

EDI New Standards and Operating Rules VHA Provider-side

eBilling Build 3

Requirements Specification Document

Patch IB*2*516

VA



U.S. Department of Veterans Affairs

Office of Information and Technology
Product Development

Approved:

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1. Introduction

The purpose of this Software Requirements Specification Document (RSD) is to outline the requirements for the Electronic Data Interchange (EDI) New Standards and Operating Rules – VHA Provider-side project related to Integrated Billing (IB) Patch IB*2*516.

The target audience for this RSD includes Product Development (PD), Product Support (PS), Software Quality Assurance (SQA), the Program Management Office (PMO), the Chief Business Office (CBO) and the end-users.

1.1. Scope

Patch IB*2*516 will include the following:

Integrated Billing

Enter/Edit Billing Information

- Provide the ability for users to authorize a claim for with a revenue code(s) less than 100 (remove existing fatal error for codes outside the 100-999 range).
- Provide the ability for users to add National Drug Codes and associated number or units to non-prescription claims
- Provide the ability for users to add a description to a claim with a procedure code that ends in 99 or contains the following in the code description:
 - Not Otherwise Classified
 - Not Otherwise
 - Unlisted
 - Not listed
 - Unspecified
 - Unclassified
 - Not otherwise specified
 - Non-specified
 - Not elsewhere specified
 - Not elsewhere
 - Nos (Note: Include "nos ", "nos;", "nos,")
 - Noc (Note: Include "noc ", "noc;", "noc,")
- Prevent the ability to authorize claims with non-billable providers [provider has no National Provider Identification Number (NPI)] on the claim
- Prevent the ability to authorize a Fee Basis claim with a non-VA Lab or Facility that has no NPI
- Provide the ability to authorize a claim with Service Facility data that does not have a Lab or Facility Taxonomy Code without displaying a Warning (remove existing warning)
- Provide the ability to print a TRICARE claim with a TRICARE-specific Pay-to Provider
- Provide the ability for users to re-sequence Diagnoses Codes (DX) after Procedures have been associated with the DX (Pointers) without breaking the association
- Provide the ability for users to view a list of the following Code sets by Code number when they enter ?? for Help on Billing Screen 4 and 5:
 - Occurrence Codes

- Condition Codes
 - Value Codes
- Provide the ability for users to lookup a Code from one of the following Code sets using the code number:
 - Occurrence Codes
 - Condition Codes
 - Value Codes

Data Dictionary

- Remove obsolete fields from IB files

Insurance Company Editor

- Remove functionality that provides the ability for a site to set a parameter that forces all claims to a particular payer, to use the VAMC as the Billing Provider instead of the lowest enumerated Billing Provider
- Change the Plan Type description for the Plan Type = FI- FEP (Federal Employee Plan) to Do Not Use for BC/BS when users enter ?? for Help at a Plan Type field

Reports

- Add the display of the new Health Plan Identifier (HPID) and the Other Entity Identifier (OEID) to the EDI Parameter Report
- Remove the display of the Billing Provider override parameter from the EDI Parameter Report
- Provide the ability to display partial or complete new HIPAA compliant electronic 270/271 Health Care Eligibility Benefit Inquiry and Response fields on IB reports
- Provide the ability for users to sort and display the Re-Generate Unbilled Amounts Report by Division

Third Party Joint Inquiry (TPJI)

- Provide the ability for users to see that a claim in TPJI, Active and Inactive claim lists, is an Institutional or a Professional claim
- Provide the ability for users to view the Co-payment amount associated with a claim in TPJI

COB Management Worklist (CBW)

- Provide the ability for users to sort and display the CBW by Division

Transactions

- Provide the ability to transmit the HPID in the Institutional/Professional 837 claim transaction (Loops 2010BB and 2330B) – continue to transmit legacy primary and secondary IDs in the Institutional/Professional 837 claim transaction
- Provide the ability to transmit the same NPI (organizational) for a Service Facility and a Rendering Provider (individual) on an Institutional/Professional 837 claim transaction
- Remove monthly Mailman messages that notify CBO of how sites have the EDI Parameter for Billing Provider set
- Prevent an Institutional/Professional 837 claim transaction with a Y4 Property and Casualty Number Qualifier with no corresponding Property and Casualty Number

- Provide the ability to transmit the TRICARE Pay-to Provider on all claims with Rate Type equal to TRICARE and TRICARE REIMB. INS (Loop 2010AB)
- Provide the ability to transmit a NDC code on a non-prescription 837 claim transaction
- Provide the ability to transmit a maximum of 12 procedures on an inpatient claim

Correct Rejected/Denied Bill (CRD) and Copy and Cancel Bill (CLON)

- Remove the Security Key that locks the CLON option
- Remove the ability for users to CRD secondary/tertiary claims
- Provide the ability for as many fields as possible to be copied from an original claim to a copy

View Cancelled Claim

- Provide the ability to see all the data that was in a cancelled claim

Provider ID Maintenance

- Provide the ability for users to define an Outside Facility that is a sole-proprietorship with an NPI number that is also used by the provider who is the sole-proprietor

MCCR Site Parameter Display/Edit

- Provide the ability for users to define a Pay-to Provider to be used only on claims with a Rate Type equal to TRICARE or TRICARE REIMB. INS.
- Provide the ability to lock the new TRICARE Pay-to Provider functionality
- Provide the ability to lock the existing Pay-to Provider functionality

Printed CMS – 1500 and UB - 04 Forms

- Provide the ability to print an NDC code on a non-prescription claim

1.2. Assumptions/Dependencies

1. The Product Development Database Administrator will grant approval to remove obsolete fields from the Bill/Claims File (file 399)
2. The HPID Build 1 will be installed in production prior to IOC testing of this patch
3. DSS will make any changes needed to the Claim Scrubber due to changes to the 837 map

