility #2	Previous FY	Proposed

1.11 Claim Form Review

For electronic claim submission: Prior to submitting electronic claims, confirm the format of the claims are correct based on specific payer requirements. After review, submitted claims should match the claims received prior to closing the activity in the system.

For Paper claim submission: The forms used to bill depend on payer requirements. Prior to submission, review your paper claim forms (e.g., CMS 1450, CMS 1500, ADA, NCPDP, etc.) to ensure that the form locators are completed, based on specific payer requirements.

For more information on the CMS 1500 form, reference this website:

<http://www.nucc.org>

For more information on the CMS 1450 (UB-04) form, reference this website:

<http://www.nubc.org>

1.12 Utilization Review

Authorization numbers from insurers, when obtained, shall be submitted on the bills when they are generated for billing. Documentation must be present in the record to verify, and if necessary send the information on to the payer. Utilization review needs to assure that all billable services have been captured to bill for acute care days and ambulatory care services. The purpose of the process is to assure each facility meets hospitalization and length of stay criteria as well as current standards of care.

Utilization staff, in this process, needs to work closely with Admitting, Providers, Coders, and Billing.

1.12.1 Splitting Claims Process

Hospital billing is split with professional services on the CMS1500 form or ASC X12 837 Professional format, and the hospital charges, (e.g., lab, pharmacy, radiology, anesthesia, emergency room provider, nurse) and supplies on the UB-04 or ASC X12 837 Institutional format.

Splitting claims is payer specific. For example:

- Split lab for technical and professional
- DME and medical

For more information, reference the RPMS IHS Third Party Billing (ABM) User's Manual at this website:

https://www.ihs.gov/RPMS/PackageDocs/ABM/abm_026u.pdf

1.13 Roll-Over/Cross-Over for Secondary and Tertiary Billing

Medicare currently has contractual arrangements with supplemental insurers to automatically crossover claims payment information for their policyholders. An eligibility file furnished by the supplemental insurer is used to drive the process rather than information found on the claim. These eligibility files are matched, based on the Health Insurance Claim Number (HICN), against Medicare's internal eligibility file. If a match occurs, the beneficiary's record is flagged indicating to which company we will cross claim payment information. The HICN has been replaced with Medicare Beneficiary Identifier (MBI).

The name of the crossover insurance company will appear on both the beneficiary Explanation of Medicare Benefits and the provider's Remittance Notice.

Users need to ensure the crossover payment was forwarded to the correct secondary payer by reviewing the remittance advice.

Each supplemental insurer is given the opportunity to specify criteria related to the claims the insurer wants Medicare to crossover. Examples of claims most often excluded from the crossover process:

- Totally denied claims
- Claims denied as a duplicate or for missing information
- Adjustment claims
- Claims reimbursed at 100%
- Claims for dates of service outside of the supplemental policy's effective and end/termination dates.

As part of the CMS process, it is required that for each service furnished by the provider that the provider reports each service as a separate line item on the claim form.

As claims are processed, the beneficiary's eligibility record is checked by the system to determine whether the claim should be considered for crossover. If the beneficiary's eligibility record is flagged for crossover, the claim is then checked by the system to determine whether the claim meets the crossover criteria required by the insurer. If the claim is not excluded, at this point it is marked for crossover to the appropriate company. An electronic claims payment record is then created and forwarded to the requesting insurer. This eliminates the need for the billing office to file claims for the patient's supplemental benefits.

Upon receipt of the transmittal crossover file, the system will initially edit the file and return a flat file to the contractor indicating the number of claims received and accepted. The entire file that contains any transmission error will be returned with a request for retransmission.

In regard to crossovers, Medicare cannot add, change, or delete any eligibility information furnished by an insurer. In addition, the crossover process is totally automatic, and does not require or permit any clerical intervention.

2. Paper Versus Electronic Claims Processing

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2.1 Hard-Copy Claims Processing

Administrative Simplification Compliance Act (ASCA), effective 10/16/03 states: Initial claims for payment under Medicare must be submitted electronically unless a health care professional or supplier qualifies for a waiver or exception from the ASCA requirement for electronic submission of claims. There are only a few situations where electronic billing is not required:

- Any situation where a provider can demonstrate that the applicable adopted Health Insurance Portability and Accountability Act (HIPAA) claim standard does not permit submission of a particular type of claim electronically;
- Disability of all members of a provider's staff prevents use of a computer for electronic submission of claims; and,
- Other rare situations that cannot be anticipated by CMS where a provider can establish that due to condition outside of their control, it would be against equity and good conscience for CMS to enforce this requirement.

2.2 Monitoring Approved Claims - Report

Sites should frequently monitor the Bills Awaiting Export report. This report is an RPMS Third Party Billing function and allows the user to see the number of bills approved and ready to be printed (exported).

To run this report, access the RPMS Third Party Billing system. From the main menu:

- 1) Type **PRTP** to access the Print Bills menu.
- 2) Type **AWPR** to select the Bills Awaiting Export report.

The system displays three options.

- 3) Choose Summarize Report by Insurer (2).

You will be listed as the default approving official.

- 4) At the prompt, type 4, to remove yourself as the approving official (this option allows you to view all approving officials).
- 5) Select your device.

The report will display a bill summary by insurer with an average number of days from approval date to present, plus a total billed amount.

This report may also be provided to Billing staff as a reminder to print or export existing claims.

2.3 Electronic HIPAA Compliant Claims Processing

Electronic Data Interchange (EDI) is the process of transacting business electronically. It includes submitting claims electronically, or “paperless” claims processing, as well as electronic remittance, electronic funds transfer, and electronic inquiry for claim status and patient eligibility.

Health care service information is a detailed, itemized record of health care services performed that are provided to a health plan for reimbursement. The ASC X12N 837 electronic claim form format has been adopted by the Department of Health and Human Services and Indian Health Services and is used by professionals (providers), institutions (facilities or separate clinics), and dental.

Some insurers may require specific detailed information and may communicate those specifics in a Companion Document which serves as an implementation guide (institutional or professional). It is important that you communicate with your health plans or payers to determine which of these guides will be used and what changes to the current claims submission process to expect.

In addition, the ASC-X12N 835 Health Care Claim Payment guide is used for the explanation of claim processing and/or payment sent by the health plan to a provider or facility.

However, those HIPAA standard transactions you choose to conduct electronically must comply with the HIPAA format and content requirements

The transmission of claim files may be done in batches which contain a specific amount of data. The size of the batch varies, based on the protocol selected.

Transmission of claims may also be done “on the fly”. This process means that as a bill is approved, it is also sent directly to the clearinghouse for edits and submission real time. Either way, batch or on the fly, please save your confirmation of claim status receipt.

Following the transmission of claims files, the system performs edits on the files and provides a report. Edits include:

- File level (structural, security and file requirements are validated). These edits normally provide a response to the user right away. Some payers use a 999 acknowledgement, CA277 acknowledgement, or other acknowledgement. Generally, these acknowledgements indicate missing or incorrect data or incorrect format. The user will have to make necessary corrections, re-create the batch, and re-submit.
- Batch level (structural, security and batch requirements are validated). These edits are provided to the user. Unlike the file level edits, not all claims records are rejected. The user is encouraged to make the necessary corrections once the bill is cancelled and re-approve.

- Claim level (claim field requirements are validated). During this level of edit, the payer is processing the claim, utilizing their system edits. Rejections are reported on the remittance advice or 835s. The claim usually has to be researched and re-submitted for payment. After each system cycle, accepted facility forms pay, suspend, or deny. Claims suspended due to errors related to Federal or State guidelines, require a manual review.

In preparation for submitting claims electronically, the following items need to be completed:

- Notify appropriate IT contacts.
- Identify payer that can receive an electronic format.
- Complete business associate agreement and/or trading partner agreement.
- Complete EDI application.
- Obtain companion document.
- Contact insurer and set up test file.
- Set up billing system to correctly populate electronic batch files.
- Run test file and correct transmission errors.
- Change, if necessary, testing status to production status.

The benefits of submitting claims electronically are:

- The claims will be processed faster, improving cash flow.
- Mailing and administrative costs are significantly reduced.
- The clearinghouse edits, as well as the payer front-end editing system save staff time and effort in that fewer claims are returned.
- The facility can also use Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT).
- Online query allows access to claims status information and patient eligibility in real time.
- Records and tracks timely filing – supporting documentation and submission dates to insurer.
- HIPAA compliant.

2.4 Electronic Data Interchange Alternatives

- A software vendor can be selected to enhance the software system currently in place.
- Claims can be transmitted directly to the payer or use a separate clearinghouse.

Each facility will need to use the requirements and processes established by the various payer alternatives.

2.5 Tips for Electronic Submission of Claims

- When working with a cloud-based environment, ensure your vendor is Agency Authorized to Operate (ATO), FedRAMP compliant, and approved by both HHS and IHS security (for Federal sites).
- Enrollment forms will need to be completed and agreements must be signed with all payers through your selected clearinghouse.

Note: It is important to have the appropriate approvals at your facility in the case there are terms within the agreements that cannot be agreed to, depending on your facility.)

- File Transfer Protocol (FTP), web site connectivity, or a dedicated phone line is recommended to prevent interrupted transmissions.
- Make regular backups for all patient and claim data (Disaster-Recovery Procedures).
- Consider using Un-Interruptible Power Supply (UPS) with a surge suppressor to protect your equipment if the facility is prone to power outages.
- Always read the response file from EDI to know what and when was received and whether transmission was accepted.
- Promptly make claim corrections and re-submit, ensuring the resubmission is accepted and not rejected as a duplicate. Each clearinghouse has a process for resubmitting to avoid duplicate rejection.
- When you connect to the insurance company to send claims or retrieve responses and remittances, you are connecting with their communication platform.
- Test a wide variety of claims – inpatient, outpatient, surgery, and such, based on batch limitations set by insurer.
- Reference EDI procedures under HIPAA privacy and security regulations.
- System issues that may cause payment delays should be reported to the supervisor.
- When transmitting claims, the biller needs to print a receipt from the insurer to determine that the transmission was successful.

3. Billing Medicare

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3.1 About Medicare Billing

The Centers for Medicare/Medicaid (CMS) is the regulatory agency for Medicare, Medicaid, and Managed Care Organizations. It is mandated that each facility submit electronically, Medicare and Medicaid claims in the HIPAA 837 format.

Since Medicare's inception in 1966, private health care insurers known as Part A Fiscal Intermediaries (FI) and Part B carriers have processed medical claims for Medicare beneficiaries. The Medicare Prescription Drug Improvement, and Modernization Act (MMA) of 2003 mandated that the Secretary of Health & Human Services replace Part A FIs and Part B carriers with Medicare Administrative Contractors (MACs). In CY 2006 CMS transitioned to Part A and B Medicare Administrative Contractors (MACs).

The current designated IHS MAC is Novitas Solutions. Federally Qualified Health Centers (FQHCs), rural health centers, and other non-IHS American Indian/Alaska Native entities may be enrolled with other MACs based on their jurisdiction.

Reimbursement for IHS acute care hospitals covered inpatient ancillary services and outpatient services is based on All-Inclusive Rates (AIR) negotiated annually by IHS and CMS.

Reimbursement for Critical Access Hospitals (CAHs) covered inpatient ancillary services and outpatient services is based on a facility specific rate determined by cost reports.

For the Medicare outpatient all-inclusive rate and the CAH facility specific visit rate, it is recommended that the correct E&M code be billed for Part A and Part B. Some of the Federally Qualified facilities will have their RPMS system default to an agreed upon code by Medicare for billing purposes.

All charges, except for therapies, telehealth originating site facility fee, PPV, influenza virus vaccine, hepatitis B vaccine, DME, reference labs and hospital-based ambulance services are combined and reported under revenue code 0510 (clinic visit) on TOB 13X (acute care) or 85X (CAH).

All charges for acute care and CAH hospital inpatient ancillary services, except therapies, telehealth originating site facility fee, PPV, influenza virus and hepatitis B vaccines are combined and reported under revenue code 024X (all-inclusive ancillary) on TOB 12X (hospital inpatient Part B) and include the total number of days based on the inpatient stay. Inpatient facilities must also update their room rates along with annual charge updates.

As with all insurers, the correct CPT codes should be coded at the facility, but the billing process should be done according to payer guidelines. All fees

should be updated – CPT, HCPCS, Dental, ASC.

3.1.1 **RPMS Third Party Billing and Medicare Claims Creation**

An option located on the RPMS Third Party Billing Site parameters menu allows a site to customize the claims creation process for Medicare. This option can also be accessed from the Location Edit module.

The prompt is labeled **Medicare Part B?** The user can choose one of the following:

- **YES** – Allows the system to generate Outpatient claims. These claims are generated with a Visit Type of 131 and are usually set up in the Insurer File as All-Inclusive. These are used mainly for FQHC sites that do not have the Part B authority, since the all-inclusive rate includes Part B.
- **NO** – Allows the system to generate two claims, an outpatient claim and a professional component claim:
 - Visit Type 131 – Outpatient (or 851 for Critical Access Hospitals)
 - Visit Type 999 – Professional Component

131 – Outpatient Facilities (including provider-based clinics) that are hospital-based will generally set their prompts up for this.

- **ONLY** – Allows the system to generate professional claims. These claims are generated with a visit type of 000 – Professional Component. These claims are generated with the intention of billing a fee-for-service (itemized) claim for Medicare services. This type of claim is used primarily for Freestanding Health Centers.

3.1.2 **Common Working File (CWF)**

The Common Working File (CWF) reorganizes certain claims processing functions to simplify and improve overall Medicare claims processing, by creating localized databases containing total beneficiary histories. CWF was developed by the CMS Bureau of Program Operations and was designed to:

- Create a beneficiary data set that contains all entitlement and utilization information in one location.
- Increase program savings by detecting additional duplicate and inappropriate payments.
- Enhance utilization review opportunities because all beneficiary history is in one file.
- Avoid costly adjustment processing and overpayment recovery activities with pre-payment edits and perform pre-payment A/B data exchange edits

within the claims process.

Note: CWF is now referred to as HIPAA Eligibility Transaction System (HETS). This is an industry change.

3.1.3 Medicare Part A and B Enrollment

Hospitals, clinics, providers and suppliers who wish to be certified for participation in the Medicare program or are requesting a change of information must complete a current, applicable provider enrollment application (CMS-855).

The Medicare enrollment applications are forms maintained by CMS and located on the CMS Forms website. It is important to submit the most current version of the form CMS-855 paper application.

IHS/Tribal hospitals and FQHCs will complete the CMS-855A enrollment application for any new and/or changes to Medicare Part A. These applications will require the enrollment application fee.

Provider-based and free-standing clinics, ASCs, free-standing ambulances and FQHCs wanting to bill for non-FQHC services will submit the CMS-855B enrollment application for any new and/or changes to Medicare Part B. ASC and ambulance application will require the enrollment application fee.

Individual physicians and non-physician practitioners will complete the CMS-855I and CMS-855R application to enroll with a clinic. The CMS-855I application provides a list of individual physician specialties and Non-Physician Practitioners (NPP) eligible to enroll in the Medicare Part B program.

The Patient Protection and Affordable Care Act (Public Law 111-148) amended Section 221 of the Indian Health Care Improvement Act (IHCIA) to provide as follows:

- Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State, in which the tribal program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. 450, et seq.).

Any practitioner working for IHS or a tribal health facility, must have a valid license, from any State, to enroll with the Medicare program.

For more information on any specific IHS enrollment requirements and addresses to submit the CMS-855 application, reference the IHS MAC enrollment website:

https://www.ngsmedicare.com/ngs/portal/ngsmedicare/newngs/entry!/ut/p/z1/hY5NC4JAEIZ_iwev7thaSLc1S7TCDClbS2hsq7G6opv-ZaKIOhjbjPv8z4MoihFtM76kmeqIHUm9H6gk6NDwrltz2AZRKEDxPGTLVnvbBdjtp8HUB3DlyGg-SOvAwxjl1tWHi-n2xw4I2ewA9HhCgXMn-8S-ocuxzRlp1Zy1rr2upzoVTTTU0wYRgGi0vJBbNOsjLhU6WQnULpO4maKoXLWPQrYhg3nxesbg!!/dz/d5/L2dBISEvZ0FBIS9nQSEh/.

The dental ordering and prescribing providers enrollment form (CMS-8550) can be located on the website at the end of this section.

In August 2010, CMS issued a Joint Signature Memorandum advising that effective September 1, 2010, IHS/Tribal facilities may use Internet-based PECOS or the paper enrollment application (CMS-855) to initially enroll or submit a change of information. For more information on instructions on how to use PECOS, reference Enrollment section on the Novitas-Solutions website: https://www.novitas-solutions.com/webcenter/portal/IndianHealthServiceIHS_JH?_adf.ctrl-state=y5quqf7yy_4&_afLoop=1104346555200585#!

3.2 Procedures for Billing Medicare

3.2.1 Part A

Most, if not all, Medicare Administrative Contractors (MACs) offer the online Direct Data Entry (DDE) software for Medicare Part A billing including claims follow-up and correction. However, it is strongly recommended that each facility that bills to their MAC use the DDE software to perform Medicare billing (when applicable) and follow-up on claim status, denials and rejections.

DDE user manuals are available on the MAC website that is utilized by the facility.

3.2.2 Bill Types

Multiple bill types exist to provide specific pieces of information. The alphanumeric code is broken down to three pieces of information:

- The first digit identifies the type of facility.
- The second classifies the type of care.
- The third indicates the sequence of the bill in this particular episode of care. This is also known as the “frequency” code.

Bill Types		
First digit	Type of Facility	1 – Hospital 7 – FQHC 8 – CAH
Second Digit	Bill Classification	1 – Inpatient Part A 2 – Inpatient Part B Only 3 – Outpatient 5 – CAH Outpatient 7 – FQHC
Third Digit	Frequency	0 – Nonpayment/Zero Claim 1 – Admit through Discharge Claim 2 – Interim – First Claim 3 – Interim – Continuing Claim 4 – Interim – Last 5 – Late Charge Only Claim 6 – Adjustment of Prior Claim 7 – Replacement of Prior Claim 8 – Void /Cancel of a Prior Claim

3.2.2.1 Type of Bills (Locator 4 on the UB-04)

3.2.2.1.1 Inpatient Claims (111)

The total days in the hospital has been determined to be medically necessary based on the severity of the illness according to the utilization review criteria, or stated another way, the services to the patient have been labeled as “covered services.”

3.2.2.1.2 No Pay Claims (110)

During the utilization review, the severity of the illness did not warrant hospitalization. The utilization review will indicate “0 Bill”. Remarks should include why the services were not covered.

3.2.2.1.3 Inpatient Part B Only (121)

The severity of the illness has been determined not medically necessary based on the utilization review criteria. Room and board for the hospitalization are not covered nor are any provider visits.

3.2.2.1.4 Acute Care Outpatient Claims (131)

Refers to a claim billed in an outpatient hospital setting indicating the admit through discharge dates.

3.2.2.1.5 Critical Access Hospital Outpatient Claims (851)

These bill types are to be used for outpatient services.

3.2.2.1.6 Other Alternate Resources (117)

A claim was processed and paid; however, the patient had other alternate resources that should have been billed. Using “117” will instruct the system to “recoup” reimbursement.

3.2.3 Part B

3.2.3.1 Assignment

New IHS/Tribal practices/providers that enroll with the designated IHS MAC, will complete the CMS-460 (participating assignment). Medicare pays the clinic 80% of the physician fee schedule allowable.

3.2.3.2 Reasonable Charges

Reasonable Charges is the amount that Medicare lists on the Remittance Advice (RA) – formerly known as Explanation of Benefits (EOB) – which is the allowed (approved) charge for the procedure. This charge may be lower than the fee the physician lists on the claim.

When a physician accepts assignment, he or she may bill the non-beneficiary only 20% of what Medicare considers a reasonable (allowed) charge.

Do not collect the Medicare co-payment up front on American Indian/Alaska Native patients. However, it is permissible to collect the deductible up front for non-beneficiaries only.

3.2.3.3 Patient’s Signature Authorization

Signatures are required on all CMS-1500 claims forms, except Medicare/Medicaid cases.

Sometimes it is not possible to obtain the signature of a Medicare patient because of confinement in a nursing facility or hospital or at home. In such cases, physicians can obtain a lifetime signature authorization from the patient. The lifetime beneficiary claim authorization and information release form is an example that can be used for Medicare claims and kept in the patient’s health records.

The CMS-1500 form (or electronic equivalent) should be submitted with the notation in the patient’s signature block: “Signature on file.” If the claim will be automatically crossed over and paid by a Medigap carrier, obtain a lifetime signature authorization for the Medigap carrier.

3.2.3.4 Required Form

Medicare claims are to be submitted electronically in the latest ASC x12 837P or 837I format. For more information on the exceptions to electronic filing, reference the CMS IOM Claims Processing Manual (100-04), chapter 24, Section 90.

3.2.3.5 Covered Services

The following list shows the kinds of physicians' services that Medicare Part B will help pay for:

- Medical and surgical services by a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Ophthalmology (OD) or a Doctor of Dental Medicine (DDM) or Dental Surgery (DDS).
- Certain services by Doctor of Podiatry (DPM).
- Limited services by chiropractors (DC), such as subluxation of the spine.

3.2.4 Ambulatory Surgery Center (ASC)

Effective January 1, 2008, CMS implemented a new ASC payment system based on Section 626 of MMA. IHS and tribal hospital ASCs were directly affected by this new requirement. In order to continue reimbursement for the ASC service, IHS and tribal hospitals were required to enroll with Medicare Part B and obtain a Part B ASC Provider Transaction Access Number (PTAN). For ASC, reimbursement is based on the ASC fee schedule. A deductible and coinsurance applies to the outpatient services. Effective with date of service January 1, 2008, Part A claims (TOB 831) submitted as ASC services will be denied. If a hospital elected not to enroll as an ASC with Part B, then the All-Inclusive Rate (AIR) could be billed to Part A using revenue code 0510.

For more information on the most up-to-date guidance for Ambulatory Surgery Center (ASC) services, reference the Novitas website:

www.novitas-solutions.com

3.2.5 Editing a Claim for Facility Billing

For more information on editing a claim for facility billing, reference the RPMS Third Party Billing User's Manual, which is available at this website:

https://www.ihs.gov/RPMS/PackageDocs/ABM/abm_026u.pdf

3.2.5.1 Billing for Professional Component

The following screen output displays a sample walkthrough of billing for professional component.

An asterisk (*) indicates that review is needed by the billing technician.

Note: The information provided in this example is for demonstration purposes only and demonstrates billing for a Cataract Extraction.

- 1) In the Add/Edit Claim Menu option, type **ED**.

```
Select Add/Edit Claim Menu Option: ED EDIT CLAIM DATA
```

- 2) Enter the Claim Number.

```
Select CLAIM or PATIENT: 11111111
```

- 3) Upon entry to the claim, the user will see Page 0 – Claim Summary. Press Enter to proceed to the next page.

```
~~~~~ PAGE 0 ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31258
..... (CLAIM SUMMARY) .....

Pg-1 (Claim Identifiers) Pg-4 (Providers)
Location..: INDIAN HOSP | Attn: NEARSIGHTED, SOLOMAN I
Clinic....: DAY SURGERY |
Visit Type: PROFESSIONAL COMPONENT | Pg-5A (Diagnosis)
Bill From: 02-09-2015 Thru: 02-09-2015 | 1) CATARACT NOS ****ICD****

Pg-2 (Billing Entity) Pg-8 (CPT Procedures)
MEDICARE ACTIVE | 1) CATARACT SURG W/IOL 1 STAGE

Pg-3 (Questions)
Release Info: YES Assign Benef: YES

Desired ACTION (View/Appr/Pend/Next/Jump/Quit): N//
```

- 4) Page 1 – Claim Identifiers allows for editing of the Visit Type and other identifiers. The Visit Type must be 999 – Professional Component but the Bill Type needs to correctly reflect the type of service.

```
~~~~~ PAGE 1 ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31258
..... (CLAIM IDENTIFIERS) .....

[1] Clinic.....: DAY SURGERY
*[2] Visit Type.....: PROFESSIONAL COMPONENT
*[3] Bill Type.....: 831
[4] Billing From Date..: 02/09/2015
[5] Billing Thru Date..: 02/09/2015
[6] Super Bill #.....:
[7] Mode of Export.....: 837P (HCFA) 5010
[8] Visit Location.....: INDIAN HEALTH HOSPITAL

-----
WARNING:071 - EMPLOYMENT INFORMATION UNSPECIFIED
-----
Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//
```

- 5) Page 2 – Insurers provides information on the active insurer billed. This page also indicates if an MSPQ is on file for the patient. Pay attention to MSP information as it may be required for claim adjudication.

```

~~~~~ PAGE 2 ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31258
..... (INSURERS) .....

      PAGE 2 - INSURER INFORMATION

To: MEDICARE ADMINISTRATIVE CONTRACTOR Bill Type...: 831
   PO BOX 21244                Proc. Code...: CPT4
   BALTIMORE, MD 21244         Export Mode.: 837P (HCFA) 5010
   (888)763-9836              Flat Rate...: N/A
.....
MSP STATUS AS OF AUG 04, 2008: NOT MSP ELIGIBLE
.....

      BILLING ENTITY      STATUS      POLICY HOLDER
      =====
[1] MEDICARE              ACTIVE      OLDAGE,MAN
      -----
WARNING:195 - MSP STATUS GREATER THAN 90 DAYS
      -----
Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//

```

- 6) Page 3 – Question will display. Attention must be paid to the Release of Information and Assignment of Benefits questions. These questions must reflect the patient's response as indicated during the registration process.

```

~~~~~ PAGE 3 ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31258
..... (QUESTIONS) .....

* [1] Release of Information... YES From: 08/04/2008
* [2] Assignment of Benefits... YES From: 08/04/2008
[3] Accident Related..... NO
[4] Employment Related..... NO
[5] Emergency Room Required.:
[6] Special Program..... NO
[7] Outside Lab Charges.....
[8] Date of First Symptom...:
[9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17) :
[12] Case No. (External ID)...:
[13] Resubmission(Control) No:
[14] PRO Approval Number.....:
[15] HCFA-1500B Block 19.....:
[16] Admitting Diagnosis.....:
[17] Supervising Prov.(FL19).. NPI:
    Date Last Seen:
[18] Date of Last X-Ray.....:
[19] Prior Authorization #...:
[20] Homebound Indicator.....:
[21] Hospice Employed Prov...:
[22] Delayed Reason Code.....:
[23] In-House CLIA#.....: 12A3456789
[24] Hearing/Vision Prescription Date.....:
[25] Start/End Disability Dates.....:

```

```

[26] Assumed/Relinquished Care Dates:
[27] Patient Paid Amount.....:
[28] Initial Treatment Date...:

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

```

7) Page 4 – Providers contains provider data on the various provider types.

```

~~~~~ PAGE 4 ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31258
..... (PROVIDER DATA) .....

      PROVIDER      NPI      DISCIPLINE
=====
(attn) NEARSIGHTED, SOLOMAN I      0538059458  OPHTHALMOLOGIST

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

```

8) Page 5A – Diagnosis allows the diagnosis information to be entered. The correct version of the International Classification of Diseases (ICD)-CM diagnosis code is displayed and must be the current version.

```

~~~~~ PAGE 5A ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31258
..... (DIAGNOSIS) .....

BIL  ICD
SEQ  CODE  IND  Dx  DESCRIPTION          PROVIDER'S NARRATIVE
===  =====
1    366.9    9  CATARACT NOS          CATARACT NOS

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

```

9) Review the appropriate Claim Editor pages to ensure all charges are properly reported. The example below displays the provider's charge for the surgical procedure. The current Claim Editor may contain up to eleven pages of charges.

```

~~~~~ PAGE 8B ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31258
Mode of Export: 837P (HCFA) 5010
..... (SURGICAL PROCEDURES) .....

BIL SERV  REVN  CORR  CPT
SEQ DATE  CODE  DIAG  CODE          PROVIDER'S NARRATIVE  UNITS  CHARGE
=== =====
1  CHARGE DATE: 02/09/2015
   **** 1    66984 CATARACT SURG W/IOL 1 STAGE          1 2,587.00
                                     =====
                                     $2,587.00

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

```

Claims with special instructions such as Condition Codes or claims notes that are submitted along with the claim may be entered on Page 9.

- 10) Once reviewed, return to Page 0 by typing **J0**. When the claim is ready to approve, type **A** to approve the claim. Scan the Review page to ensure all charges are correctly displaying.

```
Desired ACTION (View/Apr/Pend/Next/Jump/Quit): N// A

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

Active Insurer: MEDICARE

Charge Date      POS TOS  Corr Description      Diag  Charge  Qty
-----
02-09-2015 02-09-2015 22 2  66984          1  2,587.00  1
-----
TOTAL CHARGE                      2,587.00

Form Locator Override edits exist for POS/TOS

Enter RETURN to continue or '^' to exit:
```

- 11) The summary page displays last. Type **Yes** to approve the claim.

```
=====
SUMMARY
=====

Active Insurer: MEDICARE

Previous          Bill
Form  Charges  Payments  Write-offs  Non-cvd  Amount
-----
837P (HCFA) 5010 2,587.00    0.00    0.00    0.00  2,587.00
=====
2,587.00    0.00    0.00    0.00  2,587.00

Do You Wish to APPROVE this Claim for Billing? YES

Transferring Data....

Bill Number 31259A Created. (Export Mode: 837P (HCFA) 5010)
```

3.2.6 Billing for Anesthesia Services

The following screen output displays a sample walkthrough of billing for anesthesia services.

Note: The information provided in this example is for demonstration purposes only.

- 1) In the Add/Edit Claim Menu option, type **ED**.

```
Select Add/Edit Claim Menu Option: ED EDIT CLAIM DATA
```


2) Enter the Claim Number.

```
Select CLAIM or PATIENT: 11111111
```

3) Upon entry to the claim, the user will see Page 0 – Claim Summary. Press Enter to proceed to the next page.

```
~~~~~ PAGE 0 ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31259
..... (CLAIM SUMMARY) .....

Pg-1 (Claim Identifiers) Pg-4 (Providers)
Location...: INDIAN HOSP | Attn: UNDER,ANESTASIA
Clinic....: DAY SURGERY |
Visit Type: PROFESSIONAL COMPONENT |
Bill From: 02-09-2015 Thru: 02-09-2015 | Pg-5A (Diagnosis)
| 1) CATARACT NOS ****ICD****
Pg-2 (Billing Entity) |
MEDICARE ACTIVE |
| Pg-8 (CPT Procedures)
Pg-3 (Questions) | 1) ANESTH LENS SURGERY
Release Info: YES Assign Benef: YES |
|
|
Desired ACTION (View/Apr/Pend/Next/Jump/Quit): N//
```

4) Page 1 – Claim Identifiers allows for editing of the Visit Type and other identifiers. The Visit Type must be 999 – Professional Component but the Bill Type needs to correctly reflect the type of service.

```
~~~~~ PAGE 1 ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31259
..... (CLAIM IDENTIFIERS) .....

[1] Clinic.....: DAY SURGERY
*[2] Visit Type.....: PROFESSIONAL COMPONENT
*[3] Bill Type.....: 831
[4] Billing From Date..: 02/09/2015
[5] Billing Thru Date..: 02/09/2015
[6] Super Bill #.....:
[7] Mode of Export.....: 837P (HCFA) 5010
[8] Visit Location.....: INDIAN HEALTH HOSPITAL
-----
WARNING:071 - EMPLOYMENT INFORMATION UNSPECIFIED
-----
Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//
```

5) Page 2 – Insurers provides information on the active insurer billed. This page also indicates if an MSPQ is on file for the patient. Pay attention to MSP information as it may be required for claim adjudication.

```
~~~~~ PAGE 2 ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31259
..... (INSURERS) .....

PAGE 2 - INSURER INFORMATION
```

```

To: MEDICARE ADMINISTRATIVE CONTRACTOR Bill Type...: 831
  PO BOX 21244          Proc. Code...: CPT4
  BALTIMORE, MD 21244   Export Mode.: 837P (HCFA) 5010
  (888)763-9836         Flat Rate...: N/A
.....
MSP STATUS AS OF AUG 04, 2008: NOT MSP ELIGIBLE
.....

      BILLING ENTITY      STATUS      POLICY HOLDER
=====
[1] MEDICARE              ACTIVE      OLDAGE,MAN
-----
WARNING:195 - MSP STATUS GREATER THAN 90 DAYS
-----
Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//

```

- 6) Page 3 – Question will display. Attention must be paid to the Release of Information and Assignment of Benefits questions. These questions must reflect the patient’s response as indicated during the registration process.

```

~~~~~ PAGE 3 ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31259
..... (QUESTIONS) .....

[1] Release of Information...: YES   From: 08/04/2008
[2] Assignment of Benefits...: YES   From: 08/04/2008
[3] Accident Related.....: NO
[4] Employment Related.....: NO
[5] Emergency Room Required..
[6] Special Program.....: NO
[7] Outside Lab Charges.....
[8] Date of First Symptom...
[9] Date of Similar Symptom..
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17) :
[12] Case No. (External ID)...
[13] Resubmission(Control) No:
[14] PRO Approval Number.....
[15] HCFA-1500B Block 19.....
[16] Admitting Diagnosis.....
[17] Supervising Prov.(FL19).. NPI:
    Date Last Seen:
[18] Date of Last X-Ray.....
[19] Prior Authorization #...
[20] Homebound Indicator.....
[21] Hospice Employed Prov...
[22] Delayed Reason Code.....
[23] In-House CLIA#.....: 12A3456789
[24] Hearing/Vision Prescription Date.....
[25] Start/End Disability Dates.....
[26] Assumed/Relinquished Care Dates:
[27] Patient Paid Amount.....
[28] Initial Treatment Date..

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

```

- 7) Page 4 – Providers contains provider data on the various provider types.

```

~~~~~ PAGE 4 ~~~~~
Patient: OLDAGE,MAN [HRN:99090]          Claim Number: 31259

```

```

..... (PROVIDER DATA) .....
      PROVIDER      NPI      DISCIPLINE
=====
(attn) UNDER,ANESTASIA      2233445560  ANESTHESIOLOGIST

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

```

- 8) Page 5A – Diagnosis allows the diagnosis information to be entered. The correct version of the ICD-CM diagnosis code is displayed and must be the current version.

```

~~~~~ PAGE 5A ~~~~~
Patient: OLDAGE,MAN [HRN:99090]      Claim Number: 31259
..... (DIAGNOSIS) .....

BIL  ICD
SEQ  CODE  IND  Dx  DESCRIPTION      PROVIDER'S NARRATIVE
===  =====
1    366.9    9  CATARACT NOS      CATARACT NOS

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

```

- 9) Review the appropriate Claim Editor pages to ensure all charges are properly reported. The example below displays the provider's charge for the anesthesia charges. The current Claim Editor may contain up to eleven pages of charges.

```

~~~~~ PAGE 8G ~~~~~
Patient: OLDAGE,MAN [HRN:99090]      Claim Number: 31259
Mode of Export: 837P (HCFA) 5010
..... (ANESTHESIA SERVICES) .....

      REVN      TOTAL
      CODE      CPT - ANESTHESIA SERVICES      MIN  CHARGE
=====
[1] **** 00142-AA ANESTH LENS SURGERY      60    476.00
      (UNDER,ANESTASIA-R)
      Start Date/Time: 9-FEB-2015 9:00 AM
      Stop Date/Time: 9-FEB-2015 10:00 AM
                        =====
                        $476.00

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

```

Claims with special instructions such as Condition Codes or claims notes that are submitted along with the claim may be entered on Page 9.

- 10) Once reviewed, return to Page 0 by typing **J0**. When the claim is ready to approve, type **A** to approve the claim. Scan the Review page to ensure all charges are correctly displaying.

```

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

```

```

Active Insurer: MEDICARE

Charge Date      POS TOS  Corr Description      Diag  Charge  Qty
-----
02-09-2015 02-09-2015 22 7  00142-AA          1  476.00  60
-----
TOTAL CHARGE                                476.00

Form Locator Override edits exist for POS/TOS

Enter RETURN to continue or '^' to exit:

```

11) The summary page displays last. Type **Yes** to approve the claim.

```

SUMMARY
=====
Active Insurer: MEDICARE

Form      Previous      Bill
Charges   Payments   Write-offs   Non-cvd   Amount
-----
837P (HCFA) 5010  476.00    0.00    0.00    0.00    476.00
-----
476.00    0.00    0.00    0.00    476.00

Do You Wish to APPROVE this Claim for Billing?

Transferring Data....

Bill Number 31259A Created. (Export Mode: 837P (HCFA) 5010)

```

3.2.7 Medicare Ambulatory Surgery Billing Procedure

The coder completes the coding for all ambulatory surgery visits. The coding will be entered in the PCC menu.

The claims generator will convert and create a bill in the Third Party Billing application overnight.

The biller will print out a Flag-As Billable Brief Summary listing and will use this listing as a guide to what visits/claims to bill.

All edits need to be accomplished to complete a “clean” claim. Once all the edits have been made, the biller will determine the approval of the bill and will submit the bill on the appropriate claim form, which will be transmitted electronically.

- Review the Inpatient or Ambulatory Surgery abstracts from the Utilization Review (UR).
- Verify completeness and accuracy.
- Enter the claims data into the system for processing.
- Review data for completeness and accuracy.

3.3 Medicare Secondary Payer (MSP)

Medicare Secondary Payer (MSP) is used by Medicare when Medicare is not responsible for paying first. It is important to check if Medicare or Medicaid has already been billed and take the appropriate action.

For accounts with two insurance companies, the RPMS Accounts Receivable application requires documentation of the primary billing company.

By Federal law, Medicare is secondary payer to a variety of government and private insurance benefit plans. Medicare should be viewed as the secondary payer when a beneficiary can reasonably be expected to receive medical benefits through one of more of the following means:

- An Employer Group Health plan for working aged beneficiaries
- A Large Group Health Plan for disabled beneficiaries
- Beneficiaries eligible for End State Renal Disease
- Liability/Automobile medical or no-fault insurance/Personal Injury Protection (PIP)
- Veterans Administration (VA)
- Workers' Compensation Plan
- Federal Black Lung Program

Any conditional primary payment(s) made by Medicare for services related to an injury is subject to recovery. Conditional payments can be made on:

- Liability
- Automobile medical or no-fault insurance
- Workers' Compensation

For more information on MSP guidelines, reference the CMS IOM, Medicare Secondary Payer (100-05) website:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html>

3.3.1 Working Aged

Medicare is secondary for the **Working Aged** when the following conditions apply:

- Employer Group Health Plan of 20 or more employees;
- Employer Group Plan covers the same services as Medicare;
- Beneficiary is age 65 or older;
- Beneficiary is entitled to Part A (hospital insurance of Medicare; and,
- Beneficiary or spouse of beneficiary is actively employed and covered by an employer group plan by reason of his/her employment.

3.3.2 Disability

Medicare is secondary for beneficiaries who are under age 65 and are entitled to Medicare due to a **disability** other than End State Renal Disease (ESRD) for the following criteria:

- The beneficiary has coverage under a Large Group Health Plan with 100 or more employees;
- The beneficiary is entitled to Medicare based solely on a disability (other than ESRD); and,
- The beneficiary is actively employed or covered as a dependent of an actively employed person covered under a Large Group Health Plan with 100 or more employees.

3.3.3 End Stage Renal Disease (ESRD)

The **End Stage Renal Disease (ESRD)** criteria applies to individuals, including dependent children who are entitled to Medicare on the basis of ESRD and who are covered under an Employer Group Plan, regardless of the size of the plan. The criteria are:

- If an Employer Group Health Plan (EGHP) is offered through an employer because of his/her employment or employment of spouse or other family member's active employment; then Medicare is secondary to an EGHP for individuals who have Medicare benefits based on ESRD. The beneficiary can be any age; and,
- The period in which Medicare is secondary is called the coordination of benefit period. Secondary benefits are payable for a period up to 30 months.

3.3.4 Liability/Automobile Medical or No-Fault/Personal Injury Protection Insurance

Section 953 of the Omnibus Budget Reconciliation Act of 1980, amended by the Deficit Reduction Act of 1994, precludes Medicare payment for items or services to the extent that payment has been made or can reasonably be expected to be made under auto medical, Personal Injury Protection (PIP), no-fault, or any **liability** insurance plan or policy, including self-insurance plans.

Services that should be billed to these insurance plans are:

- Services payable under one of the above plans (except third party liability) – that plan should be billed until all benefits are exhausted.
- Any payments made by Medicare for services payable under one of these policies constitute overpayments and are subject to recovery.
- Liability insurance plan is an exception to the above rule. The physician/supplier has the option to bill Medicare for conditional primary payment.

3.3.5 Veterans

Veterans who are also entitled to Medicare may choose which program will be responsible for payment for services that are covered by both programs. Claims for services for which the veteran elects Medicare coverage should be submitted to Medicare in the usual manner. A denial from the VA is not needed prior to submitting a claim for Medicare.

Medicare will be primary to the VA in the following situations:

- VA denies the services and the services are covered under Medicare.
- Correspondence is received indicating “No VA Coverage.”