1.3. Acronyms and Definitions

1.3.1. Acronyms

Term	Definition
AITC	Austin Information Technology Center located in Austin, Texas; responsible for maintaining the hardware that supports the Lockbox system, including FSC servers, the Mailman routing system, and EPHRA database
AR	Accounts Receivable
COB	Coordination of Benefits
CBO	Chief Business Office
CSA	Claim Status Awaiting Resolution

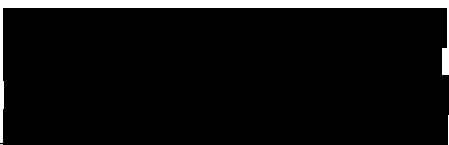
DMI	Data Management Interface
EDI	Electronic Data Interchange
EGHP	Employer Group Health Plans
EIN	Employer's Identification Number
EOB	Explanation of Benefits
FSC	Financial Services Center – Austin, Texas
HCCH	Health Care Clearing House
HIPAA	Health Insurance Portability and Accountability Act of 1996
HPID	Health Plan Identifier
ICN	Individual Control Number
IB	Integrated Billing software version 2.0
MRA	Medicare-equivalent Remittance Advice
MRW	MRA Management Work List
M (MUMPS)	Massachusetts General Hospital Utility Multi-Programming System
Non-MRA	Translates to non-Medicare
NPI	National Provider Identifier
NUBC	National Uniform Billing Committee
OEID	Other Entity Identifier
RX	Prescription (Outpatient Medication)
TPJI	Third Party Joint Inquiry
VAMC	Veterans Administration Medical Center
VistA	Veterans Health Information Systems and Technology Architecture
VPE	View/Print EDI Bill Extract Data
WNR	Will Not Reimburse

1.3.2. Definitions

Term	Definition
837	Transaction set for Health Care Claim, used to send a claim to a trading partner
835	Transaction set for Health Care Claim Payment Advice (or remittance advice). This is returned from the insurer to the billing facility. Generally this is referred to as an Explanation of Benefits (EOB or MRA)
CMS-1500	Preprinted forms to which professional third-party claims can be printed

Term	Definition
Emdeon	The clearinghouse which handles both VA claims printing and the transmission of claims to electronic payers.
EOB	This is the return file (835) from non-Medicare payers that provides data pertaining to the claim adjudication and the amounts paid by the payer.
MRA Request claim	This is the initial claim request to Medicare that is submitted for the purpose of obtaining MRA notice only.
MRA	This is the return file (835) from Medicare that provides data on allowable amounts. MRA reports are normally required for creation of secondary claims.
MRA Secondary Claim	This secondary claim is a result of the primary claim being an MRA Request claim.
Non-MRA Secondary Claim	This secondary claim is a result of the primary claim being to any insurer other than Medicare WNR.
Payer	An insurance company, fiscal intermediary, government agency, other agency, or individual responsible for the payment of health care claims.
Translator	A software package owned and residing at the Austin Services Center that allows reformatting data in internal VA formats to EDI formats and Vice Versa. This includes the ability to simultaneously handle multiple versions of EDI. The FSC translator also provides for non ASC X12 formats.
UB04	Preprinted forms to which institutional third-party claims can be printed
User	The person or persons who operate or interact directly with VistA.

1.4. References

Name	Location	Date
ASC X12N/005010X221 Health Care Claim Payment/Advice (835) – Technical Report Type 3	http://www.wpc-edi.com/	May 2006
ASC X12N/005010X222 Health Care Claim - Professional (837) – Technical Report Type 3	http://www.wpc-edi.com/	May 2006
ASC X12N/005010X223 Health Care Claim - Institutional (837) – Technical Report Type 3	http://www.wpc-edi.com/	May 2006
Patch IB*2*447 ICD (5010)		June 2010

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2. Overall Description

2.1. Accessibility Specifications

The user interface for the VistA Integrated Billing module is composed of two color, roll and scroll screens developed in M. The VistA modules are exempt from the standards for the 508 Section of the Rehabilitation Act.

2.2. Business Rules Specification

The electronic claims transactions are based on the following specifications:

- ASC X12N/005010X222 – Health Care Claim Professional (837)
- ASC X12N/005010X223 – Health Care Claim Institutional (837)

2.3. Design Constraints Specification

The design constraints for this project are those imposed by the existing VistA system which was developed in M.

The eIV Patch IB*2*497 added new fields with HIPAA Compliant field lengths. Where possible, the new field lengths will be displayed on IB Reports. Where existing data is already truncated due to lack of available space, the data from the new fields will also be truncated.

2.4. Disaster Recovery Specification

There are no disaster recovery requirements specific to this development effort. The affected modules are integrated parts of the overall VistA system that exists at each site and will be subject to the normal backup and recovery procedures.

2.5. Documentation Specifications

The following documents will be delivered as part of this project:

- Current Workflow Analysis Document
- Future Workflow Analysis Document
- Requirements Specification Document (RSD)
- Requirements Traceability Matrix (RTM)
- Software Design Document (SDD)
- Updated Interface Control Document (ICD) (Note: includes additional data mapping)
- Entity Relationship Diagrams (ERD)
- Release Notes/Installation Guide
- Technical/Security Manual
- Updated User Guide

2.6. Functional Specifications

2.6.1. System Feature: Enter/Edit Billing Information

2.6.1.1. **Modified 5/30/14 - Functional Requirement: Revenue Codes <100**

The IB System shall provide the ability for users to authorize a claim with one or more revenue codes outside the 100-999 range.

2.6.1.2. **Functional Requirement: Line Level NDC Codes to Non-Prescription Claims - Professional**

The IB System shall provide the ability for users to add a line level 5-4-2 format National Drug Code to a non-prescription procedure when creating a professional claim.

2.6.1.3. **Functional Requirement: Line Level NDC Codes to Non-Prescription Claims - Institutional**

The IB System shall provide the ability for users to add a line level 5-4-2 format National Drug Code to a non-prescription procedure when creating an institutional claim.