Insurers frequently see the following situations with Medicare and VA:

- If the VA is unable to provide treatment for the services at one of its own facilities or by one of its own physicians, they may refer the beneficiary to an outside facility or physician.
- Pre-authorization is obtained from the VA to use an outside facility.
- The beneficiary has been issued a “fee basis” card. This card is an agreement by the VA to pay up to a specified dollar amount for treatment of a specific disability or for any condition specified on the face of the “fee basis” card.

3.3.5.1 VA and IHS Agreement

A MOU was signed on December 5, 2012 between the Veterans Administration (VA) and the Indian Health Service. The MOU allows for I/T/U facilities to bill to the VA’s central claim center (VISN 20) for American Indian/Alaska Native (AI/NA) veterans. This requires enrollment to

the VA's Health Eligibility Center (HEC) prior to claims submission. Under the MOU, VA eligibility is considered the payer of last resort and covers the following services:

- Outpatient
- Inpatient
- Emergency Room Services
- Pharmacy
- Dental – limited services which requires verification of coverage

NA/AI veterans may not be billed for copays.

Non-Indian Beneficiaries are not covered under the MOU and must be billed to the local VA facility.

3.3.6 **Workers' Compensation**

Federal law precludes payment for services payable under a **Workers' Compensation** policy. If services are work-related, the Workers' Compensation policy should be billed until all benefits are exhausted.

Medicare remains primary payer for services not related to Workers' Compensation.

With Workers' Compensation:

- Medicare may make payments for Medicare covered services, if not payable under the Workers' Compensation policy.
- Services payable under a Workers' Compensation policy that have been paid by Medicare constitute overpayments and are subject to recovery.
- A beneficiary's statement that an injury or illness is not work-related may be accepted in absence of reasonable doubt.

3.3.7 **Black Lung**

Medicare will pay secondary to an insurance company paying for **Black Lung** diagnosis with the exception of the United Mine Worker's Association (UMWA). UMWA is their own government entity; therefore, Medicare Part B will deny charges.

However, services rendered to these beneficiaries for conditions not related to black lung diagnoses should be billed directly to Medicare, such as cardiac failure brought on by renal failure. Medicare will pay primary for services not related to black lung disease.

3.3.8 Provider Responsibilities under MSP

Part A provider (hospitals):

- Obtain billing information prior to providing hospital services, using the recommended CMS Medicare Secondary Payer Questionnaire (MSPQ) (or a questionnaire that asks similar types of questions). The MSPQ must be obtained at every inpatient admission and outpatient service, except for repetitive services (i.e., therapy) and reference labs (TOB 141). For repetitive services and reference labs, the MSPQ must not be older than 90 days from the date of service. For more information on MSPQ Guidelines, reference Chapter 3 of the CMS IOM MSP Manual (100-05):
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html>.
- Submit any MSP information to the intermediary, using condition and occurrence codes on the claim.

Part B provider (physicians and suppliers):

- Follow the proper claim rules to obtain MSP information, such as group health coverage through employment or non-group health coverage resulting from an injury or illness;
- Inquire at the time of the visit if the beneficiary is taking legal action in conjunction with the services performed.

3.3.9 Submitting Medicare Secondary Payer (MSP) Claims

To ensure correct reimbursement when Medicare is secondary payer to another insurance company, use the following instructions:

- Screen Medicare beneficiaries for secondary coverage.
- Send claims to the primary insurance and then to Medicare. Services submitted to Medicare must be the same as those filed to the primary insurance.
- Submitting an MSP claim electronically requires the submission of the following data elements:
 - Insured's name.
 - Patient's relationship to insured.
 - Insured's address and telephone number.
 - "Yes" or "No" response to whether service is related to employment, auto liability or accident. If yes, enter the state where auto accident occurred (if applicable).
 - Insured's date of birth and sex.

- Subscriber's payer identification (group plan or plan name).
- Primary insurer type code (i.e., working aged-12, disability-43).
- Amount paid by primary payer.
- Amount allowed by primary payer.
- OTAF amount (if applicable).
- CAS codes (as applicable).

For more information on tribal self-funded insurance and Medicare Part A and B claim submission requirements, reference the Novitas' IHS website.

3.3.10 Medicare Secondary Payer (MSP) Claims Investigation

The CMS Benefits Coordination and Recovery Center (BCRC) consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The BCRC takes actions to identify the health benefits available to a Medicare beneficiary and coordinates the payment process to prevent mistaken payment of Medicare benefits. For more information on the MSP regulations, reference the CMS Coordination of Benefits website:

<http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits.html>

3.4 Medicare Timely Filing

Section 6404 of the Affordable Care Act (ACA) states that claims with dates of service January 1, 2010 and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

For Part A institutional claims that include span dates of service (i.e., a "From" and "Through" date span on the claim), the "**Through**" date on the claim will be used to determine the date of service for claims filing timeliness. For Part B professional claims (CMS-1500 Form and 837P) submitted by physicians and other suppliers that include span dates of service, the line item "**From**" date will be used to determine the date of service and filing timeliness.

3.5 Claims Resubmission Guidelines

- In some instances, the claim may not be considered unless billing errors are corrected. These Remittance Advices or Explanation of Benefits are routed back to the individual billing clerks for correction and then

resubmitted to the respective insurer.

- Claim resubmission may be done via fax, mail, or electronically.
 - The filing limit for Medicaid varies by state, from as low as 120 days to one year. Resubmission of claims is usually within 6 months from the date of the remittance advice.
- For claims submitted electronically to Medicare Part A, the DDE system will show the following abbreviations that may be returned for denied or un-processable claims:

R status	Rejected
T status	Return to Provider (RTP)
D status	Medically denied
Type of Bill	XXP (PRO adjustment) <i>or</i> XXI (Intermediary adjustment)

The original bill can be resubmitted on both the status of T or R, if additional or corrected information is supplied. The original type of bill frequency codes should be used. The T status cannot be adjusted (XX7) or voided (XX8), since it is not considered an active bill.

For more information on how to perform claim adjustments and corrections, reference the Novitas DDE manual. The DDE manual is located on the Novitas EDI website.

Claim Change Condition Codes

Claim change reason codes are used in DDE when making an adjustment or change to a Part A claim.

Valid Code	Code Description
D0	Change to Service Dates
D1	Changes to Charges
D2	Changes to Revenue Codes/HCP/PCS/HIPPS
D3	Second or subsequent interim PPS bill
D4	Change in Grouper input
D5*	Cancel only to correct a HICN or provider identification number
D6*	Cancel only to repay a duplicate OIG payment
D7	Change to make Medicare the Secondary Payer
D8	Change to make Medicare the Primary Payer
D9	Any other change
E0	Change in Patient Status
*D5 and D6 are for XX8 Type of Bill only.	

- Medicare Part B professional claims that have been denied can be appealed by the designated IHS MAC within 120 days of the date of the remittance notice or corrected and resubmitted as a new claim (within timely filing). Claims that have been rejected as unprocessable (remark code CO-16) must be corrected and resubmitted as a new claim, within timely filing.
- Most Private Insurance companies have a one-year filing limit. Some private insurers are longer than one year. Resubmissions on denied claims must be completed by December 31 of the next calendar year
- The claim may then be rolled for further billing to secondary/tertiary insurer as applicable.

3.5.1 Steps for Approving a Secondary/Tertiary Claim in RPMS

- 1) Exit the Accounts Receivable (A/R) menu.
 - 2) Go to the RPMS Third Party Billing application and select the Add/Edit Claim Menu.
 - 3) At the prompt, type **EDCL** (Edit Claim Data) and press Enter.
 - a) Examine claim for accuracy and make corrections if necessary.
 - 4) On **Page 1**, check for visit type and mode of export.
 - a) Visit type is set to Secondary or similar, based on site set up
 - b) Mode of export allows you to bill the claim on a CMS-1500 or UB-04 manually. Since Medicare/Medicaid claims are transmitted electronically by utilizing the HIPAA 837P and/or 837I, the mode of export needs to be changed to CMS-1500 and/or UB-04 so claims can be resubmitted manually.
 - 5) On **Page 2**, select the billing entity and insurer address.
 - 6) On **Page 3**, review Assignment of Benefits and Release of Information.
 - 7) On **Page 4**, check for provider name and credential.
- Note:** If corrections are needed on Pages 5A through 9F, claim is routed to Billing technician.
- 8) JO (Jump Zero) to claim summary.
 - 9) Type **A** to approve the claims.

10) Verify the mode of export and correct dollar amount(s). Then type **Y** (Yes) to approve claim.

11) Exit EDCL.

3.5.2 Steps for Exporting a Claim

- 1) Go to the Print Bills Menu and select **EXPR** to export the approved claim.
- 2) Select form to be exported (CMS-1500 or UB-04) and press Enter.
- 3) Select a print device for the CMS-1500 or UB-04 form by entering the device for your printer, and press Enter.

3.5.3 Steps for Reprinting a Claim for Resubmission

- 1) Exit the Accounts Receivable (A/R) Menu.
- 2) Got to REPR or reprint bill.
- 3) At the prompt, type **1** for Selective Bill(s) and press Enter.
- 4) Enter the claim number(s) and press Enter.
- 5) Enter the print device and enter the device for your printer for either the CMS-1500 or UB-04 to reprint ADA.
- 6) Press Enter to start the print jobs.

For all resubmissions, attach a copy of the Remittance Advice, Explanation of Medicare Benefits, and Commercial insurance EOBs when appropriate.

3.6 Reimbursement for Clinical Nurse Specialist (CNS), Nurse Practitioner (NP) and Physician Assistant (PA)

The services of a CNS, NP and PA may be covered under Part B if all of the following requirements are met:

- They are the types that are considered physician's services if furnished by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).
- They are performed by a person who meets all of the CNS, NP and PA qualifications.
- For NP and CNS services, they are furnished in collaboration with an MD/DO as required by state law.

- The PA must be employed, and services are performed under the general supervision of an MD/DO.
- They are not otherwise non-covered.

Examples of the types of services that a CNS, NP and PA may provide include services that traditionally have been reserved for physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting X-rays and other activities that involve an independent evaluation or treatment of the patient's condition.

For more information on a list of non-physician practitioners eligible to enroll in the Medicare program, reference the CMS-855I enrollment application.

3.7 Medicare Resources

3.7.1 CMS Internet Only Manual (IOM)

The following are not all of the CMS manuals that provide coverage and billing guidelines. For more information, reference the CMS manuals website:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>

- **Medicare Benefit Policy Manual (100-02)**
 - Chapter 15 - Covered Medical and Other Health Services.
- **Claims Processing Manual (100-04)**
 - Chapter 1 – General Billing Requirements
 - Chapter 3 – Inpatient Hospital Billing
 - Chapter 12 – Physician/Non-Physician Billing
 - Chapter 19 – Indian Health Service
 - Chapter 25 – Completing and Processing the CMS-1450 (UB-04) Claim
 - Chapter 26 – Completing and Processing the CMS-1500 Claim
- **Medicare Secondary Payer Manual (100-05)**
- **Medicare Program Integrity Manual (100-08)**
 - Chapter 15 – Provider Enrollment

3.7.2 Novitas Solutions

For more information on the Indian Health Manual that was developed by the

previous IHS designated MAC, TrailBlazer Health, reference the Novitas website:

www.novitas-solutions.com

4. Billing Medicaid

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4.1 About Medicaid Billing

The Centers for Medicare/Medicaid (CMS) is the regulatory agency for Medicare, Medicaid, and Managed Care Organizations. CMS has allowed each state to develop and operate its own Medicaid program. Medicaid regulations are set forth in Title XIX of the Social Security Act.

- **Medicaid** is a program administered at the state level, which provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. It may be known by different names in different states.
- IHS hospitals and clinics will bill Medicaid at current per diem rates according to the Federal Register for inpatient and outpatient visits. For hospitalizations, professional fees can be billed to Medicaid; however, each state determines the fee schedule that will be used.
- Each state provides different benefits and eligibility packages for their population. Please contact your state for specific information.
- It is recommended that each facility submit Medicaid claims electronically in the HIPAA 837 format, if acceptable to the State. Each Medicaid insurer provides a reference manual on setting up and submitting electronically.

4.2 Medicaid Approval and Export Process

- Review the RPMS Third Party Billing system “flagged as billable” report for inpatient, outpatient and ambulatory billing. This report is a review of claims automatically flagged by the nightly claims generator that are ready for billing.
- Review claim data for accuracy and completeness.
- Any issues with coding, system problems, or missing information needs to be corrected before approval.
- Bill according to the state’s billing format.
- Approve and export claim.

There are various ways of submitting claims electronically. Refer to your State Medicaid guidelines for batching and submitting claims electronically.

4.2.1 Electronic Claim Submission for Medicaid

- 1) Communicate with the State Medicaid Program to understand their current capabilities and protocol and request a copy of the payer’s Companion Document for electronic submission of claims.
- 2) Reference the current RPMS Third Party Billing Manual or Software

Vendor Guide for Electronic Claim Submission Process.

- 3) Each bill type (inpatient, outpatient, or ambulatory surgery, etc.) will process individually and a separate file will also be created by location.
- 4) Assign an appropriate file name to the selected type of bill.
- 5) Use File Transfer Protocol (FTP) software, modem, or web-based communication to submit electronically in the correct transfer mode format. The mode of transfer may vary by State Medicaid Program.

4.3 Medicaid Timely Filing

Most claims for services submitted to Medicaid must be submitted within the state required guidelines; for example, a State Medicaid Program has a timely filing limit of within 120 days of the date the service. Some states require transmission as early as within 90 days. Some States allow 365 days.

States may also have timelines for resubmissions of adjusted, rejected or denied claims; for example, a State Medicaid Program may require that providers submit claims within six (6) months of the date on the “remittance advice” form which accompanied the payment or denial of the claim.

Follow your State requirements for finalizing claims. Know your State Medicaid’s timely filing limit.

These are examples of exceptions to general time limitations for Medicaid submission:

Note: Not all States will accept all exceptions. Know your State’s requirements.

- If claims are submitted more than 120 days after the date of service, the statement of benefits from the other insurance or the denial of benefits from the other insurance must be attached to the claim to verify that the other payment source has been pursued.
- If a provider receives payment from the other insurance or liable third party after receiving payment from Medicaid, an amount equal to the lower of either the insurance payment or the amount paid by Medicaid must be immediately remitted to Medicaid.
- Claims for services furnished by out-of-state providers must be submitted within 120 days (or the timeframe authorized by the state Medicaid, if different) of the date of service. In the event the out-of-state provider does not have a Medicaid provider number for that state, the request for the provider number must also be submitted within the 120-day limit.
- Claims for services provided during a period for which retroactive

eligibility has been established must be submitted within 120 days (or timeframe authorized by that state Medicaid) of the date the Medicaid claims processing area was notified of the retroactive eligibility.

- Corrected claims which are originally submitted within the timely filing limit and need corrections or additions must be completed and submitted to Medicaid or its claims processing area within 365 days of the date of service.
- Duplicate claims which are used to replace lost or unprocessed claims must be submitted within the same timeframe as an original date of service claim.

5. Billing Private Insurance

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5.1 Procedure for Billing Private Insurance

Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company.

The Indian Health Care Improvement Act grants the authority to bill and receive reimbursement from Private Insurance Companies.

Each Private Insurance Company may vary in coverage for patients, billing requirements, etc.

Communicate and understand each Private Insurance Companies' current coverages, capabilities and protocol, etc. and request a copy of the payer's Companion Document for electronic submission of claims.

It is recommended that each facility submit Private Insurance claims electronically, where feasible, either directly to the payer, or through a Clearinghouse, in the HIPAA 837 format.

All billable claims/visits are identified through the RPMS Patient Registration, PCC, and Third Party Billing system through the system parameter set up and claim generator process. Claims are completed and released in PCC. The claim generator process runs overnight and creates the claims to appear on the Brief (Single-line) Claim Listing (BRRP) Reports.

In order to identify billable claims, run your BRRP report. This can be run without any specific criteria, just everything in there, or by payer, by date, by location, by clinic, etc.

- 1) Begin by entering your claim number and begin your review of the claim information.
- 2) Quick reference for Third Party Billing Claim Editor:

Enter the Claim Number or the patient's last name and first name, and social security number or health record number or date of birth.

Note: After the system checks for errors, checks eligibility file, checks for release of information, and assignment of benefits, it displays the claims summary.

Review the **Claim Summary**.

Page 0 is the first screen to appear. This screen provides a high-level summary of the claim.

Check "Claims file error exists."

This is the first place to review for any missing or inaccurate information. These errors must be corrected (by page).

Page 1	Claim Identifiers	<ul style="list-style-type: none"> • Location • Clinic • Visit Type (drives property of claims editor) • Bill From and Through Dates • Bill Type (edits in system) (Bill type should not be changed to 999) • Mode of Export (claim form using to bill)
Page 2	Billing Entity	<ul style="list-style-type: none"> • Name of insurance company • Status of claim
Page 3	Questions	(both should be answered “yes”) <ul style="list-style-type: none"> • Release of information • Assignment of benefits
Page 4	Providers	(list all providers on record) <ul style="list-style-type: none"> • Attending physician • Operating physician (if applicable)
Page 5A	Diagnosis	<ul style="list-style-type: none"> • List all coded diagnosis in words not codes • Review the visit to ensure correct diagnosis sequence is listed. • Diagnosis code should be linked to the HCPCS code
Page 5B	ICD Procedures	<ul style="list-style-type: none"> • List all coded ICD procedures in words not codes
Page 8	CPT Procedures	<ul style="list-style-type: none"> • List all coded CPT procedures in words not codes

- 3) At the Desired Action prompt, type **N (Next)** to move from page to page, and on each page, review the data for accuracy.