2.6.1.4. **Functional Requirement: Line Level Description – 99 Procedure Codes – Professional**

The IB System shall provide the ability for users to add a line level, 1-80 character free text description to a procedure code that ends in 99 on a professional claim.

2.6.1.5. **Functional Requirement: Line Level Description – 99 Procedure Codes – Institutional**

The IB System shall provide the ability for users to add a line level, 1-80 character free text description to a procedure code that ends in 99 on an institutional claim.

2.6.1.6. **Functional Requirement: Line Level Description – NOC Procedure Codes – Professional**

The IB System shall provide the ability for users to add a line level, 1-80 character free text description to a procedure code (CPT/HCPCS) on a professional claim that contains the following text in the procedure's description (file 81, field 81.01,01):

- Not Otherwise Classified
- Not Otherwise
- Unlisted
- Not listed
- Unspecified
- Unclassified
- Not otherwise specified
- Non-specified
- Not elsewhere specified
- Not elsewhere
- Nos (Note: Include "nos ", "nos;", "nos,")
- Noc (Note: Include "noc ", "noc;", "noc,")

2.6.1.7. Functional Requirement: Line Level Description – NOC Procedure Codes – Institutional

The IB System shall provide the ability for users to add a line level, 1-80 character free text description to a procedure code (CPT/HCPCS) on an institutional claim that contains the following text in the procedure's description (file 81, field 81.01,01):

- Not Otherwise Classified
- Not Otherwise
- Unlisted
- Not listed
- Unspecified
- Unclassified
- Not otherwise specified
- Non-specified
- Not elsewhere specified
- Not elsewhere
- Nos (Note: Include "nos ", "nos;", "nos,")
- Noc (Note: Include "noc ", "noc;", "noc,")

2.6.1.8. Functional Requirement: Fatal Error - Non-billable Providers - Professional

The IB System shall prevent users from authorizing a professional claim that contains an individual provider who has no NPI number:

- Rendering
- Supervising
- Referring

2.6.1.9. Functional Requirement: Fatal Error - Non-billable Providers – Institutional

The IB System shall prevent users from authorizing an institutional claim that contains an individual provider who has no NPI number:

- Attending
- Operating
- Other Operating

2.6.1.10. Functional Requirement: Screen – Non-billable Provider – Institutional

The IB System shall automatically remove all individual providers who have no NPI number from an institutional claim.

2.6.1.11. Functional Requirement: Screen – Non-billable Provider – Professional

The IB System shall automatically remove all individual providers who have no NPI number from a professional claim.

2.6.1.12. Functional Requirement: Fatal Error – Missing non-VA Lab or Facility NPI - Professional

The IB System shall prevent users from authorizing a professional Fee Basis claim with a non-VA Facility that does not have an NPI.

2.6.1.13. Functional Requirement: Fatal Error – Missing non-VA Lab or Facility NPI - Institutional

The IB System shall prevent users from authorizing an institutional Fee Basis claim with a non-VA Facility that does not have an NPI.

2.6.1.14. Functional Requirement: Warning – Missing Lab or Facility Taxonomy Code - Institutional

The IB System shall no longer provide a non-fatal warning message to users when an institutional claim contains a Lab or Facility which has no active taxonomy code.

2.6.1.15. Functional Requirement: Warning – Missing Lab or Facility Taxonomy Code - Professional

The IB System shall no longer provide a non-fatal warning message to users when a professional claim contains a Lab or Facility which has no active taxonomy code.

2.6.1.16. Functional Requirement: Print – TRICARE-specific Pay-to Provider – UB04 – TRICARE REIMB.

The IB System shall provide the ability for users to print the TRICARE-specific Pay-to Provider data on a UB04 when the rate type of the claim is TRICARE REIMB..

2.6.1.17. Functional Requirement: Print – TRICARE-specific Pay-to Provider – UB04 - TRICARE

The IB System shall provide the ability for users to print the TRICARE-specific Pay-to Provider data on a UB04 when the rate type of the claim is TRICARE.

2.6.1.18. Functional Requirement: Print – TRICARE-specific Pay-to Provider – CMS 1500 – TRICARE REIMB.

The IB System shall provide the ability for users to print the TRICARE-specific Pay-to Provider data on a CMS - 1500 when the rate type of the claim is TRICARE REIMB..

2.6.1.19. Functional Requirement: Print – TRICARE-specific Pay-to Provider – CMS 1500 - TRICARE

The IB System shall provide the ability for users to print the TRICARE-specific Pay-to Provider data on a CMS - 1500 when the rate type of the claim is TRICARE.

2.6.1.20. *Deleted 4/7/14* - Functional Requirement: Section 4/Screen 5 Navigation – Partial

The IB System shall provide the ability for users to navigate within Section 4 of Screen 5 using an up caret and partial name of a prompt within Section 4.

2.6.1.21. *Deleted 4/7/14* - Functional Requirement: Section 4/Screen 5 Navigation – Complete

The IB System shall provide the ability for users to navigate within Section 4 of Screen 5 using an up caret and the complete name of a prompt.

2.6.1.22. Functional Requirement: Re-sequence Diagnoses/Maintain Pointers

The IB System shall provide the ability for users to re-sequence a diagnosis code which has been associated with a procedure code(s) while maintaining the association (diagnoses pointers).

2.6.1.23. Functional Requirement: Value Code Help

The IB System shall provide the ability for users to view the list of available Value Codes by NUBC code number when users enter ?? for Help.

2.6.1.24. Functional Requirement: Value Code – External Code Lookup

The IB System shall provide the ability for users to lookup a Value Code by NUBC code number.

2.6.1.25. Functional Requirement: Occurrence Code Help

The IB System shall provide the ability for users to view the list of available Occurrence Codes by NUBC code number when users enter ?? for Help.

2.6.1.26. Functional Requirement: Occurrence Code – External Code Lookup

The IB System shall provide the ability for users to lookup a Occurrence Code by NUBC code number.

2.6.1.27. Functional Requirement: Condition Code Help

The IB System shall provide the ability for users to view the list of available Condition Codes by NUBC code number when users enter ?? for Help.

2.6.1.28. Functional Requirement: Condition Code – External Code Lookup

The IB System shall provide the ability for users to lookup a Condition Code by NUBC code number.

2.6.1.29. Functional Requirement: One-Time HPID - Professional

The IB System shall provide the ability for users to enter a one-time (the ID will not be stored in the Insurance Company file) Health Plan Identifier for the following payers when present on a professional claim:

- Primary
- Secondary
- Tertiary

2.6.1.30. Functional Requirement: One-Time HPID - Institutional

The IB System shall provide the ability for users to enter a one-time (the ID will not be stored in the Insurance Company file) Health Plan Identifier for the following payer(s) when present on an institutional claim:

- Primary
- Secondary
- Tertiary

2.6.1.31. *Added 4/7/14* - Functional Requirement: Line Level NDC Code Units to Non-Prescription Claims - Professional

The IB System shall provide the ability for users to add a line level number of units for each National Drug Code on a non-prescription procedure when creating a professional claim.

2.6.1.32. **Added 4/7/14 - Functional Requirement: Line Level NDC Code Units to Non-Prescription Claims - Institutional**

The IB System shall provide the ability for users to add a line level number of units for each National Drug Code on a non-prescription procedure when creating an institutional claim.

2.6.2. **System Feature: Data Dictionary**

2.6.2.1. **Modified 4/7/14 - Functional Requirement: Remove Obsolete Fields – File 399**

The IB System BILL/CLAIMS file (file 399) shall no longer contain obsolete fields:

- 51 *CPT PROCEDURE CODE (1)
- 52 *CPT PROCEDURE CODE (2)
- 53 *CPT PROCEDURE CODE (3)
- 54 *ICD PROCEDURE CODE (1)
- 55 *ICD PROCEDURE CODE (2)
- 56 *ICD PROCEDURE CODE (3)
- 57 *HCFA PROCEDURE CODE (1)
- 58 *HCFA PROCEDURE CODE (2)
- 59 *HCFA PROCEDURE CODE (3)
- 61 *PROCEDURE DATE (1)
- 62 *PROCEDURE DATE (2)
- 63 *PROCEDURE DATE (3)
- 65 *ICD DIAGNOSIS CODE (2)
- 66 *ICD DIAGNOSIS CODE (3)
- 67 *ICD DIAGNOSIS CODE (4)
- 68 *ICD DIAGNOSIS CODE (5)
- 168 *PLACE OF SERVICE
- 169 *TYPE OF SERVICE
- **170** ***PPS – Deleted 4/7/14***
- **202** ***OFFSET AMOUNT – Deleted 4/7/14***
- **203** ***OFFSET DESCRIPTION – Deleted 4/7/14***
- 204 *UB82 FORM LOCATOR 2
- 205 *FORM LOCATOR 9
- 206 *FORM LOCATOR 27
- 207 *FORM LOCATOR 45
- 208 *BILL COMMENT
- 209 *FISCAL YEAR 1
- 210 *FY 1 CHARGES
- 211 *FISCAL YEAR 2
- 212 *FY2 CHARGES
- 213 *FORM LOCATOR 92

- 214 *FORM LOCATOR 93
- 399.042,.13 *UB92 FORM LOCATOR 49 – Revenue Code
- 399.0304,2 *ADDITIONAL PROCEDURE NAME - Procedure

2.6.3. System Feature: Insurance Company Editor

2.6.3.1. Functional Requirement: Federal Employee Plan – Help Description

The IB System shall display the following description for the Plan Type of FEP when users enter ?? for Help at the Electronic Plan Type field in Change Plan Info under View/Edit Plan:

- Do Not Use for BC/BS

2.6.4. System Feature: Billing Reports

2.6.4.1. Functional Requirement: Sort - Re-generate Unbilled Amounts Report - Division

The IB System shall provide the ability for users to sort the Re-generate Unbilled Amounts Report by Division.

2.6.4.2. Functional Requirement: Display - Re-generate Unbilled Amounts Report - Division

The IB System shall provide the ability for users to display the Re-generate Unbilled Amounts Report by Division.

2.6.4.3. Functional Requirement: Print - Re-generate Unbilled Amounts Report - Division

The IB System shall provide the ability for users to print the Re-generate Unbilled Amounts Report by Division.

2.6.4.4. Functional Requirement: Display new HIPAA Compliant Fields on IB Reports

The IB System shall retrieve the data for existing report fields on existing reports from the following new HIPAA length compliant fields:

- Sub-file 2.312
 - SUBSCRIBER ID – Maximum 80 A/N – 2.312, 7.02
 - NAME OF INSURED – Maximum 130 A/N – 2.312, 7.01
- Sub-file 2.3226
 - COMMUNICATION NUMBER – Maximum 245 A/N – 2.3226, 1
- Sub-file 355.3
 - GROUP NAME – Maximum 80 A/N – 355.3, 2.01
 - GROUP NUMBER – Maximum 55 A/N – 355, 2.02
- Sub-file 355.33
 - GROUP NAME – Maximum 80 A/N – 355.33, 90.01
 - GROUP NUMBER – Maximum 55 A/N – 355.33, 90.02
 - SUBSCRIBER ID – Maximum 80 A/N – 355.33, 90.03
 - NAME OF INSURED – Maximum 130 A/N – 355.33, 91.01
- Sub-file 365