On this page...	Review these data for accuracy:
Page 1 - Claim Identifiers	<ul style="list-style-type: none"> • Visit Location – Name of Clinic • Billing Location – Name of Clinic • Clinic – General, Day Surgery, Outpatient, Walk-in, etc. • Visit Type – Inpatient, Ambulatory Surgery, Outpatient

	<ul style="list-style-type: none"> • Bill Type – 111 (Inpatient), 831 (Day Surgery), 131 (Outpatient) • Billing From Date – Admission or Visit Date • Filling Through Date – Discharge or Visit Date • Super Bill Number – Leave Blank
Page 2 – Insurers	<ul style="list-style-type: none"> • Review the insurance companies for accuracy • Confirm that the primary and secondary carriers are correct • Confirm that the correct Export mode is selected
Page 3 – Questions	<ul style="list-style-type: none"> • Release of Information, • Assignment of Benefits, must always be “yes” • Accident Related, • Employment Related, would be “yes” if applicable • Emergency Room Required, would be “yes” if the patient had an emergency room visit or was admitted from the emergency room • Prior Authorization Number, enter if applicable
Page 3A – Ambulance Data	<ul style="list-style-type: none"> • Indicate origin (location of patient pick-up) • Destination (location where patient was transported) • Medical necessity indicator must be answered • Indicate covered/uncovered mileage • Indicate condition codes
Page 4 – Provider Data	<ul style="list-style-type: none"> • Verify all providers are listed – attending, operating, etc. that took care of the patient • Verify the physician provider numbers are correct • Verify the titles of the discipline of each physician

Page 5A – Diagnosis	<ul style="list-style-type: none"> • The diagnosis codes should be listed in billing sequence order, this must be reviewed and manually entered • The ICD codes should be the providers written narrative • Limit the use of V-codes – most insurers do not pay for V-codes
Page 5B – ICD Procedures	<ul style="list-style-type: none"> • List all ICD procedures performed by provider
Page 7 – Inpatient/Day Surgery Data	<ul style="list-style-type: none"> • All inpatient services should be listed on this page • Confirm data matches the Final A sheet • Number 3 Admission Type and Number 4 Admission Source are often incorrect. Validate • Number 11 Covered Days are often incorrect. Validate and if incorrect, enter the correct number of days. All Day Surgery accounts should be blank. • Number 12 Include the Noncovered Days • Prior authorization, if applicable
Page 8A – Medical Services	<ul style="list-style-type: none"> • Multiple procedures and Evaluation and Management (E&M) codes that begin with CPT code 9 are listed on this page • Professional components for pathology with modifier 26 needs to be added • EKG's should be added on this page, if they are not list on Page 8H – Miscellaneous services • Outpatient claims – Professional fee or Evaluation and Management codes should be added based on the superbill or Patient Care Service (PCS) form

8B – Surgical Procedures	<ul style="list-style-type: none"> • Surgical codes that begin with CPT codes 1 through 6 are listed on this page • Surgical codes are submitted in the order coded • All procedures should be edited to match corresponding diagnosis codes • Only one facility fee should be list. Delete all others
Page 8C – Revenue Codes	<ul style="list-style-type: none"> • The revenue codes include a charge for: <ul style="list-style-type: none"> 12X Room & Board 17X Nursery Room & Board 20X Intensive Care 21X Coronary Care 370 Anesthesia 710 Recovery Room 72X Labor room/Delivery (hourly charges) 272 Sterile Supply 278 Other Implants (also referenced on Page 3, Item 12) • Confirm data with file folder, correct price and units • Outpatient – revenue codes not applicable
Page 8D – Medication	<ul style="list-style-type: none"> • Pharmacy revenue codes include: <ul style="list-style-type: none"> 250 General Pharmacy 253 Take Home Drugs 257 Non Prescription Drugs 258 IV Solutions • For outpatient, view the medications in the medication profile • Add any medications not listed, match medications to corresponding diagnosis and ordering provider, and match dispense date with date of service
Page 8E – Laboratory Services	<ul style="list-style-type: none"> • The laboratory services include all labs with revenue codes 30X and CPT codes that begin with “8”

	<ul style="list-style-type: none"> No pathology services (31X) should be listed on this page. The professional components should be listed on page 8A and the technical components listed on page 8H For outpatient, check labs in the Lab Profile Add any missing services and match the labs to the corresponding diagnosis A CLIA number may be entered for reference lab charges
Page 8F – Radiology Services	<ul style="list-style-type: none"> The radiology services include all diagnostic radiology services with revenue codes 32X and CPT codes that begin with “7”. CT Scans are also entered on this page For outpatient, check radiology reports to make sure the x-ray was completed Match x-ray to the corresponding diagnosis
Page 8G – Anesthesia Services	<ul style="list-style-type: none"> This page is only used for adding manual anesthesia charge. Anesthesia services are automatically interfaced by the system and are listed on Page 8C Outpatient – this page is not applicable
Page 8H – Misc. Services	<ul style="list-style-type: none"> This page is used to enter HCPCS codes for supplies. CPT codes are also entered on this page if required
Page 8I – Inpatient Dental Services	<ul style="list-style-type: none"> Payer specific
Page 8K – Ambulance Services	<ul style="list-style-type: none"> Attendant and mileage may be entered on this page
Page 9A – Occurrence Codes	<ul style="list-style-type: none"> Accident related codes and dates are used, if applicable Medical condition codes and dates are used, if applicable

	<ul style="list-style-type: none"> Insurance related codes and dates are used, if applicable Service related codes and dates are used, if applicable
Page 9B – Occurrence Span Codes	<ul style="list-style-type: none"> Payer specific
Page 9C – Condition Codes	<ul style="list-style-type: none"> Payer specific
Page 9D – Value Codes	<ul style="list-style-type: none"> Payer specific
Page 9E – Special Program Codes	<ul style="list-style-type: none"> Payer specific
Page 9F – Remarks	<ul style="list-style-type: none"> E codes and injury-related comments would appear on the UB92 Payer specific This page can also be used to note additional information

4) Approve, print, and mail claims to insurer.

5.2 Private Insurance Timely Filing

Check with insurance companies to determine specific filing limits. Know your Private Insurance Companies' timely filing limit. Timely filing timeframes are changing. Most private insurance companies allow claims to be filed within one year from the date of service and some even will allow reimbursement up to and including the end of the calendar year following the year in which the service was rendered. Insurers such as Workers' Compensation may request that bills be submitted with 60-to-90 days from the date of service.

6. Third Party Liability Billing

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6.1 Third Party Liability Billing

It is the policy of the IHS to comply with all laws and regulations as they relate to reporting third party tortfeasor claims and to recover funds that are properly owed to the HIS for providing direct care or contract health services. The IHS will ensure that all potential third party liability claims are properly identified and reported to OGC (or its designee) for recovery of those funds owed to the IHS for health care services provided when a patient's injury was due to a negligent third party.

The Federal Medical Care Recovery Act (FMCRA), passed in 1962, provides a legal basis to recover funds for the delivery of medical services provided to an injured person in third party liability claims. Prior to November 23, 1988, all recoveries were retained by the Department of the Treasury. However, the passage of the "Indian Health Care Amendments of 1987, Title II," on November 23, 1988, which was an amendment to the IHCIA, allowed the IHS, to retain recovered funds. The FMCRA claims provide an additional source of revenue for the IHS, and equivalent time and effort should be committed to properly identifying, reporting, and pursuing the recovery of these funds.

The IHS has a distinct right of recovery against a negligent third party for the reasonable value of medical care provided to the injured person. The only two conditions precedent to such right of recovery are: (1) the furnishing of medical care to the injured person at the IHS's expense, and (2) circumstances creating a tort liability upon a third party. When these two conditions are met, the IHS has a legal and independent right to recover medical costs from the tortfeasor. Funds may be recovered for the reasonable value of medical care provided to injured persons for direct care services or services paid through contract health care. The IHS does not have the authority to make legal determinations of tort liability. All potential third party liability claims are reported by the IHS to the OGC or its designee. The OGC is responsible for making determinations of tort liability and asserting all IHS FMCRA claims.

For more information, reference Part 4, Appendix, "FMCRA" document. It contains a step-by-step process for one Area that works very closely with their OGC Regional Counsel. All forms, all information, tracking mechanisms, letters sent, etc. are included in this process.

7. Billing Private Dental Insurance

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7.1 About Dental Insurance

Dental insurance is an insurance coverage for individuals to protect them against dental costs. It insures against the expense of treatment and care of dental disease and accident to teeth. The most common types of dental insurance plans are Preferred provider organizations (PPO) or dental health maintenance organizations (DHMO).

By and large, dental care is provided by a general dental practitioner, although some cases may require the services of a dental specialist. Dental benefit plans are structured to encourage patients to receive regular, routine dental care vital to prevention of any oral health diseases, or major reconstructive procedures.

Most dental benefit plans require patients to assume a greater portion of the costs for treatment of dental disease than for preventive procedures. Health insurance companies provide coverage only for health-related services that they define or determine to be medically necessary. This includes dental care. Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfigurement or dysfunction.

Even if a particular procedure or service is considered medically necessary, some payers impose limits on how many times a provider may render a specific service within a specified timeframe. Within payer-specific benefit policy or guidelines, payers may define where or when they will cover a specific service but may limit coverage to a specific diagnosis.

When billing, it is important to demonstrate medical necessity and adhere to payer specific billing guidelines. For treatment of oral health conditions, most payers require a treatment plan.

7.1.1 Supporting Documentation

Dental claims are able to be submitted electronically and manually. It is encouraged to submit most claims electronically, and through use of electronic applications, these claims may be submitted efficiently and accurately. Check with your vendor to verify if the electronic format is acceptable.

Dental insurers publish a list of covered procedures that require supporting documentation. Supporting documentation may include pertinent health records such as diagnostic results, treatment plans and/or other records. Each facility will determine most appropriate process for supplying the required documentation in either electronic or paper format.

On certain procedures such as crowns, extractions, pulpectomies, it may be helpful to attach the x-rays with the claim to facilitate a timelier payment.

7.2 Reporting Dental Services

The CDT (Current Dental Terminology), also known as ADA (American Dental Association), has been designated as the national standard for reporting dental services by the Federal Government under HIPAA, and is recognized by third party payers nationwide.

IHS uses the ADA coding structure, which is four digits. However, RPMS has the capability of adding “D” or “0” as a prefix, if the payer requires this on paper claims. This information may be added for respective payers through RPMS site parameters

7.3 Dental Billing Guidelines

- Billers should understand the coverage limitations, exclusions, and benefits of the specific dental benefit plan *before* filing the claim. Many dental policies limit the number of examinations, consultations, or office visits within a benefit year. Beyond this limit, the dental insurer may deny the claim and any additional visits are considered the patient’s responsibility.
- X-rays must be dated, of diagnostic quality, and provide the ability to discern tooth structure, supporting structure, and pathology.
- Many dental insurers limit the number of cleanings in a benefit year. The average is two per year. Any additional cleanings would be the responsibility of the patient.
- Many insurers require pre-authorization prior to a procedure. This needs to be verified with the payer. Each facility needs to determine who is responsible for obtaining the pre-authorization. This should also be documented on Page 5 in RPMS, or on the Authorization tab in BPRM. Pre-authorization numbers should be included on the claim when necessary.
- Many of the dental insurers limit dental sealants to the occlusal surface of caries and restoration-free first molars to age 9. Usually, sealants applied to caries and restoration-free second molars are limited to age 14.
- For emergency palliative treatment, these services are usually payable per visit, not per tooth, and the fee includes all treatment provided, except necessary x-rays. A description of the nature of the emergency and the treatment provided must be included. This visit and this procedure is primarily used to relieve the patient of pain or discomfort and is not considered definitive treatment.
- For most dental insurers, when a periapical film is provided, the procedure should be submitted using the appropriate procedure code for the first film and an appropriate code for each additional film.

- Narratives or explanations should be included with the claim submission to prevent delayed reimbursement or denied services.

For example, if the biller files a claim for a crown without any narrative but with an x-ray, the dental consultant might be unable to detect a fractured cusp that may have prompted the dentist to place a crown. The same is true of a crown provided for a tooth that appears on x-rays to have a satisfactory amalgam restoration. The rationale for the crown is only apparent when the dentist describes any recurrent decay that is only evident through a clinical examination.

- Questions related to medical necessity or benefit coverage need to be anticipated prior to claim submission.

For example, if you replace a crown that is less than five years old, anticipate the need for explanation as to why the replacement was medically necessary.

- For more information on Dental billing guidelines for the Veterans Administration, reference Chapter 10 “Billing Veterans Administration (VA).”

In summary, understand the difference between what is covered, and what is not. Some necessary procedures will not be covered regardless of documentation submitted. In such cases, it is important to understand that while a recommended treatment is appropriate – it may not be a covered benefit under the terms of the specific dental plan.

For example, if you provide treatment for erosion, there is a good chance the claim will not be paid because erosion is a common exclusion under most dental programs. The same principle applies to treatments that address cosmetic needs rather than dental disease. If erosion or cosmetics is the reason for treatment, no amount of explanation will allow the payer to approve the claim for payment.

7.4 Filing Dental Claims

For most dental plans, there is a limitation for the number of procedures and/or dollar amounts in a given benefit year. Check with insurance companies to determine specific filing limits.

8. Billing Pharmacy

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8.1 About Point-of-Sale Pharmacy Billing

The Point-of-Sale (POS) application allows pharmacists to send claims to the Pharmacy Benefit Administrator (PBA) and subsequently to the insurer, via a telecommunications network. This electronic submittal is started with the printing of the label or the final step of the prescription processing asking if the claim should be resubmitted to insurance, followed by printing of the label. This then allows time for the filling of the prescriptions at the facility, as the insurance is processing the information. Those claims are adjudicated online and in real time. This allows for an efficient search of solutions and efforts to ensure the claim is paid in a timely manner.

The following online functions are usually performed at the point of service:

- Verify client eligibility.
- Validate claim data.
- Identify duplicate services and drug caps.
- Verify coverage of a drug due to formulary restrictions, obsolete dates or other reasons.
- Price the claim and provide co-pay and reimbursement amounts.
- Perform conflict checking prior to filling the prescription.
- Obtain PRIOR authorization and document that information appropriately.

Point-of-Sale drugs are entered into the Pharmacy package and then forwarded electronically to the insurer. The pharmacy can choose to watch POS live (the POS monitor is a useful tool some sites are using to help with this process) while processing prescriptions to help fix errors, such as refills too soon, drug interactions and eligibility issues, that are best fixed prior to the patient leaving pharmacy. By fixing pharmacy eligibility issues, this often helps to fix medical eligibility issues as well, thus maximizing efficiency of staff and billing while increasing revenue. If the claim is denied, an error report or rejected claim will be generated back to the pharmacy from the insurer. This report should be run daily in order to effectively track all rejections. At some point during the day, a designated person in the pharmacy will research, correct, and re-submit rejections electronically. The responsibility may be distributed between pharmacy staff and the pharmacist across areas.

Handling the correcting and resubmitting of rejected Pharmacy claims may be a team effort. It is beneficial to have a pharmacy background or a background in the pharmacy package, as well as a registration background; however, this is not always feasible. Providing proper training to all personnel handling rejected pharmacy claims is essential.

If Billing is responsible for correcting and resubmitting rejected pharmacy claims, sufficient training must be provided. There are many tools that assist in the resubmission of these claims. Regardless of the tool used to adjudicate claims, the billers need to be granted appropriate system security/access in order to work the claims correctly.

An example of the handling rejections across workstreams would be the Billing office working with registration if an incorrect pharmacy insurer number was listed or if the patient was not covered under the policy. Pharmacy would be responsible for researching rejections related to the National Drug Code (NDC) number errors, drugs not covered under the formulary, or if prescription was denied due to 30-day limitation.

Once the pharmacy is paid, the Billing and Accounts Receivable (A/R) packages will be updated and reconciled. If the claim is denied, neither the Billing nor the A/R system is updated.

As a precaution with POS, the third party biller should review all clinic bills to ensure that the drugs billed electronically are not being submitted in the billing package with the clinic claim also.

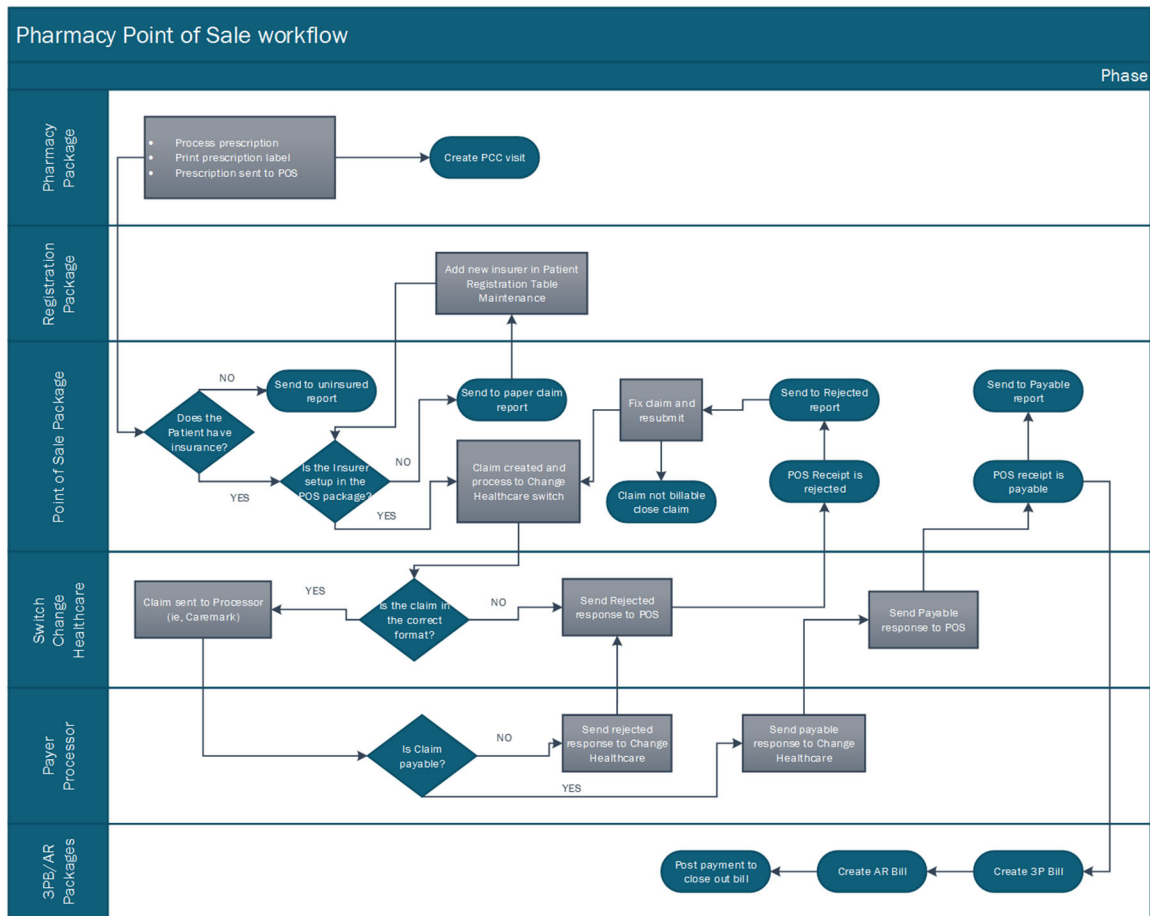
When the prescription is filled, the pharmacy enters the prescription data into the RPMS Pharmacy POS application.

If an agreement is not in place to bill electronically with the pharmacy insurer or the facility has elected not to bill electronically via POS, a pharmacy charge will need to be entered into the Pharmacy package and forwarded to the Billing package. It will then be the responsibility of the Billing Office to generate a hard-copy claim using a Universal Claim Form (CMS) 1500 (i.e., VMBP).

Many pharmacy insurers are requesting that billing for pharmacy services be done electronically and will defer or limit payment for those submitted manually. Therefore, all IHS facilities are encouraged to move forward with electronic pharmacy billing.

For more information, reference Part 4, Appendix, Pharmacy POS Tutorial and RCR Example.

8.2 Pharmacy POS Workflow



8.3 POS / Business Office / Patient Registration

1) How does POS affect the business office?

- a) RPMS POS Pharmacy Billing is a package that transmits prescription claims real time to payers (sometimes called Pharmacy Benefit Manager - PBM). The advantage of real-time claim submission is that we know instantly if there is a problem with the claim.

Business Office – The person with the keys to Third Party Billing Table Maintenance will add/edit and manage the pharmacy insurers, including the names that are displayed. This process is usually controlled and coordinated by the Business Office Manager.

Patient Registration – The Business Office will be involved in correcting claims having to do with missing or incorrect eligibility information. If processes are put in place up front, the time spent correcting pharmacy claims that have rejected will be minimal.

2) Which POS Menu Keys do the Business Office and Patient

Registration personnel need?

- a) They can have the ABSP USER keys. This will give them access to the POS User Menu and Reports Menu. The Primary Lead for Point of Sale at the facility should have ABSP MANAGER keys. Many times, this person sets up the insurer in 3PB. In order to link insurers to POS format, the person with the ABSP Manager key will also need to add fileman access “pP” (a pharmacist with ABSP Manager already has the correct fileman access).

Note: Users should be cautious with the keys identified above. Modifications are hard to track within POS, and resubmitting claims that have been returned to stock is fraudulent and this can accidentally happen if not trained properly.

- 3) Are there any other menu options that business office staff would need?
 - a) The following menus might be useful for business office staff when reviewing rejected claims, reversed claims or doing backbilling:
 - i. VWRX i.e., **Prescriptions [PSO VIEW]** – to view the activity log of a particular prescription.
 - ii. **MEDP Medication Profile [PSO P]** – to view the medications a patient has received over a particular time period.
- 4) Are there menu options that pharmacy staff would need?
 - a) The pharmacy staff may have the ABSP USER keys. The Primary Lead for Point of Sale at the facility should have the ABSP MANAGER. If the pharmacy wants to understand rejections related to eligibility issues, this menu option will be View Only keys. (AGView Only)
- 5) Who should be responsible for correcting rejected claims?
 - a) Correcting rejected claims should be a coordinated effort between the departments involved. In general, it works well if the rejected claims are worked as follows:
 - i. Business Office/Registration/Pharmacy Point of Sale Billing Department: rejections related to eligibility.
 - ii. Pharmacy/Pharmacy Point of Sale Billing Department: rejections related to the drug file. Almost all pharmacy related rejections are corrected in the Outpatient Pharmacy package – EDRX.
 - iii. Some rejections require a phone call to the processor to obtain a special code for the claim to go through. These rejections will need to be coordinated between either of the departments. In many cases an assessment of the patient's therapy or diagnosis is needed to obtain approval. An example is prior authorization.

- iv. Some rejections require management decisions on the amount of resources needed to obtain payable claims.
 - 1. Days Supply rejections – Several insurances only pay for a 30-day supply. The claim is rejected if dispensing more than a 30-day supply. A policy limiting the days supply to 30 days in many facilities will dramatically increase the workload at the facility (registration, health records, data entry, pharmacy, business office).

6) Why are claims rejected?

- a) Claims are rejected for several reasons. The most common rejections are due to incorrect registration/insurance and pharmacy information. Some of the common rejection codes related to Registration and Insurance information are:

Code	Explanation
06	M/I GROUP NUMBER
07	M/I CARDHOLDER ID NUMBER
09	M/I BIRTHDATE
10	M/I SEX CODE
11	M/I RELATIONSHIP CODE
25	M/I PRESCRIBER ID
35	M/I PRIMARY PRESCRIBER
52	NON-MATCHED CARDHOLDER ID
65	PATIENT IS NOT COVERED
68	FILLED AFTER COVERAGE EXPIRED

8.4 POS Administrative Setup

SET-UP: It is recommended that you contact RPMS User Support for assistance in completing the initial POS set-up.