- NAME OF INSURED – Maximum 130 A/N – 365, 13.01
 - SUBSCRIBER ID – Maximum 80 A/N – 365, 13.02
 - GROUP NAME – Maximum 80 A/N – 365, 14.01
 - GROUP NUMBER – Maximum 55 A/N – 365, 14.02
- Sub-file 365.03
 - COMMUNICATION NUMBER 1 – Maximum 245 A/N – 365.03, 1
 - COMMUNICATION NUMBER 2 – Maximum 245 A/N – 365.03, 2
 - COMMUNICATION NUMBER 3 – Maximum 245 A/N – 365.03, 3
- Sub-file 365.26
 - COMMUNICATION NUMBER – Maximum 245 A/N – 365.26, 1.01

2.6.5. System Feature: Third Party Joint Inquiry

2.6.5.1. Functional Requirement: TPJI Visual Indicator - Institutional

The IB System shall display a visual indicator for each institutional claim on a claim list identifying the claim as institutional, when users access one of the following list in TPJI:

- Inactive Bills
- Third Party Active Bills

Note: Maintain the current Inpatient/Outpatient indicator

2.6.5.2. Functional Requirement: TPJI Visual Indicator - Professional

The IB System shall display a visual indicator for each professional claim on a claim list identifying the claim as professional, when users access one of the following lists in TPJI:

- Inactive Bills
- Third Party Active Bills

Note: Maintain the current Inpatient/Outpatient indicator

2.6.5.3. Functional Requirement: Co-Payment Amount – TPJI

The IB System shall provide the ability for users to view the co-payment amount when one is associated with a claim in TPJI.

2.6.6. System Feature: COB Management Worklist

2.6.6.1. Functional Requirement: Sort – COB Management Worklist – Division

The IB System shall provide the ability for users to sort the COB Management Worklist by Division.

2.6.6.2. Functional Requirement: Display – COB Management Worklist – Division

The IB System shall provide the ability for users to display the COB Management Worklist by Division.

2.6.6.3. Functional Requirement: Print – COB Management Worklist – Division

The IB System shall provide the ability for users to print the COB Management Worklist by Division.

2.6.7. System Features: Health Care Claim Transactions (837)

2.6.7.1. Functional Requirement: Transmit HPID – Destination Payer - Institutional

The IB System shall provide the ability to transmit the Health Plan Identifier for the destination payer in an institutional X12N 5010 Health Care Claim (837) transaction to FSC.

2.6.7.2. Functional Requirement: Transmit HPID – Destination Payer - Professional

The IB System shall provide the ability to transmit the Health Plan Identifier for the destination payer in a professional X12N 5010 Health Care Claim (837) transaction to FSC.

2.6.7.3. Functional Requirement: Transmit HPID – Other Payer(s) - Institutional

The IB System shall provide the ability to transmit the Health Plan Identifier for the other payer(s) in an institutional X12N 5010 Health Care Claim (837) transaction to FSC.

2.6.7.4. Functional Requirement: Transmit HPID – Other Payer(s) - Professional

The IB System shall provide the ability to transmit the Health Plan Identifier for the other payer(s) in a professional X12N 5010 Health Care Claim (837) transaction to FSC.

2.6.7.5. Functional Requirement: Transmit Sole-Proprietorship NPI - Institutional

The IB System shall provide the ability to transmit the same NPI for an individual provider and a non-VA lab or Facility in an institutional X12N 5010 Health Care Claim (837) transaction to FSC.

2.6.7.6. Functional Requirement: Transmit Sole-Proprietorship NPI - Professional

The IB System shall provide the ability to transmit the same NPI for an individual provider and a non-VA lab or Facility in a professional X12N 5010 Health Care Claim (837) transaction to FSC.

2.6.7.7. Functional Requirement: Transmit TRICARE-specific Pay-to Provider – Institutional – TRICARE REIMB.

The IB System shall provide the ability to transmit the following TRICARE-specific Pay-to-Provider data in an institutional X12N 5010 Health Care Claim (837) transaction to FSC when the claim has a rate type of TRICARE REIMB.:

- NM101 – 87 - Required
- NM102 – Non-Person Entity - Required
- N301 – Pay-To Address Line - Required
- N302 – Pay-To Address Line - Situational
- N401 – Pay-To Address City – Required
- N402 – Pay-To Address State Code – Required in USA
- N403 – Pay-To Address Postal Zone or ZIP Code – Required in USA

2.6.7.8. Functional Requirement: Transmit TRICARE-specific Pay-to Provider – Institutional – TRICARE

The IB System shall provide the ability to transmit the following TRICARE-specific Pay-to-Provider data for an institutional X12N 5010 Health Care Claim (837) transaction to FSC when the claim has a rate type of TRICARE:

- NM101 – 87 - Required
- NM102 – Non-Person Entity - Required
- N301 – Pay-To Address Line - Required
- N302 – Pay-To Address Line - Situational
- N401 – Pay-To Address City – Required
- N402 – Pay-To Address State Code – Required in USA
- N403 – Pay-To Address Postal Zone or ZIP Code – Required in USA

2.6.7.9. Functional Requirement: Transmit TRICARE-specific Pay-to Provider – Professional – TRICARE REIMB.

The IB System shall provide the ability to transmit the following TRICARE-specific Pay-to-Provider data in a professional X12N 5010 Health Care Claim (837) transaction to FSC when the claim has a rate type of TRICARE REIMB.:

- NM101 – 87 - Required
- NM102 – Non-Person Entity - Required
- N301 – Pay-To Address Line - Required
- N302 – Pay-To Address Line - Situational
- N401 – Pay-To Address City – Required
- N402 – Pay-To Address State Code – Required in USA
- N403 – Pay-To Address Postal Zone or ZIP Code – Required in USA

2.6.7.10. Functional Requirement: Transmit TRICARE-specific Pay-to Provider – Professional – TRICARE

The IB System shall provide the ability to transmit the following TRICARE-specific Pay-to-Provider data in a professional X12N 5010 Health Care Claim (837) transaction to FSC when the claim has a rate type of TRICARE:

- NM101 – 87 - Required
- NM102 – Non-Person Entity - Required
- N301 – Pay-To Address Line - Required
- N302 – Pay-To Address Line - Situational
- N401 – Pay-To Address City – Required
- N402 – Pay-To Address State Code – Required in USA
- N403 – Pay-To Address Postal Zone or ZIP Code – Required in USA

2.6.7.11. Functional Requirement: Transmit NDC Code – non-RX - Institutional

The IB System shall provide the ability to transmit the following line level 5-4-2 format NDC in an institutional X12N 5010 Health Care Claim (837) transaction to FSC (Loop 2410):

- LIN02 – N4 – Required
- LIN03 – National Drug Code – Required

2.6.7.12. Functional Requirement: Transmit NDC Code – non-RX - Professional

The IB System shall provide the ability to transmit the following line level 5-4-2 format NDC in a professional X12N 5010 Health Care Claim (837) transaction to FSC (Loop 2410):

- LIN02 – N4 – Required
- LIN03 – National Drug Code – Required

2.6.7.13. Functional Requirement: Transmit NOC Procedures - Free Text Description - Institutional

The IB System shall provide the ability to transmit a line level 1-80 A/N procedure description in an institutional X12N 5010 Health Care Claim (837) transaction to FSC (Loop 2400):

- SV202-7 – Description - Situational

2.6.7.14. Functional Requirement: Transmit NOC Procedures – Free Text Description - Professional

The IB System shall provide the ability to transmit a line level 1-80 A/N procedure description in a professional X12N 5010 Health Care Claim (837) transaction to FSC (Loop 2400):

- SV101-7 – Description – Situational

2.6.7.15. Added 4/7/14 - Functional Requirement: Transmit NDC Code Units– non-RX - Institutional

The IB System shall provide the ability to transmit the following line level NDC unit count in an institutional X12N 5010 Health Care Claim (837) transaction to FSC (Loop 2410):

- CTP04 – National Drug Unit Count – Required
- CTP05 - 1 - Code Qualifier – UN (Units) – Required

2.6.7.16. Added 4/7/14 - Functional Requirement: Transmit NDC Code Units – non-RX - Professional

The IB System shall provide the ability to transmit the following line level NDC unit count in a professional X12N 5010 Health Care Claim (837) transaction to FSC (Loop 2410):

- CTP04 – National Drug Unit Count – Required
- CTP05 - 1 - Code Qualifier – UN (Units) – Required

2.6.7.17. Added 5/30/14 – Functional Requirement: Transmit Maximum 12 Procedures – Inpatient/Institutional

The IB System shall provide the ability to transmit a maximum of 12 procedure codes in an inpatient, institutional X12N 5010 Health Care Claim (837) transaction to FSC (Loop 2300 – HI01-2).

2.6.8. System Feature: Copy and Cancel a Bill (CLON)/Correct Rejected/Denied Bill (CRD)

2.6.8.1. Functional Requirement: CRD - Prevent Correction of Secondary Claim

The IB System shall prevent users from copying rejected/denied secondary claims using the Correct Rejected/Denied Bill option (CRD).

2.6.8.2. Functional Requirement: CRD - Prevent Correction of Tertiary Claim

The IB System shall prevent users from copying rejected/denied tertiary claims using the Correct Rejected/Denied Bill option (CRD).

2.6.8.3. Functional Requirement: CLON – Copy Secondary/Tertiary Claim Data to New Secondary/Tertiary Claim

The IB System shall provide the ability for users to copy data from an original secondary/tertiary claim, including COB data from the electronic EOB(s) to a new claim using the Copy and Cancel a Bill (CLON) option.

2.6.8.4. Functional Requirement: CRD – Copy Primary Claim Data to New Primary Claim

The IB System shall provide the ability for users to copy data from an original primary claim to a new claim using the Correct Rejected/Denied Bill (CRD) option.

2.6.8.5. Functional Requirement: CRD – Prevent Correction of Claim in MRA Request Status

The IB System shall prevent users from copying an MRA claim in an MRA Request status using the Correct Rejected/Denied Bill option (CRD).

2.6.9. System feature: Provider ID Maintenance

2.6.9.1. Functional Requirement: Sole-Proprietorship Designation - non-VA Facility

The IB System shall provide the ability for users to designate a non-VA Facility as a sole-proprietorship.

2.6.9.2. Functional Requirement: Link non-VA Facility to Sole-Proprietor

The IB System shall provide the ability for users to link a non-VA Facility that is a sole-proprietorship to an individual provider.

2.6.9.3. Functional Requirement: Sole-Proprietorship non-VA Facility – NPI

The IB System shall provide the ability for users to enter an NPI number for a non-VA Facility that is defined as a sole-proprietorship that has previously been entered for an individual provider.

2.6.9.4. *Deleted 5/30/14* - Functional Requirement: Individual Sole-Proprietor - NPI

The IB System shall provide the ability for users to enter the same NPI for an individual provider that has previously been entered for a non-VA facility designated as a sole-proprietorship.

2.6.10. System Feature: MCCR Site Parameter Display/Edit

2.6.10.1. Functional Requirement: Default TRICARE Pay-to Provider

The IB System shall provide the ability for users to define a default Pay-to Provider for TRICARE claims with the following data:

- Pay-to Provider from the Institution file
- Pay-to Provider Name – default from Institution file
- Pay-to Provider Address Line 1 – default from Institution file
- Pay-to Provider Address Line 2 – default from Institution file

- Pay-to Provider City – default from Institution file
- Pay-to Provider State – default from Institution file
- Pay-to Provider Zip Code – default from Institution file
- Pay-to Provider Phone Number:
- Pay-to Provider Federal Tax ID Number
- Default Flag

2.6.10.2. Functional Requirement: Default TRICARE Pay-to Provider Associations

The IB System shall automatically associate all divisions of the VAMC with the default TRICARE Pay-to Provider.

2.6.10.3. Functional Requirement: Additional TRICARE Pay-to Providers

The IB System shall provide the ability for users to define additional non-default Pay-to Providers for TRICARE claims with the following data:

- Pay-to Provider from the Institution file
- Pay-to Provider Name – default from Institution file
- Pay-to Provider Address Line 1 – default from Institution file
- Pay-to Provider Address Line 2 – default from Institution file
- Pay-to Provider City – default from Institution file
- Pay-to Provider State – default from Institution file
- Pay-to Provider Zip Code – default from Institution file
- Pay-to Provider Phone Number:
- Pay-to Provider Federal Tax ID Number
- Default Flag

2.6.10.4. Functional Requirement: Associate Division(s) with TRICARE Pay-to Provider

The IB System shall provide the ability for users to re-associate one or more divisions of the medical center with additional non-default Pay-to Providers for TRICARE claims.

2.6.10.5. Functional Requirement: Edit a TRICARE Pay-to Provider

The IB System shall provide the ability for users to edit a TRICARE Pay-to Provider.

2.6.10.6. Functional Requirement: Delete a TRICARE Pay-to Provider

The IB System shall provide the ability for users to delete a TRICARE Pay-to Provider.

2.6.10.7. Functional Requirement: Re-associate Divisions - Delete TRICARE Pay-to Provider

The IB System shall automatically re-associate all divisions associated with a deleted TRICARE Pay-to Provider with the default provider.

2.6.10.8. Functional Requirement: TRICARE Pay-to Provider Security Key

The IB System shall provide a Security Key to allow users to access the capability to define TRICARE Pay-to Provider(s).

2.6.10.9. *Added 4/7/14* - Functional Requirement: Pay-to Provider Security Key

The IB System shall provide a Security Key to allow users to access the capability to define Pay-to Provider(s).

2.6.11. System Feature: View Cancelled Claim

2.6.11.1. Functional Requirement: View Cancelled Claim

The IB System shall provide the ability for users to view the non-computed data stored in the Bill/Claim file (file 399) for a Cancelled claim.

2.6.12. System Feature: Miscellaneous Existing Requirements

The following requirements exist and either require correction, modification or deletion along with the existing functionality.

2.6.12.1. *Correct* - FEAT604 Functional Requirement: Transmit Property and Casualty Claim Number

The IB system shall transmit the following data with a Professional 837 claim transmission only when a Property/Casualty Claim Number is present on a claim (2010CA REF01, REF02):

- Y4 - Agency Claim Number Qualifier
- Property Casualty Claim Number

2.6.12.2. *Delete* – FEAT435 Functional Requirement: VAMC as Billing Provider

The VistA IB system shall provide the ability for authorized users to designate by insurance company and form type, that the Billing Provider will always be the main facility (VAMC) on claims to the payer.

2.6.12.3. *Change* – FEAT102 Functional Requirement: EDI Parameter Report

The Vista system shall provide the ability for users to view a report which includes the contents of the following fields in the Insurance Company file for all active entries:

- Insurance Company Name; and
- Insurance Company Address (Line 1, City and State); and
- Electronic Type; and
- Type of Coverage; and
- Electronic Transmit?; and
- Inst Electronic Bill ID; and
- Prof Electronic Bill ID; and
- Inst Use VAMC as Billing Provider - *Delete*
- Prof Use VAMC as Billing Provider – *Delete*
- HPID(s) - *Add*
- OEID(s) - *Add*

2.6.12.4. *Removed 4/7/14* - FEAT200 Functional Requirement: MRA Management Worklist - Sort Display

The VistA system shall provide the ability for a user to sort the MRW based on the following criteria:

- Biller
- Days Since Transmission of Latest Bill
- Date Last MRA Received
- Secondary Insurance Company
- MRA Status
- Patient Name
- Patient Responsibility
- Service Date

Note: The need to correct this existing requirement is no longer needed. The existing software is working correctly.

2.6.12.5. ~~Delete~~ – FEAT443 Functional Requirement: Schedule Mailman Message/Payer Settings for Billing Provider/Service Facility

The Vista system shall provide the ability for users to schedule the task to generate the mailman message that reports a site's settings in the Insurance Company Editor for the Billing Provider/Service Facility parameters.

2.6.12.6. ~~Delete~~ – FEAT444 Functional Requirement: Default Schedule Mailman Message/Payer Settings for Billing Provider/Service Facility

The Vista system shall automatically set the default frequency for the task to generate the mailman message that reports a site's settings in the Insurance Company Editor for the Billing Provider/Service Facility parameters, upon installation of the patch, to one time per month.

2.6.12.7. ~~Delete~~ – FEAT445 Functional Requirement: Mailman Message with Payer Settings/Billing Provider/Service Facility

The Vista IB system shall generate a mailman message that reports a site's settings in the Insurance Company Editor for the Billing Provider/Service Facility parameters, when at least one of the Always use main VAMC as Billing Provider parameters is set to 'Yes', which includes the following data:

- Insurance Company Name; and
- Insurance Company Address; and
- Date of Report; and
- Station ID; and
- Electronic Transmit; and
- Inst Electronic Bill ID; and
- Prof Electronic Bill ID; and
- Inst Use VAMC as Billing Provider; and
- Prof Use VAMC as Billing Provider.

2.6.12.8. ~~Delete~~ – FEAT446 Functional Requirement: Mailman Message with Payer Settings/Billing Provider/Service Facility

The Vista IB system shall generate an mailman message that reports a site's settings in the Insurance Company Editor for the Billing Provider/Service Facility parameters, when both of the Always use main VAMC as Billing Provider parameters is set to 'No', which includes the following data:

- Date of Report; and
- Station ID

2.6.12.9. *Delete* – FEAT573 Functional Requirement: Security Key for Copy_Cancel a Claim

The IB system shall provide the ability for authorized users to assign a security key to a user which will allow them to use the existing Clon – Copy/Cancel a Claim option [IB COPY AND CANCEL].