Assign Security Keys as appropriate for the staff working these roles. Only users and billers of the pharmacy point of sale need these keys, data entry needs the Pharmacy POS User Menu U-Claims Data Entry Screen, if they are coding medications to verify the claims have not already been billed and paid:

- Business Office Staff – ABSPZMENU, ABSPZREPORTS, ABSPZUSER
- Pharmacy Staff – ABSPZMENU, ABSPZREPORTS, ABSPZUSER
- The Primary Lead for Point of Sale at the facility should have ABSPZMENU, ABSPZREPORTS, ABSPZUSER, ABSPZMANAGER
- Optional: Administrator may want ABSPZMENU, ABSPZREPORTS

Be familiar with Manager Menu Options including:

- SET Pharmacy Point of Sale Setup Menu - keep original set-up on file
- MGR Statistics & misc. options screen... to be viewed before calling RPMS support if reporting transmission problems
- RPT Pharmacy electronic claims reports ...
- COMM Communications – View Dial Out Log File – *used by programmer when troubleshooting*
- BACK Pharmacy POS background scan ... – *non-applicable*
- USER Claims data entry screen... – be familiar with List Manager
- TEST Test it (send claim, receive response) – only used during set-u

Be familiar with the Reports Menu:

- CLA Claim results and status ...
- SITE Claims result and status by site...
- MNT Maintenance Reports...
- ADM Administration reports...
- SET Setup (Configuration) reports ...
- SURV Surveys of RPMS database...
- ELIG Medicare Part D Eligibility Check
- OTH Other reports...

Be familiar with the Parameters in the Pharmacy Package (SFUN/SITP/IHS).

Things to do each month:

- 1) AWP (APSA Benchmark Price) Monthly Update – make sure it is loaded each month. New updates emailed out from Office of Information Technology (OIT) sends with Benchmark in Title and AWP in document, this may help prevent confusion for new users or ones not use to pricing.
- 2) Monitor for stranded claims. POS/RPT/MNT/STR or POS/MGR/MGR

8.5 Guidelines for Submitting a Claim Form Manually

- The exact name and address of the pharmacy must be included on the form.
- The National Provider Identifier (NPI) assigned to your specific pharmacy must be listed (if paper, it may be National Association of Boards of Pharmacy Number (NABP)).
- The pharmacist must sign the form.
- The Rx number assigned to the pharmacy must be included.
- Use “N” for a new prescription; use “R” for a refill.
- Enter the number of tablets or capsules dispensed, the number of grams of ointments or powders, or “cc” or “ml” amounts of liquids. Use whole units only.
- Enter the number of days this prescription will supply.
- Enter the eleven-digit National Drug Code (NDC) number assigned to the product.
- Enter the prescriber’s DEA number for controlled substances and NPI number of all prescriptions.
- Enter the total charge for this prescription or product.

8.6 Correcting Duplicate Claim Rejections in POS

Duplicate claims occur when a claim has been submitted via RPMS POS and either:

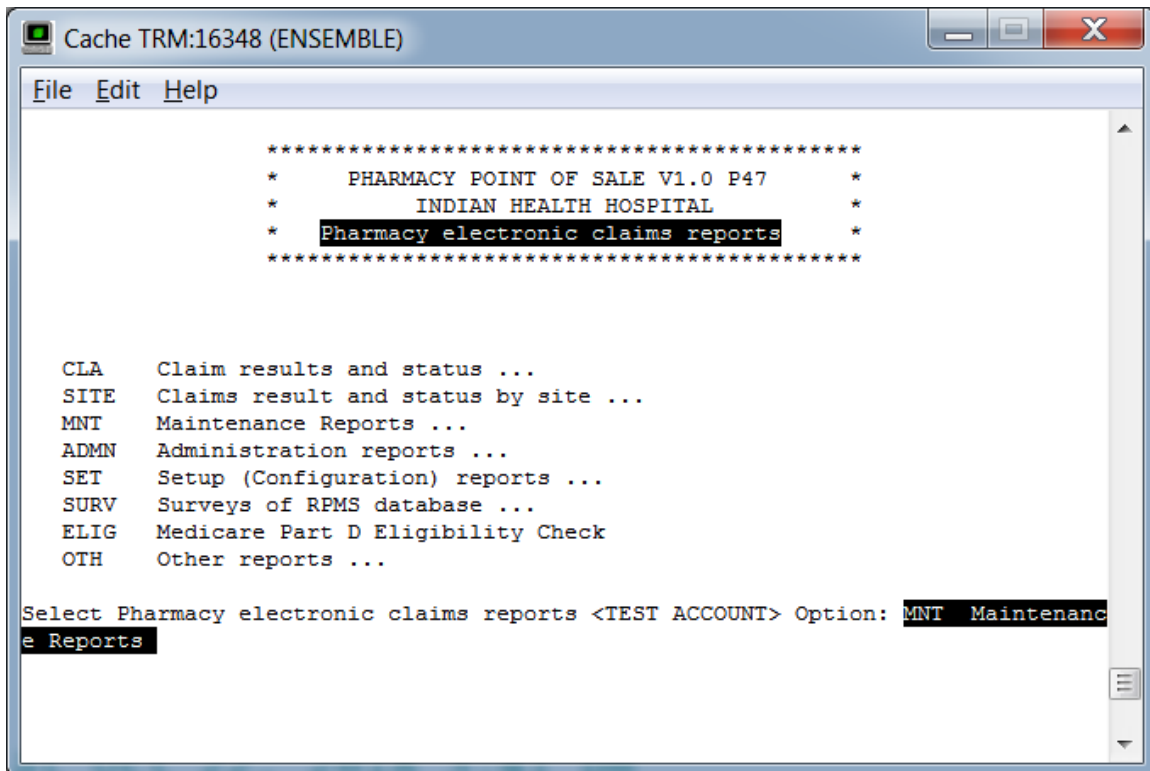
- 1) The response of PAYABLE is not received by the POS application, and the claim is later resubmitted resulting in duplicate claim rejections, or
- 2) The prescription claim is re-submitted before the initial response is returned.

Unless PAYABLE is displayed in the response, the claim does not “cross over” to RPMS Third Party Billing where a claim is created, approved and then crosses to the Accounts Receivable package. This has caused some problems for staff doing the posting payment received in A/R since there is

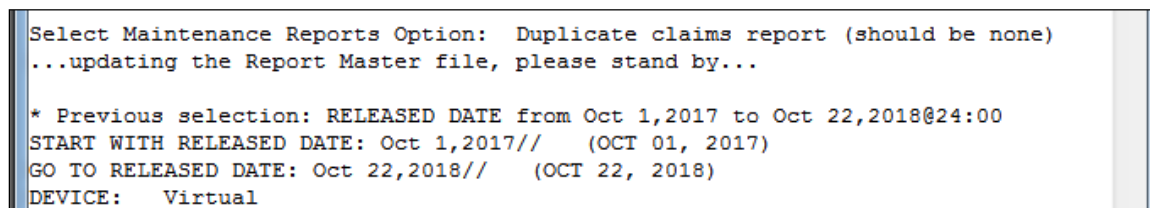
not a claim to post against.

The following are instructions for correcting duplicate claims:

- 1) Check Duplicate Claims Report:
 - a) Run URM report, go back at least as far as you'll be looking for Duplicate Claims).
 - b) At a minimum, it is recommended that those involved in correcting rejections in POS, run the Duplicate Claims Report weekly.



- 2) Select Pharmacy electronic claims reports Option:



10.154.33.164 - Cache Telnet

File Edit Help

POS DUPLICATE claims for prescriptions RELEASED on OCT 3,2017 10/22@16:15
 2013 DEMO HOSPITAL
 NPI #9114113001 NCPDP (NABP) #0324626 Medicaid #156572
 CVS CAREMARK Help Desk: (800)4212342

Trans. Date	Presc/Fill	\$billed
OCT 3,2017 POS,CAREMARK	`1715713/0	7.18 IBUPROFEN 400MG TAB *
OCT 4,2017	`1715713/1	7.18 IBUPROFEN 400MG TAB *

SUBTOTAL		14.36
SUBCOUNT		2
SUBMEAN		7.18

SUBTOTAL		14.36
SUBCOUNT		2
SUBMEAN		7.18

TOTAL		14.36
COUNT		2
MEAN		7.18

Press ENTER to continue:

- 3) Pull up the patient in POS (POS / U / EV / 3 – single patient / enter Patient Name from Duplicate Claim report.

10.154.33.164 - Cache Telnet

File Edit Help

PHARMACY POINT OF SALE Oct 22, 2018 16:24:57 Page: 1 of 1
 All prescriptions for patient POS,CAREMARK
 With activity in the past 365 da

#	PATIENT/PRESCRIPTION	COMMENTS
1	done POS,CAREMARK	** FINISHED ** 2 rejected *2 not electronic *2
2	LISINOPRIL 20MG TAB *	NOV 28,2017@17:27, FILL OCT 6,2017 Duplicate (17
3	LISINOPRIL 20MG TAB *	MAR 2@16:16, FILL ? Missing ^PSRX(1715715,1,3,0)
4	IBUPROFEN 800MG TABLET	OCT 18@14:18, FILL FEB 15@ *REVERSAL* Accepted (
5	METFORMIN 500MG TAB	FEB 15@11:27 Rejected(NN:Transaction Rejected At
6	PENICILLIN VK 500MG TA	FEB 15@11:24 Rejected(NN:Transaction Rejected At
7	PENICILLIN VK 250MG TA	JUL 5@12:57 Payable (1715782.00001)
8	PENICILLIN VK 250MG TA	SEP 5@10:55 Payable (1715790.00001)

Enter ?? for more actions >>>

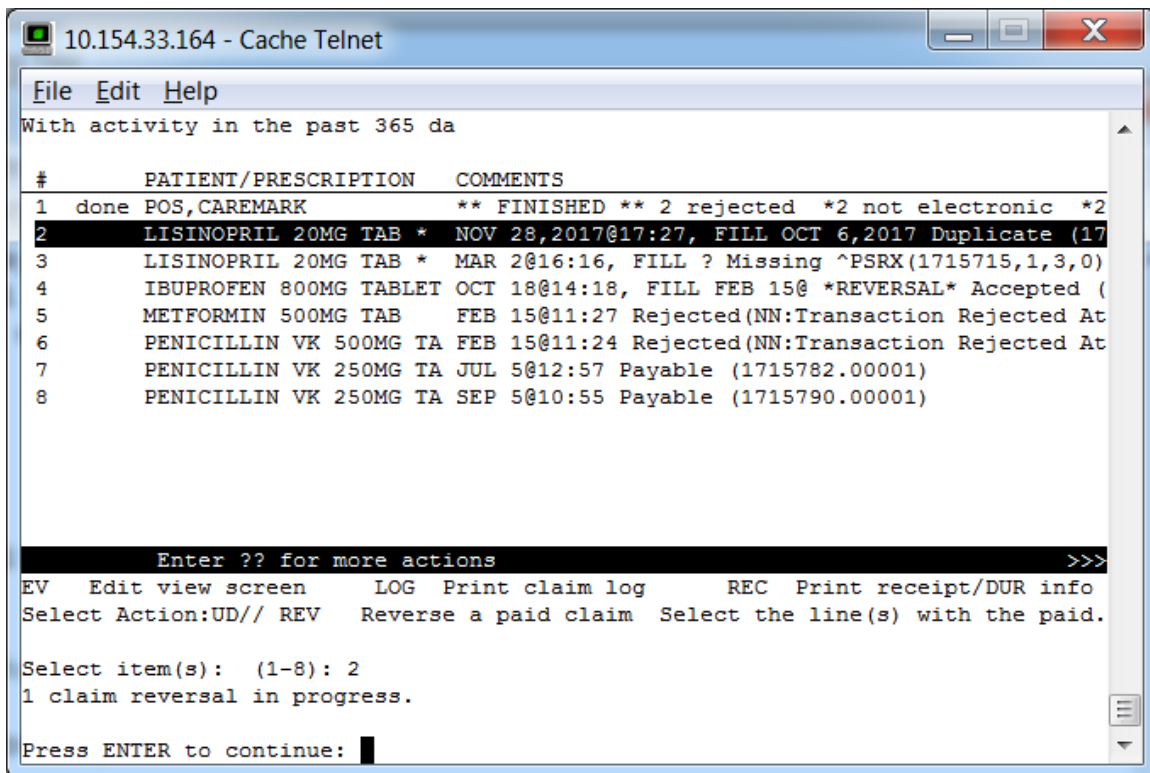
NEW	Send new claims	DIS	Dismiss patient	RCA	Request cancellation
CU	Continuous update	SP	Print single patient	REV	Reverse a paid claim
CLO	Close Claim	PA	Print all	RES	Resubmit a claim
EV	Edit view screen	LOG	Print claim log	REC	Print receipt/DUR info

Select Action:UD//

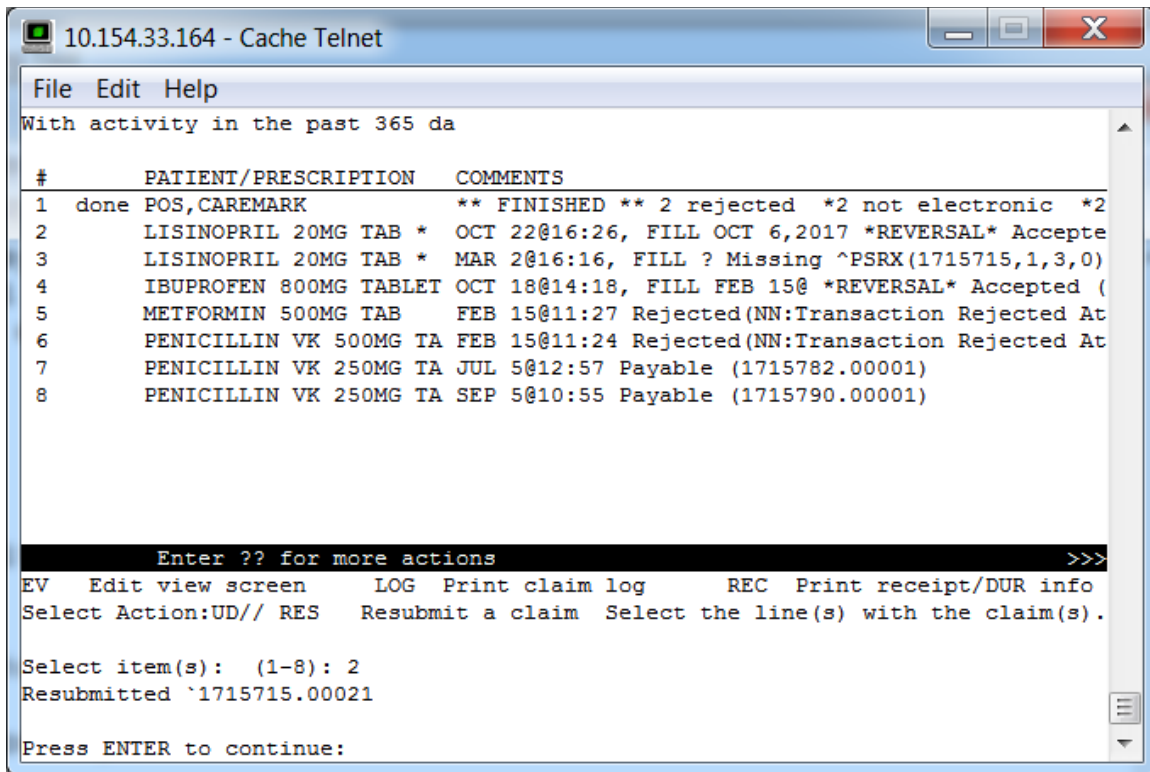
- 4) Select, “REV” “Reverse a paid claim.” The message returned should be

“reversal accepted.”

Note: that claims more than one month old may be too old to resubmit.



- 5) **Select “RES” Resubmit a claim.** This results in either a payable (hopefully) or rejection (if the claim is too old).



8.7 Missed Claims

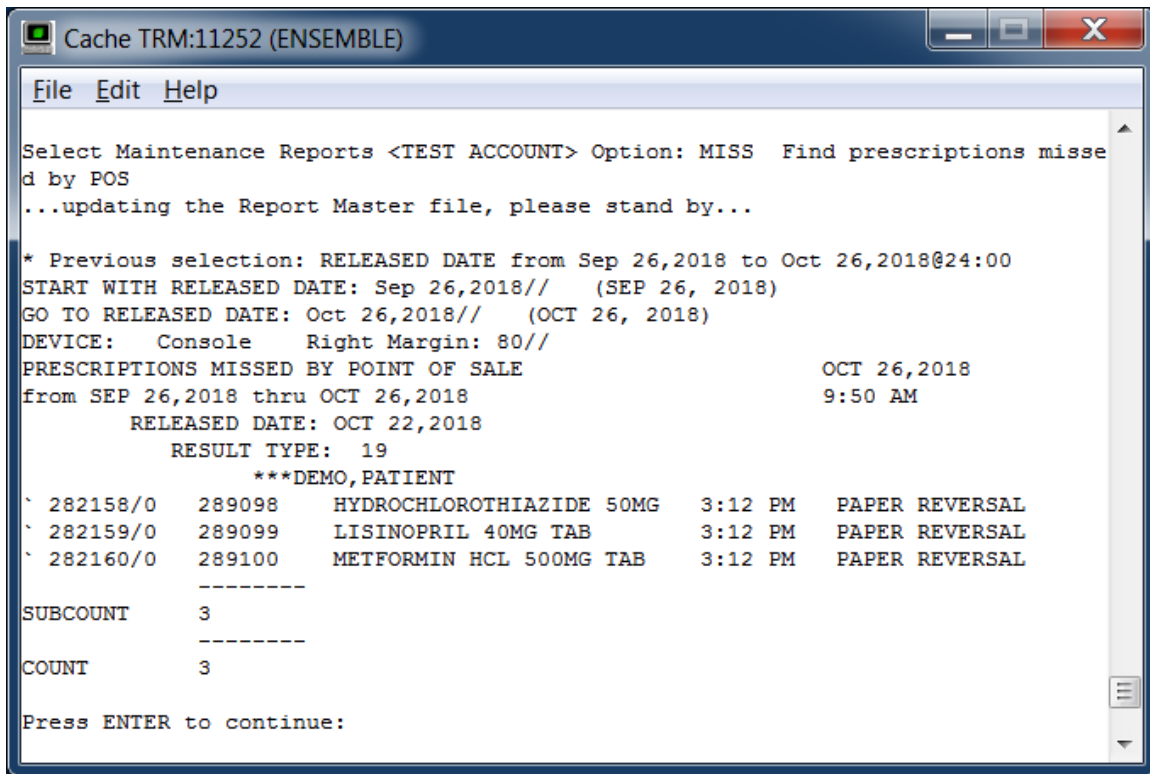
Check for missed claims. Missed claims mainly occur in sites that utilize CMOP for mailing of prescriptions. The Missed claim report can reveal filled prescriptions that did not cross over to the POS package. It will also show all reversed claims, identified at the right side of the screen with the message REVERSAL ACCEPTED. Anything on the report that does not say REVERSAL ACCEPTED needs attention.

Check for Missed Claims:

POS menu: POS / RPT / MNT / MISS

Enter the date range you want to check.

The following is an example of what the report would look like if Missed claims exist. The MELOXICAM for PATIENT ONE does not say REVERSAL ACCEPTED and needs further attention to determine if it needs billed or not.



Consolidated Mail Outpatient Pharmacy (CMOP) will cancel back prescriptions that they cannot fill (either out of stock, wrong pack size, refrigerated item to PO box, etc.). The site will then fill and mail locally. If Cancel Backs are processed incorrectly, this leads to prescriptions showing up on the MISS report. Investigate the activity log to determine if the prescription was filled. The '99999 RX number can be manually entered as a NEW claim in POS if necessary.

8.8 POS Stranded Claims

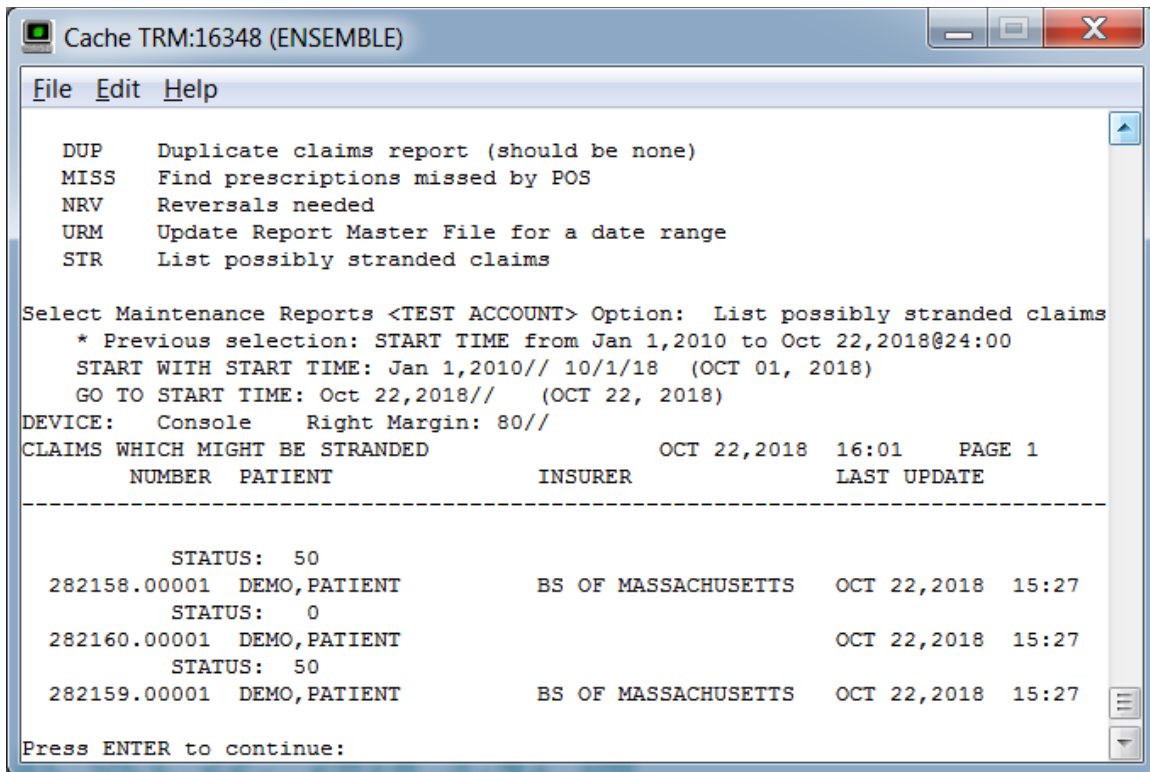
Stranded claims are usually caused by interruptions to the IHS network. The Stranded Claim report should be checked when there are power outages and changes to the network.

Here are the instructions to check for stranded claims **and** how to fix the stranded claims if they are there. If you have further questions, contact RPMS support at: (888) 830-7280, or e-mail: support@ihs.gov

CHECK FOR STRANDED CLAIMS:

POS menu: POS / RPT / MNT / STR

Use "FIRST" as the Start Time. If you run this report and it is blank, there are no stranded claims. The following is an example of what a report would look like if there are stranded claims:

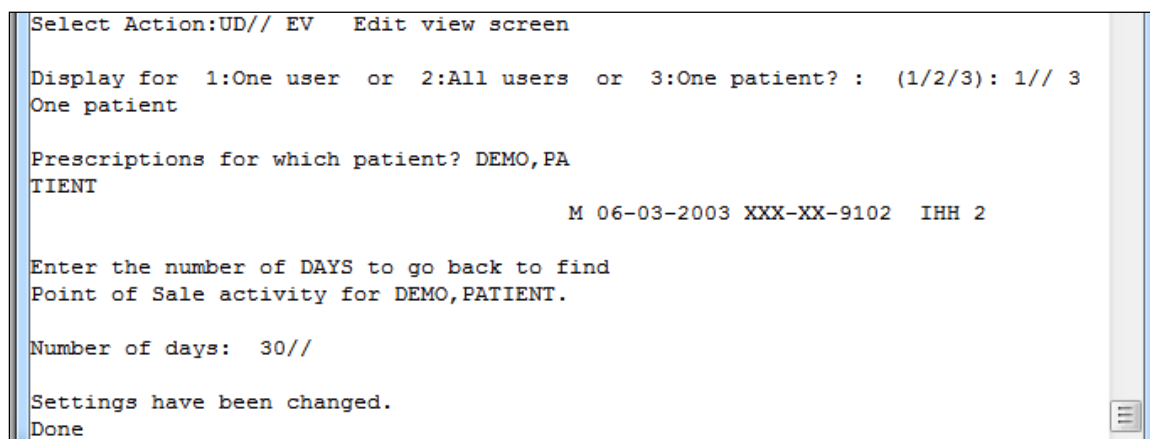


If the stranded claims are from more than a year ago, contact RPMS Support.

FIXING STRANDED CLAIMS

- 1) In POS, look up each patient on the Stranded Claim Report starting with the first person on the list.

POS Menu: POS / U / EV / 3: one patient



The following patient data displays showing the stranded claims from the

Stranded Claims report.

Cache TRM:16348 (ENSEMBLE)

File Edit Help

PHARMACY POINT OF SALE Oct 24, 2018 07:57:43 Page: 1 of 1

All prescriptions for patient DEMO, PATIENT
With activity in the past 30 da

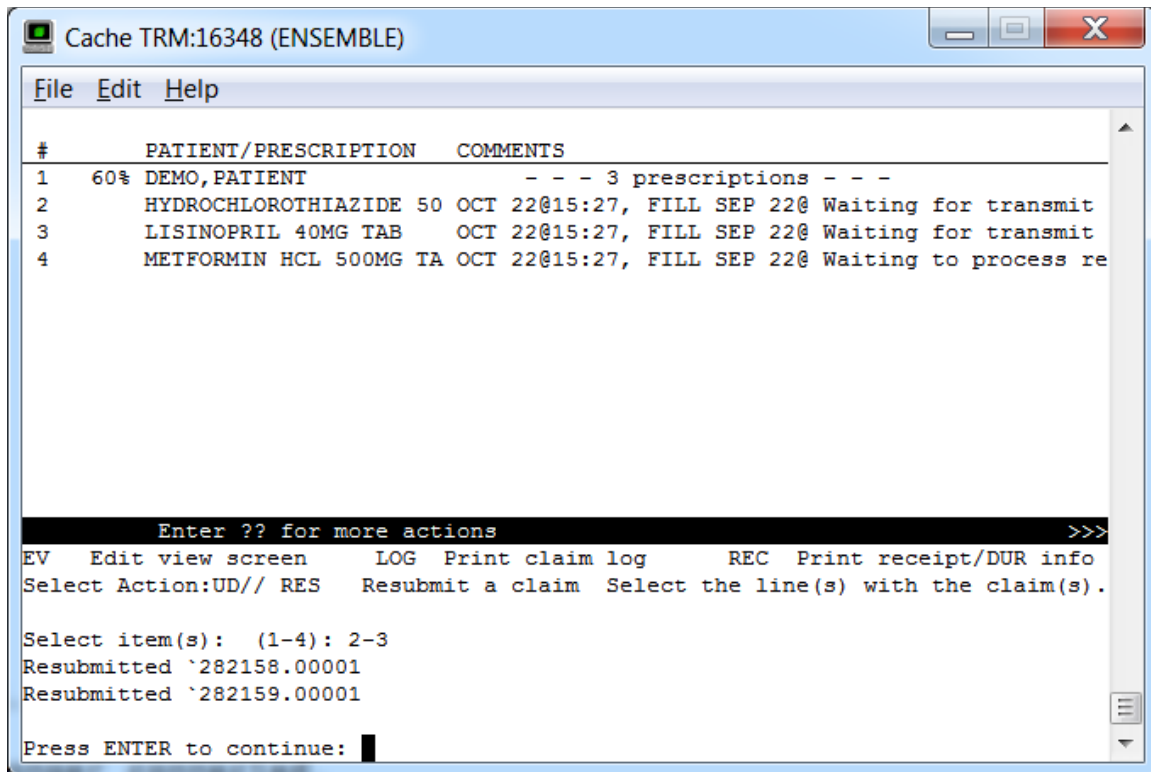
#	PATIENT/PRESCRIPTION	COMMENTS
1	60% DEMO, PATIENT	- - - 3 prescriptions - - -
2	HYDROCHLOROTHIAZIDE 50	OCT 22@15:27, FILL SEP 22@ Waiting for transmit
3	LISINOPRIL 40MG TAB	OCT 22@15:27, FILL SEP 22@ Waiting for transmit
4	METFORMIN HCL 500MG TA	OCT 22@15:27, FILL SEP 22@ Waiting to process re

Enter ?? for more actions >>>

NEW	Send new claims	DIS	Dismiss patient	RCA	Request cancellation
CU	Continuous update	SP	Print single patient	REV	Reverse a paid claim
CLO	Close Claim	PA	Print all	RES	Resubmit a claim
EV	Edit view screen	LOG	Print claim log	REC	Print receipt/DUR info

Select Action:UD//

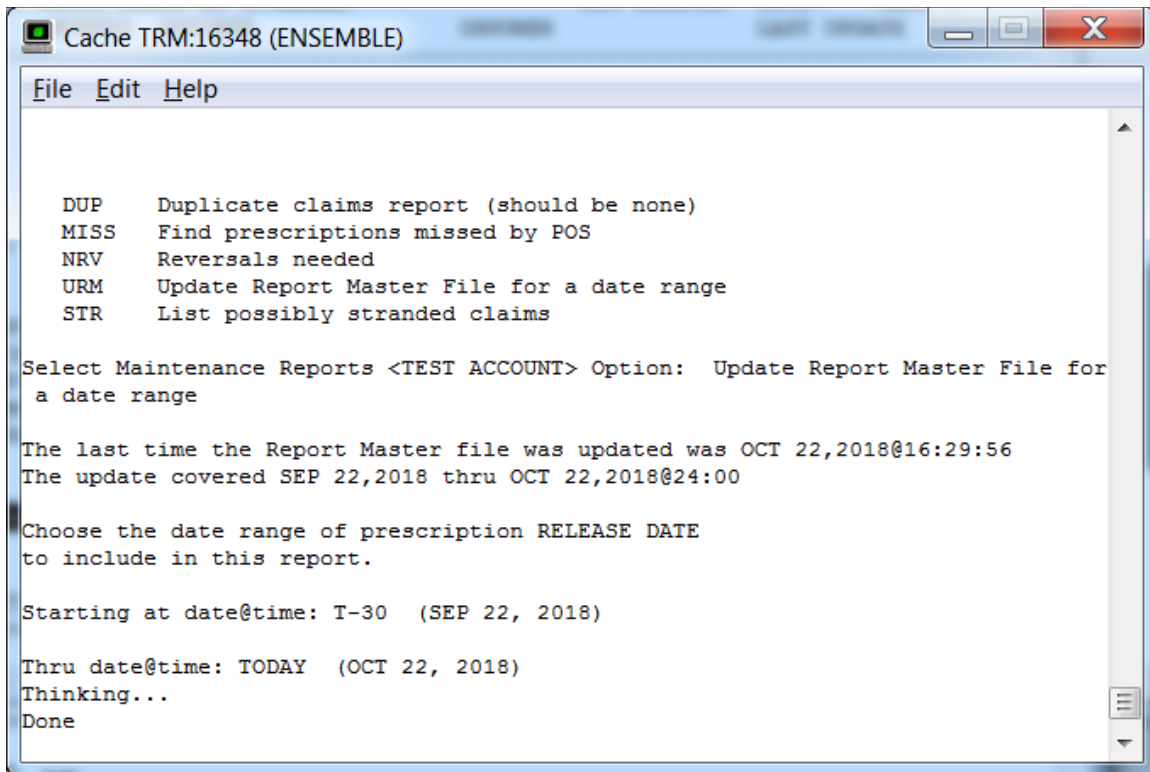
- 2) Note which claims are stranded.
- 3) Resubmit (RES) the stranded claims.



The stranded claims should go through. If not, contact RPMS support.

- 1) Run the URM report to update the POS Reports.

POS Menu: POS / RPT / MNTT / URM



8.9 Reasons for Pharmacy Denials

The most frequent reasons for Pharmacy denials that require follow-up are mentioned below:

- Duplicate claim submission
- Not a covered drug or requires pre- or prior authorization before dispensing
- Patient not covered under pharmacy insurance plan
- Not provided or authorized by designated provider
- Incomplete or invalid place of service listed
- Did not complete or enter accurately the referring/order/supervising physician's name and/or their NPI number
- Did not complete or enter the correct NPI and/or billing name or address
- Information required to make the payment was missing
- Modifier was missing or inaccurate
- Dispensing drugs for more than 30 days
- Dispensing drugs before the maximum percentage of previous days' supply is used per fill history – resulting in refill too soon or plan limits exceeded

- Max on Medicare drug program allowance (\$600 cap)
- Incorrect NDC number
- Missing or invalid BIN, PCN or group number

8.9.1 Updating the Master File Report

POS > RPT > MNT > URM

This option must be run daily to ensure the most update to date data that generates on the Pharmacy POS reports.

```
Select Maintenance Reports <TEST ACCOUNT> Option: URM  Update Report Master File
for a date range

The last time the Report Master file was updated was OCT 24,2018@08:10:10
The update covered JAN 1,2018 thru OCT 24,2018@24:00

Choose the date range of prescription RELEASE DATE
to include in this report.

Starting at date@time: -30  (SEP 24, 2018)

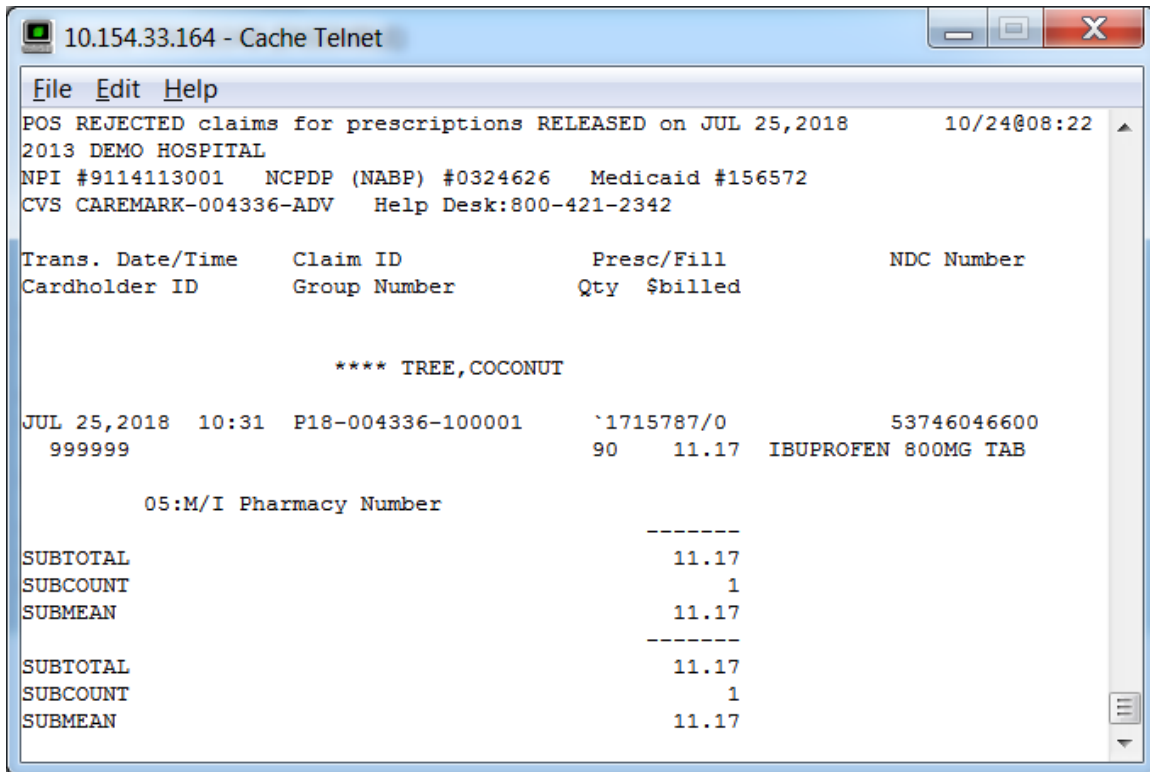
Thru date@time: T  (OCT 24, 2018)
Thinking...
Done
```

8.9.2 Printing the Rejection Report

POS > RPT > CLA > REJ

This report will generate a list of rejections by date and insurer. Use this list to identify and work rejected claims.

Note: Focus on high-cost drugs and keep filing limits in mind when working the rejection report.



8.9.3 Rejections Related to Patient Registration (Page 4)

The following rejections occur as a result of patient registration errors.

Code	Description
69	Filled after coverage terminated
52	Non-Matched Cardholder ID
51	Non-Matched Group ID
11	M/I Patient Relationship Code
06	M/I Group Number
09	M/I Birth Date
41	Submit to Other Processor/Primary Pay (Pt has a primary insurer to bill)
81	Claim Too Old (this comes up when you are trying to back bill RX and it has a cut off to how far you can go back)

How to fix: Go to the Patient Registration insurance page and fix the incorrect or missing information.

8.9.4 Rejections That Need a Prior Authorization

These rejections will appear if a prior authorization is needed.

Code	Description
75	Prior Authorization Required
569	Provider Beneficiary with CMS Notice of Appeal (non-formulary drug may need PA)
608	Step Therapy, Alt Drug Therapy Reg Prior to (<i>insurer requesting other meds</i>)

How to fix: Prior Authorizations are done by using the override function in the user screen.

```

Ask Insurance? NO      +-----+ <PF1> E when done, to file claims
Ask Preauth #? YES    | PHARMACY | <PF1> Q to quit without filing claims
Ask Qty/Price? NO     | POINT OF | <PF3> insert/overstrike modes
Ask Fill Date? NO     | SALE    | <PF4> to go back one field
Ask Overrides? NO     | DATA ENTRY | Arrow keys may be used, too
+-----+
| 1 POS,MEDICAID      | <PF1> C to close this pop-up page |
| LISINOPRIL 20MG TAB * | - - - - PRICING - - - - - |
|                       | Quantity: |
| Primary insurance:    | Price per unit: $ |
|                       | from |
| Do you want to view/edit | Qty x Price = $ |
| the ORDER of INSURANCE? NO | Dispensing Fee: $ |
|                       | Incentive Amnt: $ |
| Prior Auth Type: Prior Authorization | Total Price: $ |
| Prior Auth #: X1234500 | Done with this page? YES |
+-----+

```

Completing a Prior Authorization

- Covermymeds is a website that is linked to most insurer prior authorization forms. <https://account.covermymeds.com/login>
- Request a form from insurer to be faxed and completed by the pharmacist or provider
- The pharmacist can initiate a prior authorization by phone; the phone number for PAs will display with the rejection

8.9.5 Rejections That Require an Override

An override may be needed to submit a claim with information that is missing or to provide greater detail needed to process a claim. The override may also be needed to fulfill a payer requirement.

IHS publishes the DAW/DUR codes which are located on the RPMS Pharmacy POS website: <ftp://ftp.ihs.gov/rpms/POS/POS%20User%20Guides/>

Code	Description
------	-------------

22	M/I Dispense As Written (DAW) Product Selection Code (<i>this can be fixed and an override code</i>)
88	DUR Rejection Error (comes up with an early refill or conflict with drug other drugs the patient is taking)
39	M/I Diagnosis Code

How to fix: Use the override function in the user screen.

```

Ask Insurance? NO      +-----+      <PF1> E  when done, to file claims
Ask Preauth #? NO     | PHARMACY |      <PF1> Q  to quit without filing claims
Ask Qty/Price? NO     | POINT OF |      <PF3> insert/overstrike modes
Ask Fill Date? NO     | SALE     |      <PF4> to go back one field
Ask Overrides? YES    | DATA ENTRY |      Arrow keys may be used, too
+-----+
P| Enter Y to select needed overrides.
1 ` Please <PF1> C to close the screen.
2
3 Enter General Overrides (Y/N) ?      NO
4
5 Enter NCPDP DUR Overrides (Y/N) ?    YES
6
7 Enter Diagnosis Codes (Y/N) ?      NO
8
9
+-----+

```

Note: Overrides should not be used to correct patient registration/drug/insurance setup.

8.9.6 Rejections That Require Pharmacist Intervention

Some rejections require the pharmacist to provide input to fix the rejection.

Code	Description
E7	M/I Quantity Dispensed
9E	Quantity Does Not Match Dispense Unit
79	Refill Too Soon
88	DUR Rejection Report (error comes up with an early refill or conflict with drug other drugs the patient is taking)

How to fix: The Pharmacist must review and make corrects in the drug file.