2.7. Multi-divisional Specifications

There are no multi-divisional specifications associated with this project other than the reports and Pay-to Provider which are specified in Section 2.6.

2.8. Performance Specifications

There are no performance requirements specific to this development effort.

2.9. Quality Attributes Specification

The code for these patches will conform to all VA M coding standards and name spacing conventions.

2.10. Reliability Specifications

There are no reliability requirements specific to this development effort. The IB modules are integrated parts of the overall VistA system that exists at each site and will be subject to the normal reliability standards.

2.11. Scope Integration

The IB modules are integrated parts of the overall VistA system that exists at each site. The IB module makes use of Fileman and Mailman. The IB module transmits flat file 837 Health Care Claim data to the VA Financial Service Center in Austin, TX via Mailman.

2.12. Security Specifications

There are no security requirements specific to this development effort. The IB module is an integrated part of the overall VistA system that exists at each site and will be subject to the normal security specifications for VistA.

The interface to FSC is an existing interface to which minor data content changes will be made as part of this effort.

2.13. System Features

The following features of the IB software will be affected by this project:

Integrated Billing

- Enter/Edit Billing Information
- Data Dictionary
- Insurance Company Enter/Edit
- IB Reports
- TPJI
- MRA Management Worklist

- COB Management Worklist
- X12N 5010 Health Care Claim (837)
- Correct Rejected/Denied Claim
- Copy and Cancel Bill
- View Cancelled Claim
- Provider ID Maintenance
- MCCR Site Parameter Display/EDI

2.14. Usability Specifications

The following usability specifications pertain to this development effort:

- Training: 1-2 hour training is required for both normal and super-users to become productive with the enhancements in these patches

There are no common usability standards for the M roll and scroll user interface.

3. Applicable Standards

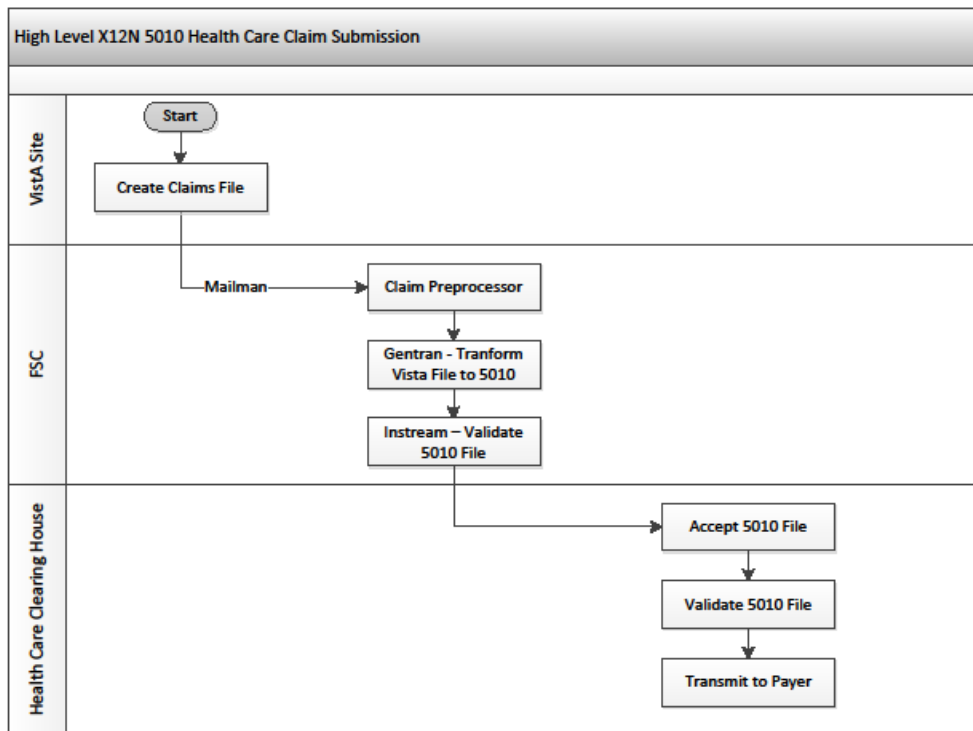
The following standards apply to these development efforts:

- 837 Health Care Claim: Professional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006
- 837 Health Care Claim: Institutional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006

4. Interfaces

The IB module transmits Mailman messages to and receives Mailman messages from the Financial Services Center (FSC) in Austin, TX.

4.1. Communications Interfaces



4.2. Software Interfaces

The IB module communicates with other VistA modules such as Accounts Receivable, Appointment Scheduling, Admission/Discharge/Transfer, Claims Tracking, and the Charge Master. These are existing interfaces.

The Claim Scrubber, a 3rd party piece of software developed by DSS, Inc. which uses the 837 message format to communicate between Enter/Edit Billing Information and the scrubber. DSS will need to make changes to correspond to the changes made to the 837 map as part of this project.

4.3. User Interfaces

Users of VistA use terminal emulation software to access VistA as if they were using a VT320/400/500 terminal. The VistA user interface is a two color, roll and scroll interface developed in M.

5. Legal, Copyright, and Other Notices

This project has been granted a waiver from compliance with the Section 508 Amendment to the Rehabilitation Act of 1973.

6. User Class Characteristics

The IB and AR software is designed to be used by Billing Supervisors, Billing Clerks, Accounts Receivable Supervisors and Accounts Receivable Clerks as well as Utilization Review and Insurance Verification personnel.

7. Approval Signatures

REVIEW DATE:

SCRIBE:

Signed:

Integrated Project Team (IPT) Chair

Date

Business Sponsor

Date

IT Program Manager

Date

Project Manager

Date