8.9.7 Rejections Related to the Insurer Setup

Some rejections may be related to how the insurer file is set up. Work with your RPMS Administrator to make corrections. If unsure how to fix, contact the national RPMS helpdesk.

Code	Description
NN	Transaction Rejected At Switch or Intermediary

R9	Value in Gross Amount Due Does Not Follow Pri
354	Submission Clarification Code
85	Basic of Cost Determination Value Not Supported
	SYNTAX ERRORS
	INTERNAL ERROR
	Pharmacy Service Type
	M/I Patient Residence

How to fix: May require a helpdesk ticket to be opened at support@ihs.gov or post to POS@listserv.ihs.gov

Note: If sending to OIT helpdesk, please exclude PHI/PII, send a receipt and insurer inquiry.

8.9.8 Rejections That May Be Due to Connectivity

Collection issues may cause rejections that may be due to the network going down or any “hiccups” in the network connection.

Code	Description
85	Claim Not Processed
98	Connection to Payer is Down
99	Host Processing File Error (this also comes up when the patient is required to fill at a participating pharmacy)
NN	Transaction Rejected at Switch or Intermediary

How to fix: Use the RES –Resubmit a claim in the user option

8.10 POS Reports

1) Totals by released day by site

POS → Pharmacy electronic claims report → Claims result and status by site

This report will give metrics of the daily claims at each facility. The data supplied by this report should be used by each site to standardize payable claims data, prescription volume, and paper claims data.

2) Rejected claims by reject code

POS → Pharmacy electronic claims report → Claim results and status

This report can be screen captured to be uploaded into a tool that was provided to IHS by CDR Nicholas Sparrow. The tool is readily available and should be used by each site pending RPMS modifications to

streamline this process.

3) Paper claims report

POS → Pharmacy electronic claims report → Claim results and status

This report should be generated and either printed or screen captured to ensure that these claims are being addressed. These claims have been flagged to be billed as a paper claim. These claims may have been flagged as paper claims for several reasons.

- a) The claims may need to be billed on paper.
- b) The claims may have exceeded the allowable billable amount.
- c) The insurer may be improperly set up.

4) AR Period Summary Report

POS → Pharmacy electronic claims report → Administration reports

This report may be generated to show what has been posted. This report dollar figure should be compared to the Totals by released day by site Report, but it should be expected that the dollar figure will not be accurate for a month or two considering that the payments are not posted immediately.

5) NCPDP Fields

POS → Pharmacy electronic claims report → Other report → List

This report should be screen captured and printed to be used for correcting rejected claims.

6) Medicare Part D Eligibility Check

POS → Pharmacy electronic claims report

This should be used to check the Medicare Part D eligibility of uninsured patients.

7) Survey if recent providers have ID #s

POS → Pharmacy electronic claims report → Surveys of RPMS database

This report will provide a list of all providers, their DEA #'s, and their NPI #'s.

8) POS Setup – Detailed Report

POS → Pharmacy POS Manager Menu → Pharmacy Point of Sale Setup Menu

Print this report out and use it to remove any unbillable NDCs that are setup as a whole or under specific insurers. This report will show all the detailed information of the insurers in the system. It will also show whether or not OTC drugs are set to billable. The report will also give the DEA and Medicaid number for each site. It also lists the pricing table information to include the source, multiplier, and whether or not the formula is in use. It will also show how many points are assigned to each insurer. It is a great source of information for the entire backbone of the point of sale billing process.

8.11 Subscribing to the IHS POS ListServ

Instructions for subscribing to POS Listserv:

Send an e-mail to: listserv@listserv.ihs.gov. In the body of the message type, subscribe POS, and type in your name and e-mail. You will receive an e-mail indicating you have been added to the ListServ.

8.12 POS User Tip Chart

For additional information, reference the POS User Tip Chart in the appendix.

Note: This tip sheet is not all inclusive. Sites may have a different system setup, so this document simply serves as a reference.

For additional resources and information, reference Part 4, Appendix “Helpful Links” and “RRIP Information.”

8.13 Transfer Drug Prices from Drug File (DTFE)

In order for RPMS Third Party Billing to reflect the drug prices from the Drug file and in Pharmacy POS, the drug prices must be imported into 3PB.

This is performed as soon as the updates to the Drug file have been installed and updated in RPMS. A percentage increase or decrease must be added to correctly reflect the charge billed in the POS system.

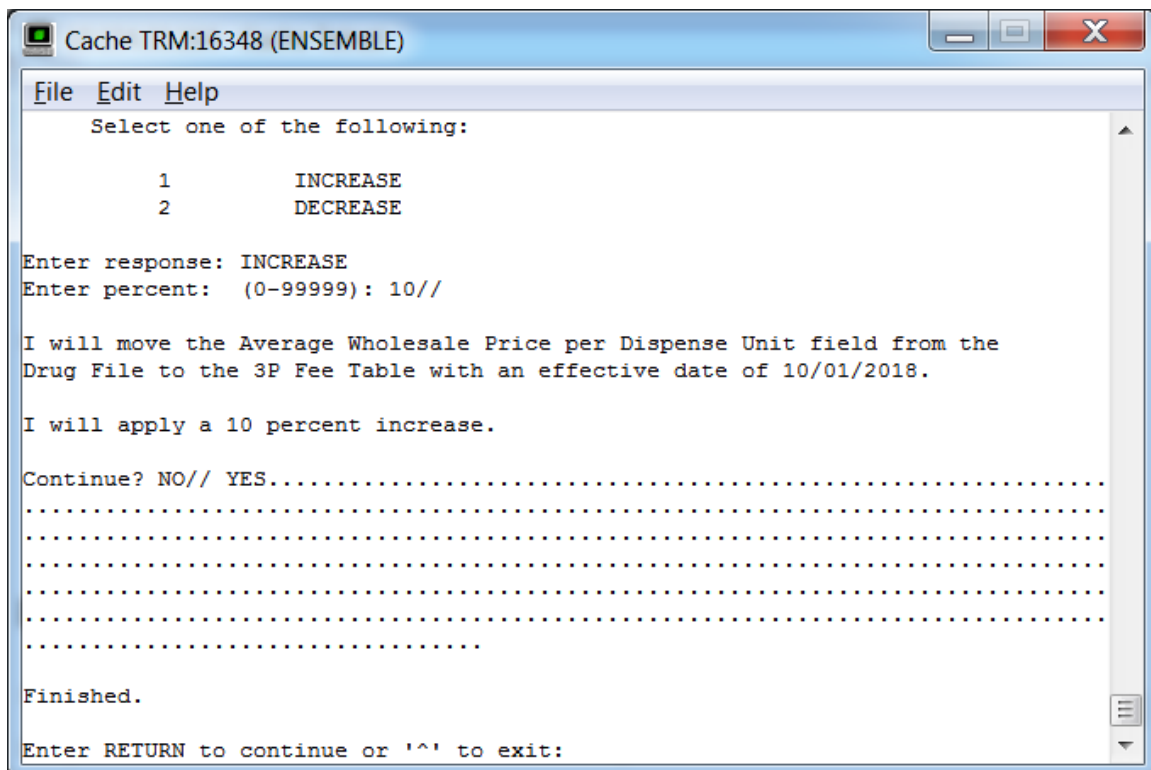
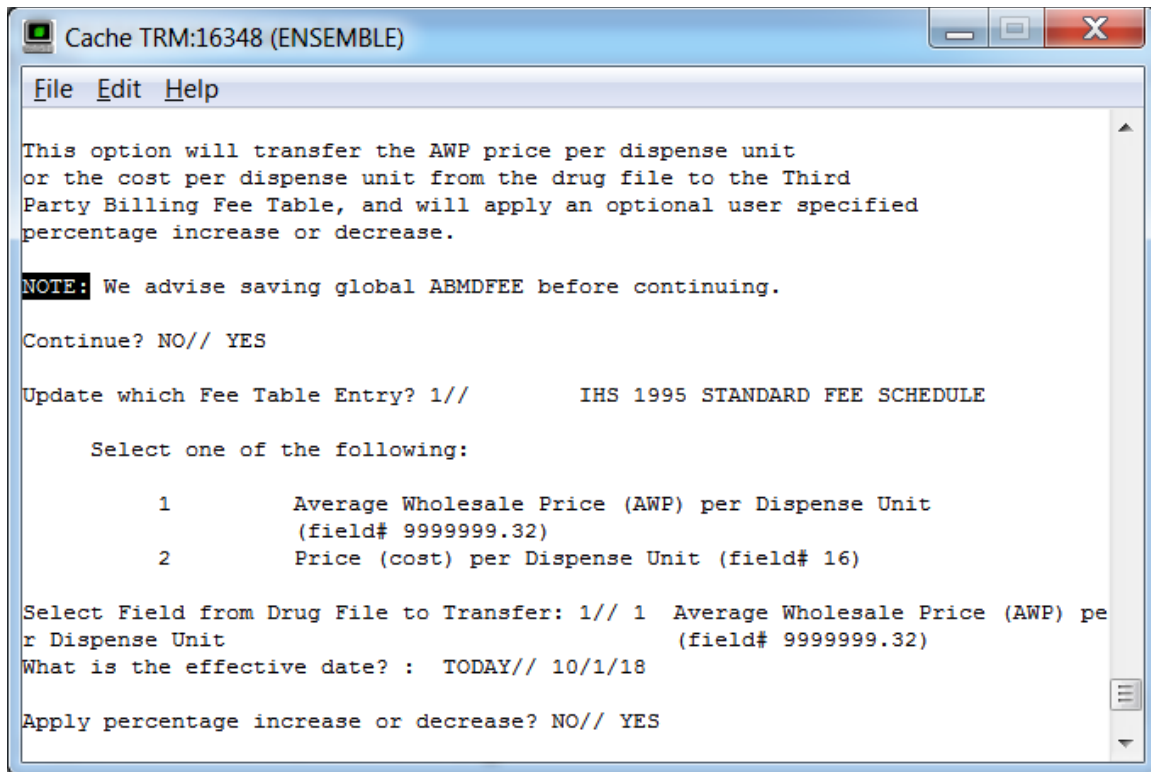
Main Menu TMTF FETM DTFE

This option enables the user to automatically transfer the Average Wholesale Price (AWP) price per dispense unit or the cost per dispense unit from the Drug file to the Third Party Billing Fee table. These values from the Drug file will be used to populate the specified fee table in Third Party Billing. Before transferring the fees, the user may elect to apply a specified percentage increase or decrease.

Note: Save the global ABMDFEE before executing this option.

- 1) Type Y or N at the “Continue? No/” prompt. If you type N, you will be returned to the Fee Schedule menu.
- 2) Type the fee table entry number at the “Update which Fee Table Entry:” prompt. If you need to see a list of options, type a question mark (?) at the prompt and make your selection from the list of options that appears.

- 3) Type the number that corresponds to the Drug file field that you wish to transfer data from at the “Select Field from Drug file to Transfer: 1//” prompt.
- 4) Type Y or N at the “Apply Percentage Increase or Decrease?” prompt. If you type **Y**, you will apply a percentage increase/decrease to the price before storing it in the Third Party Billing Fee Table. If you do not want to apply an increase or decrease to the price, type N and skip to step 7.
- 5) Type 1 (increase) or 2 (decrease) at the “Enter Response:” prompt.
- 6) Type the percentage that you wish to either increase or decrease the price by at the “Enter Percent (0-99999):” prompt. This number should be entered as a whole number (e.g., type 10 for 10%).
- 7) The system will display a review of your selections. Verify that you’ve entered your selections correctly and type Y or N at the “Continue: No//” prompt. If you type Y, the system will process the drug data transfer. If you type N, you will be returned to the Fee Schedule menu.



8.14 Frequently Asked Questions (FAQ)

For all Q&A, contact your local IT and follow the local IT Tiering structure. Most of the below items can be handled at the local IT level, before contacting RPMS/IHS support.

- 1) What happens if I run the Stranded Claim Report and have a stranded claim?
 - a) If there are one or two claims “stranded” but the POS claims are otherwise processing okay, try Resubmitting the “stranded” claims (POS User Screen/ EV/3 – Patient / RES). If that doesn’t work, contact RPMS Support at 1-888-830-7280 or support@ihs.gov.
 - b) If POS claims have stopped processing and all seem to be stuck, contact RPMS Support at 1-888-830-7280 or support@ihs.gov.
- 2) What does the “asleep” error message mean?

Wait for retry (insurer asleep) after 19:58:22 for BC/BS OF ARIZONA INC. (572512.00...001)

This is a safety feature (pause) built into the system to keep claims from overloading the system. It will also go into sleep mode when the processor (payer end) has downtime and isn’t processing.

These claims will resume processing on their own. If it has been more than a day since claims have been processing, contact RPMS support at 1-888-830-7280 or support@ihs.gov.

- 3) Are there any other menu options that business office staff would need?

The following menus might be useful for business office staff when reviewing rejected claims, reversed claims or doing back-billing.

VWRX – View Prescriptions [PSO VIEW] – to view the activity log of a particular prescription.

MEDP – Medication Profile [PSO P] – to view the medications a patient has received over a particular time period.

- 4) Are there any other menu options that pharmacy staff would need?

If the pharmacy wants to understand rejections related to eligibility issues, this menu option will be helpful:

VIEW – View patient's registration data [AGVIEWONLY]

- 5) The claim did not transmit, and this message was displayed: **PCC Link problem during visit lookup**. What does that mean?

There is something wrong with the prescription. This can happen when trying to submit a prescription under NEW claim (from POS User screen), which has been deleted from the system. Another reason could include a visit date not being merged with the pharmacy date and data entry or IT can merge the visits.

- 6) When exiting the NEW claims window, I press the <F1> key and the letter “E” and nothing happens except the letter “E” being typed.

The <F1> key needs to be reprogrammed to <PF1>. See your site manager for assistance.

- 7) Is there any regular maintenance the site manager should be doing?

On a daily basis, check the Error Trap for program errors – D ^XTER.

- 8) What if it is reported that POS claims are not processing anymore?

Verify that there have not been changes to the network.

- 9) It has been reported that the prices and drug file information is not correct anymore.

Verify that the last AWP patch was loaded correctly.

- 10) How do I fix a rejected reversal?

If a reversal rejects you will need to contact the insurance company and have them reverse it for you or find out why they rejected it. Some insurers have a set amount of days you have to do a reversal.

Note: Even if the insurance reverses the claim manually on the phone, it does not fix the claim within Point of Sale. It is as if the claim is corrupt. The claim will still say Reversal “rejected” within POS, making the reports inaccurate. If the claim is not manually reversed, you will still receive a payment on these claims. This occurs if the claim is Reversed, then Resubmitted, but the “Reversal” is rejected (generally due to a time out error), and the “resubmittal” is submitted, the resubmittal will not go through, thus creating a payment for the initial claim, and no payment for the second claim, however, the receipt in POS, may appear that the second transmittal for the same prescription number was paid, when in fact, the claim is still paid for the first transaction because it was never reversed, due to the error Rejected “83:Duplicate Paid/Captured Claim”. A Rejected claim cannot be reversed in POS. Once insurance manually reverses these claims, if needed, the claim can then be resubmitted in POS, the claim should then be “Paid” with the corrected information in the Receipt and with the insurance. This will fix the claim in Point of Sale, and also fix it for posting to the EOB for the payment.

9. Secondary Billing Process

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9.1 About Secondary Billing

Secondary billing refers to the process of identifying other payers that may be billed on behalf of the patient for a remaining balance that would otherwise be billed to the patient. If the patient, either via work benefits, state assistance or other means carries additional health coverage, that coverage may be billed. This allows the site to maximize benefits on behalf of the patient.

Using the coordination of benefits model, the biller determines the primary payer and any supplemental payers that may be billed for the services the patient received. This eligibility is recorded in the practice management system and should appear as a billable entity if the benefits allow for billing of that service.

All supplemental billing must be completed in a timely manner. This must be completed prior to billing the nonbeneficiary patient for their balance due. Once a claim is processed, the patient may be liable for a copayment, coinsurance or deductible. These balances are usually billed to the supplemental payer. Amounts that were denied or not covered by the payer may not be billed to a supplemental payer. All supplemental billing must contain the prior payers Remittance Advice to inform the payer of the prior payers processing of the claim. In many cases, these documents (attachments) are now able to be sent electronically.

9.2 Creating Secondary Claims

This is the procedure for creating secondary claims. For this process to be successful, keep the following points in mind:

- Ensure that your Accounts Receivable staff are rolling back the payment/adjustment data.
- Have all supporting documentation (copy of primary remittance advice) on hand during secondary billing.
- Never submit the original primary EOB to the secondary payer.
- If the primary EOB contains multiple claims for different patients, on a copy of the EOB, cross out patient data not related to the claim being submitted.

9.3 Identifying Supplemental Claims

Claims that have been posted and the balance brought to a zero balance will need to be “rolled back” to the Third Party Billing system in RPMS from Accounts Receivable. In order for the bill to roll back the transaction data, the following must be true:

- The bill balance must post to a current balance of \$0.00.
- The user must answer **Yes** to the *Rollover as you Post* question.

9.3.1 Rollback to Third Party Billing

The process of rollback occurs when the transactions posted to the bill result in a zero balance (\$0.00) to the bill. The system will check eligibility for other payers that may be billed, regardless of the payers billed on the original claim. When eligibility is found, the user will see the following screen.

```

Reviewing Bill 31254A-IH-123567          6743
BILL 31254A-IH-123567>PAYMENTS<      >ADJUSTMENTS<
BILLED 30.00 3-P CRD 0.00 NON-PAY 8.10
PAY TOT 0.00 PAYMENTS 0.00 DED 0.00
ADJ TOT 30.00 PAY CRD 0.00 CO-PAY 21.90
      WR OFFS 0.00 PENALTY 0.00
      GROUPER 0.00 STC 0.00
      REFUND 0.00 TOTAL ADJ* 30.00
ROLLOVER 30.00 TOTAL PAY* 0.00

Pat: DEMO,JOHN      Visit Type.: OUTPATIENT
      Bill Status:

Original bill approved with the following:

P: BC/BS OF ARIZONA INC
S: MEDCO HEALTH PRESCRIPTION
T: ARIZONA MEDICAID

Enter RETURN to continue:

CHECKING FOR UNBILLED SOURCES.
  [1] MEDCO HEALTH PRESCRIPTION
  [2] ARIZONA MEDICAID

Re-open claim for further billing? (Y/N)? YES

Claim Number: 31254 is now Open for Editing!

```

To re-open the claim for editing, type **Yes** and press Enter. The claim will open in Third Party Billing with a claim status of Rolled-In Edit Mode. This means that running the Brief Claims Listing (BRRP) allows the user to select a claim status of Rolled-In Edit Mode for a list of claims ready to be billed to a supplemental insurer.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|  THIRD-PARTY BILLING SYSTEM - VER 2.6p13  |
+   Edit Claim Data   +
|  INDIAN HEALTH HOSPITAL  |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: LUJAN,ADRIAN M      1-APR-2015 9:33 AM

```



```
Select CLAIM or PATIENT: 31254 DEMO,JOHN  
Cln:31254 12-14-2014 OUTPATIENT LABORATORY SERV INDIAN HOSP  
MEDCO HEALTH PRESCRIPTION ROLLED-In Edit Mode  
Correct Claim? YES//
```

The claim is now ready to be edited and billed.

9.4 Medicare as a Secondary Payer (MSP)

“Medicare secondary payer” is the term used by Medicare when it is not responsible for paying a claim first. When Medicare is secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first and Medicare pays second.

The role of Medicare as the secondary payer is similar to the coordination of benefits clause in private health insurance policies. By federal law, Medicare is secondary payer to a variety of government and private insurance benefit plans. Medicare should be viewed as the secondary payer when a beneficiary can reasonably be expected to receive medical benefits through one or more of the following means:

- An Employer Group Health Plan (EGHP) for working aged beneficiaries.
- A Large Group Health Plan (LGHP) for disabled beneficiaries.
- Beneficiaries eligible for End Stage Renal Disease (ESRD).
- Auto/medical/no-fault/liability insurance.
- Veterans Affairs (VA).
- A Workers’ Compensation plan. The Federal Black Lung Program.

Individuals not subject to the MSP provision include:

- Individuals enrolled in Part B only.
- Individuals enrolled in Part A on the basis of a monthly premium.

9.4.1 Tribal Self-Funded Insurance

For American Indian and Alaska Native (AI/AN) beneficiaries receiving care in an IHS/tribal/CAH, Medicare will make a conditional payment for those beneficiaries that are employed by the tribe and covered under tribal self-insurance. Medicare is primary for services rendered in an Indian Health facility; however, once the patient receives services at a non-IHS facility, the tribal self-funded insurance is primary.

During the collection of MSPQ information, if it is determined that the beneficiary is employed by the tribe, a conditional payment claim must be submitted each time the beneficiary receives either an outpatient encounter or

an inpatient admission.

Medicare's systems cannot distinguish self-insurance from third party insurance. This does not affect claims processing or payment; however, CMS' Medicare Secondary Payer Recovery Contractor (MSPRC) may later include IHS provider claims in a demand for repayment. The tribe's self-insurance is a valid defense against the inclusion of such claims; to assert this defense, the tribe must provide the MSPRC with documented proof that it was self-insured at the time the IHS facility provided the relevant services. Upon receiving the appropriate documentation, the MSPRC will remove the IHS provider claims from the debt.

For more information, reference the Medicare Administrative Contractor's website.

9.5 Medicaid as a Secondary Payer

Medicaid is typically referred to as the "payer of last resort" and may cover most, if not all services when billed as a secondary provider. Each state and sometimes their Managed Care Organizations (MCO's) require different billing situations. For example, When Medi-Cal is the secondary payer to Medicare or a Medi-Cal Managed Care Plan, the negotiated wrap-around rate is billed to Medi-Cal. The 3PB claim is split – one bill is submitted to the Managed Care Plan, the other is billed to Medi-Cal for the wrap-around. The programs do an annual reconciliation with DHCS Audits and Investigations for these payments.

When Medi-Cal is secondary payer to private Insurance, the total all-inclusive rate is billed regardless of the primary payer payment.

The State Medicaid plan will advise based on their policy how the claim will need to be submitted. Contact your state's plan for additional information.

10. Billing Veterans Administration (VA)

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10.1 About VA Billing

The Indian Health Service and Veterans Affairs (VA) are working together to improve the health status of American Indian and Alaska Native (AI/AN) veterans. In October 2010, an MOU between VA and IHS was renewed and signed to establish coordination, collaboration, and resource-sharing between VA and IHS.

The Department of Veterans Affairs, signed a MOU with the IHS to provide reimbursement for direct care services provided by the IHS to eligible American Indian/Alaska Native (AI/AN) Veterans.

On December 5, 2012, VA and IHS signed the National VA/IHS Reimbursement Agreement which sets the guidelines of this reimbursement agreement. The agreement marks an important partnering achievement for VA and the IHS and is consistent with mutual goals to increase access to care for Veterans.

As a result of the National VA-IHS Reimbursement Agreement, *VA-IHS Local Implementation Plans* were established in 2013 between IHS facilities and local VA Health Care Systems in order to facilitate reimbursement.

10.2 Billing

10.2.1 Coordination of Benefits

The VA Medical Benefit Plan (VAMB) is considered the payer of last resort. Currently in the RPMS Third Party Billing system, VAMB will generate before Medicaid and Medicare. Billing staff must ensure all insurance plans have been sequenced correctly to ensure correct Coordination of Benefits.

If a claim is submitted to other insurers where the VAMB insurer is listed as another payer and the insurer denies the claim stating that the VA must be billed first, the biller should submit a copy of the IHS-VA agreement to that insurer, indicating that the VA is the payer of last resort.

Secondary Billing is to be done only when Private Insurance has been billed first. You must provide a copy of the Payment/Denial EOB from the Private Insurance Company. DO NOT secondary bill from Medicaid or Medicare.

10.2.2 Claim Form Requirements

The VA Station Number and the Contract Number will need to print on each paper claim form. The entries are added in the RPMS Third Party Billing Site Parameters.

The VA Station Number is a three-digit number and identifies the VA Medical Center associated to the IHS facility where the patient was seen.

VA STATION NUMBER					
Export Mode	Form Locator	RPMS Page	RPMS Field Description	Example	VA Facility
CMS-1500 or 837 Professional	Block 23	3	Prior Authorization Number	568	Fort Mead VA
UB-04 or 837 Institutional	Block 63	3	PRO Approval Number	0568	Fort Mead VA
ADA2012	Check with your local VA regarding Dental Claim Requirements				

The Contract Number is the number that the VA assigns to the IHS facility once the Local Implementation Plan has been signed. This number must be included on the claim.

CONTRACT NUMBER					
Export Mode	Form Locator	RPMS Page	RPMS Field Description	Example	VA Facility
CMS-1500 or 837 Professional	Block 19	3	HCFA-1500 BLOCK 19	VA-568-IHS-0001	Fort Mead VA
UB-04 or 837 Institutional	Block 80	9F	Remarks	VA-568-IHS-0001	Fort Mead VA
ADA	Check with your local VA regarding Dental Claim Requirements				

10.2.3 Itemization of Charges

Although the Reimbursement Agreement states that the IHS facilities shall be reimbursed for outpatient services at the All-Inclusive Rate as published in the Federal Register, all claims must be submitted displaying the itemized charges. The initial set up of the insurer allows the claim to itemize in the Claim Editor.

10.2.4 Outpatient Claims

Outpatient services, as indicated in the Insurer File setup, are to be billed on the CMS-1500 or the 837 Professional export mode.

Note: With the exception of Pharmacy, all services must be billed on one claim form which means only one claim may be submitted per visit.

Medications may be billed but the charges would need to be split from the Medical claim onto a new claim.

Note: Billers should double check that pharmacy claims are not also being billed via POS to a private payer, as they will appear on the flagged as billable report for VA billing.

10.2.5 ASC Claims

All services pertaining to Ambulatory Surgery are presented (billed) on a CMS-1500 ONLY. Do not bill professional services on a separate claim form. All services, facility and professional, are billed on one claim form.

10.2.6 Emergency Room

Emergency Room services may be billed but will need to be billed out on a UB-04 or 837 Institutional claim form. Sites that normally split the Emergency Room claim to bill the Professional Component separate from the facility charges will need to ensure that all billing is approved on one claim form. This means the Professional Component must be billed along with the facility charges.

10.2.7 Inpatient Claims

Inpatient claims will need to be billed on the UB-04 or the 837 Institutional claim form. Charges will be itemized and the DRG added to Form Locator 71. The Inpatient Professional Component may be split onto a separate claim and billed using the CMS-1500 or the 837 Professional claim form.

10.2.8 Dental

The VA agreement allows for billing dental services but is very limited in the services that are covered. Prior to billing any dental services, please contact the VA to ensure the services provided will be covered.

Covered dental services may be billed under the ADA 2012 claim form.

10.2.9 Pharmacy Billing

The VA requires prior authorization for coverage of non-VA formulary drugs dispensed at Tribal Health Programs (THPs) who have entered into a VA/THP Agreement. The VA may require prior authorization for coverage of non-VA formulary drugs dispensed at IHS facilities in the future. This section will be updated as more information becomes available.

At this time, medications are not billed using the Pharmacy POS. Medications shall be split from the medical claim. Medications are billed on a CMS 1500 Form to the VA using J3490. For more information, reference the “VA Medical Benefits User Manual” in the appendix.

11. Billing for Commissioned Officers and Their Dependents (BMP)

Contents

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11.1 About BMP Billing

The Commissioned Corps of the U.S. Public Health Service is a team of more than 6,500 full-time, well-trained, highly qualified public health professionals dedicated to delivering the Nation's public health promotion and disease prevention programs and advancing public health science. As one of America's seven uniformed services, the Commissioned Corps fills essential public health leadership and service roles within the Nation's Federal Government agencies and programs. Officers serve their country in communities that are most in need by providing essential health care services to underserved and vulnerable populations.

BMP Billing refers to the Beneficiary Medical Program billing program that provides reimbursement for medical services provided to Commissioned Officers and their dependents who seek care at an Indian Health Care facility. Tricare may also be used to bill for services, but the facility may only bill one entity, not both. Historically, I/T/U providers have billed BMP for all visits.

Billing may not occur to BMP for Commissioned Officers and their dependents who reside in the following urban cities where services from non-I/T/U facilities may be provided. The locations are:

- Washington D.C. Metropolitan Area
- Phoenix, Arizona
- Tucson, Arizona
- Albuquerque, New Mexico
- Lawton, Oklahoma
- Claremore, Oklahoma
- Rapid City, South Dakota
- Tucson, Arizona

Tricare has a sufficient number of providers in the locations listed above to require all PHS beneficiaries (officers, dependents and retirees) to access local Tricare providers in these areas for medical services. **IHS will not be reimbursed for PHS beneficiary care provided in these locations.**

11.2 Covered Services

Encounters that are considered medically necessary and conducted face-to-face are covered. Diagnostic or Prognostic services provided to a commissioned officer or their Dependent is billed using the All-Inclusive Rate, as published in the Federal Register as *Other Federal Agency*.

The following table lists examples of billable/reimbursable visits:

Type of Service	Billed and Reimbursed at...		
	Outpatient AIR	Inpatient AIR	Itemized

Medically necessary Outpatient services provided by a licensed provider	X		
Medically necessary Inpatient services provide by a licensed provider		X	
Medically necessary Physician Services			X
Medically necessary Optometry, Dental, Physical Therapy, etc.	X		
Medically necessary “stand alone” Lab, Radiology, etc. visits	X*		
Medically necessary Pharmacy visits (regardless of the number of prescriptions)	X*		
Medically necessary Ambulatory Surgery visits			X

***If counted as a separate visit for visit count purposes**

Use the discretionary thought: “would we be reimbursed by any other Third Party Resource” for definition of non-billable visits. For example:

- Over the Counter Medications, i.e., vitamins, aspirin, nonprescription cough syrup, lice shampoo.
- Eye glass adjustments, hearing aid adjustments, if it would normally be a courtesy visit in conjunction with another visit.
- Split Visits – DO NOT SPLIT ancillary services off of a medical visit and bill separately, if you would normally include them in the visit count as a “combined visit”.
- Administrative Encounters – Example, providing paperwork to an individual should not be billed as a Medically Necessary Visit.

11.3 Billing Basics

Normal billing guidelines and submission timelines apply when billing to the Beneficiary Medical Program. Be sure to follow up with BMP to ensure timely processing.

The RPMS Third Party Billing application is used to create a claim from the visit data in the Patient Care Component (PCC). Historically, spreadsheets listing a summary of visits were provided to BMP, which were processed and paid but creating the claim and submitting a Transmittal Listing from RPMS allows for the receivable to be tracked in the Accounts Receivable application and aides the facility in knowing the amounts billed and the outstanding receivables pending claims processing at BMP.

11.3.1 Process

The process for generating the claim and billing is as follows:

- 1) Patient Registration must contain the eligibility information for BMP.
- 2) Visits will be entered into PCC/EHR just as all other visits.
- 3) Claims will be generated, edited, and approved (bills) via the RPMS Third Party Billing package and printed. Invoices will be transmitted to UFMS using the “Other” allowance Category.
- 4) All claims/bills will be submitted to the Area Office (designee) to create a summarized SF1080 to be attached to copies of the claims and submitted to BMP. Address is:

Beneficiary Medical Program IHS,
5600 Fishers Lane, Parklawn Bldg., Room 4C-06,
Rockville, MD 20857.

Contact person: Alicia Guy: aguy@hhs.gov

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FMCRA Document



FMCRA Resource
Book.pdf

Pharmacy POS Tutorial and RCR Example



Pharmacy POS
Tutorial and RCR Exam

Pharmacy POS User Tip Chart



Pharmacy Point of Sale User Tip Chart



General RPMS Commands

- Type **HALT** at any menu option to exit the application and the RPMS system immediately.
- Type **CONTINUE** at any menu option to exit from the application and the RPMS system immediately.
 - Type **YES** when asked if you want to halt and continue with this option later to continue where you are when you return to the system.
- When you are at a menu selection point, press **ENTER** without typing a response to get back to the previous menu screen.

Remember: An option that ends with three periods indicates additional menus to the option.

- Type **one question mark (?)** to list all available options.
- Type **two question marks (??)** to list all available options and show their formal names.
- Type **three question marks (???)** to obtain a brief description of each menu option. Use this feature when you are uncertain of which menu option to select.
- Type **four question marks (????)** to show extended help for the menu displayed on your screen.
- Type an option name preceded by one question mark to show extended help for that option (some are not available).
 - I.e., **?EPT**
- Type **^** to go back one screen.
- Type **^^** to go back to the menu.

Screen Editor Function Keys

- Navigation
 - Press **ARROW** keys for incremental movement.
 - Press the **Tab** key to move to next tab stop to the right.
 - Press **F1, ←** to jump left.
 - Press **F1, →** to jump right.

- Press **F1, ↓** to jump to the bottom of the screen.
- Press **F1, ↑** to jump to the top of the screen.
- Press **F1, T** to jump to the top of the document.
- Press **F1, B** to jump to the bottom of the document.
- Exiting/Saving
 - Press **F1, E** to exit and save text.
 - Press **F1, Q** to exit without saving.
- Deleting
 - Press **Backspace** to delete a character before the cursor.
 - Press **F1, D** to delete an entire line.

Remember: Press **F1, H** to enter the Help Screen.

Ways to Identify a Patient

- Enter the patient's last name followed by a comma and first name with no spaces.
- Enter the patient's date of birth.
- Enter the patient's Social Security number.
- Enter the patient's chart number.

Remember: You may bring up the last patient that you were working on by pressing **Space Bar, Enter**.

Jump Command

- Type **^, Option Name** to jump directly to the option (I.e., **^EPT**). You do not need to go through all of the menus to get to an option.

Rubber Band Jump

- Type **^^, Option Name** to jump directly to the option and return to the original screen. (I.e., If you are in the CORE menu and type **^^EPT** you will jump to EPT. Then when you press **Enter** you will return to the CORE menu.)

Remember: To delete, select field and type **@**.



Pharmacy Point of Sale User Tip Chart



To Capture a RPMS Process

1. Click on the **Session** menu.
2. Click on the **Capture to File** menu item.
3. Click on **Start Capture. . .**
4. Complete the process. It is being recorded.
5. After you have completed the process, click on the **Session** menu.
6. Click on the **Capture to File** menu item.
7. Click on **Stop Capture**.

Security Keys Used with POS

- **ABSPZMENU** – All POS Users
- **ABSPZ REPORTS** – All POS Users
- **ABSPZ USER** – Staff who will do POS data entry (usually All POS Users)
- **ABSPZ INSURER** – Staff who will set POS operating parameters and manage POS insures
- **ABSPZ MANAGER** – Staff who will set POS operating parameters and manage POS insures
- **FILE MANAGER ACCESS CODE** – “Pp”

How to Identify POS Patch at your Site

When logging into the POS menu check the banner at the top of the screen for the version and patch as shown below:



Automatic POS Reversals

1. Pharmacist uses the Return to Stock function
2. Pharmacist deletes the prescription
3. Pharmacist edits the “*” field of a prescription

RPMS Support Center

OIT User Support (IHS)
Phone: (505) 248-4371 or (888) 830-7280
Fax: (505) 248-4363
Web: <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>
Email: support@ihs.gov

Please follow the tiered structure below when obtaining support:

- Tier 1** – Local IT Site Manager
- Tier 2** – Area Office IT Support
- Tier 3** – OIT User Support (IHS)

How to Identify the processor

Emdeon Web site:
<https://secure.ernetwork.com>

New user will need to click on Request a New Account

1. Enter in your User ID and Password
2. Click on the TOOLS tab
3. Click on the expand button + for Service: Emdeon Connect™
4. Click on Plan Search
5. Enter information you have on the plan, i.e. BIN and/or PCN
6. Click on one of the View options to see what the plan name is
7. The POS format name and Processor will display.

Tips for Contacting the Insurer Help Desk

- Research the claim identifying patient information such as Patients Name, DOB, Cardholder ID, Group #, etc
- Have your pharmacies NCPDP or NPI number available
- Know how to identify the internal RX number this is the one the insurer will recognize it has a “^” mark prior to the number

Helpful Links

1) Point of Sale (POS) Guides:

<ftp:\ftp.ihs.gov\rpms\POS\POS User Guides\>

2) Card Finder, Script View and Payer Sheets Website (login required):

<https://secure.erxnetwork.com/logon.aspx?ReturnUrl=\Default.aspx>

3) National Provider Identifier (NPI) Registry:

<https://npiregistry.cms.hhs.gov/>

4) For POS Updates (email):

POS@listserv.ihs.gov

RRIP Information

It has been a long time since an update to the RRIP has been released, and there have been some significant changes (mostly to opioid management related items) since the last version. Please replace older versions with this version and share the reports it generates with your multi-disciplinary teams. Also, please feel free to share the RRIP with anyone within our I/T/U system. Knowing where we are with opioid prescribing helps tremendously as we work as a team to ensure we are keeping risk of overdose and misuse to a minimum while providing the care our patients need.

For those of you know do not know what the RRIP is with respect to opioid management, please let me list a few of the things it can calculate for you within minutes:

- 1) MMEs for every script you have dispensed
- 2) Average Daily MMEs for all scripts combined divided by division
- 3) Average Daily MMEs prescribed by each provider
- 4) Total Daily MMEs for patients over a two different thresholds you specify and give you counts of total number of patients over those thresholds and how many of them received a benzo as well
 - a) By Total Daily MME, I mean if a person is one two different opioids concurrently, it will add those together and give you the total daily MMEs the patient is receiving
- 5) Total number of controlled substances dispensed as well as the total number of opioids dispensed
- 6) Total number of patients receiving any opioid
- 7) Total number of controlled substances dispensed by drug
- 8) Total MMEs for all scripts combined divided by division

9) Total MMEs prescribed by each prescriber

Highlights of major changes are below:

- 1) Sites using ERx or Outside Pharmacy – Print for controlled substance scripts can now monitor the opioid prescribing at their site using the new CSM + ERxT button (Yellow)
 - a) While extensive effort was made to ensure accuracy of the CMS + ERxT and ERxT report processor, there was limited availability of ERxT sites among the testing group.

Therefore, if you begin to use the RRIP with the ERxT report and notice something that doesn't seem quite right, please notify me and I will look into it and get it fixed
 - b) To run an ERxT report without the CSM report, simply cancel the window that asks for a CSM report
 - c) If RRIPing both reports, they need to be for the exact same date range
- 2) Methodology was updated to use the CDC methodology for opioid surveillance
- 3) User manual is now embedded in the main RRIP file and can be found under the "User Manual" tab
 - a) New instructions were added on how to divide multi-division files up (if you can by only choosing one division when running the report)
 - b) New instructions were added on how to combine sites that don't show up in a single report
 - c) All in-program instructions are now part of the instructions manual so they can be referenced as you go
- 4) A new "Definitions and Explanations" tab was created that explains the methodology and algorithms the RRIP uses in detail
- 5) The conversion factors used for MME calculations can be found in the "Conversion Factors" tab

If you have never used the RRIP before, please start with the user manual and follow the instructions carefully. Give yourself 1 hours to get yourself up and running.

After you have successfully created your first reports, creating reports usually takes less than 5 minutes.

If you have used the RRIP before, re-read ALL in-program pop-ups as they contain new information. Also, please take a moment to review the "Definitions and Explanations" tab as it contains valuable information to help you better understand what the numbers in the RRIP represent with respect to opioid management.

If you are using Office 2016 you will need to follow the following steps to be able to use the macros in the RRIP:

- 1) Open Internet Explorer
- 2) Click on the gear-looking icon at the upper right of the window
- 3) Click on “Internet Options”
- 4) Click on the “Security” tab
- 5) Click on the “Local intranet” icon
- 6) Click on the “Sites” button
- 7) Click on the “Advanced” button
- 8) In the field “Add this website to the zone:” type the server location where your file is stored. I would suggest not putting the specific folder in here, but rather the core folder for your department. It will be something like \\phxtestserver\departments\. You might have to ask your IT for this, but if you pull up “This PC” or “My Computer” and click on your mapped network drive, it should give you the location in the address bar at the top of the window.
- 9) Once you have entered the address, click the “Add” button.
- 10) Close Internet Explorer.
- 11) Close and reopen the RRIP. – Remember that you have to manually “Allow access to the VBA Project Module” for everything to work well if you are using the new 2016 version for the first time.

Lastly, just a tip on determining the number of chronic opioid patients. The CDC Quality Improvement collaborative defines “long-term” (also known as chronic opioid therapy (COTS)) use as ≥ 60 days in the last quarter (let’s just call that 90 days). If you want to use that definition, the way you can get a list of these patients is the following:

- 1) Session log a CSM or CSM and ERxT for 90 days
- 2) When you RRIP the report, set the “Days Above the Threshold” to 60
- 3) In the RRIP’d report, go to the TDMME by Patient tab, and all the patients in the table will be your “long-term” users

VA Medical Benefits User Manual



VA Medical Benefits
User Guide_3.0-2018.d