

# **EDI New Standards and Operating Rules VHA Provider-side**

## **eBilling Build 1**

### **Requirements Specification Document**

**Patch IB\*2\*488**

**Patch PRCA\*4.5\*300**

**VA**



**U.S. Department of Veterans Affairs**

Office of Information and Technology

*Product Development*

**Approved:**

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## Revision History

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11/21/13	1.0	Updated following Peer Review	REDACTED
11/29/13	2.0	Updated following discussion/input from CBO	REDACTED
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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\*488 and Accounts Receivable (AR) Patch PRCA\*4.5\*300.

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) Office and the end-users.

## 1.1 Scope

Patch IB\*2\*488 will include the following:

### Integrated Billing

#### Enter/Edit Billing Information

- Remove the ability to force a claim to be printed at the Health Care Clearing House (HCCH)
- Provide a Fatal Warning message to the user when EDI – Inst Payer Primary ID on an institutional claim equals:
  - HPRNT; or
  - SPRNT
- Provide a Fatal Warning message to the user when EDI – Prof Payer Primary ID on a professional claim equals:
  - SPRNT; or
  - HPRNT
- Provide the ability to prevent the authorization of a professional claim with no procedures
- Provide the ability to prevent the authorization of an outpatient, institutional claim with no procedures
- Provide the ability to display the Coordination of Benefits (COB) sequence with the patient's insurance plans when available

#### Provider ID Maintenance

- Provide the ability to enter only a 9 digit ZIP for a non-VA facility address
- Provide the ability to enter only a physical location in Address Line 1 for a non-VA facility

#### Insurance Company Editor

- Remove the ability to set the EDI - Inst Payer Primary ID equal to:
  - HPRNT
  - SPRNT
  - IPRNT
  - PPRNT
- Remove the ability to set the EDI – Prof Payer Primary ID equal to:
  - SPRNT
  - HPRNT

- IPRNT
- PPRNT
- Provide the functionality to set the value for EDI - Transmit?: to YES-LIVE when a new Insurance Company is created

#### MRA Management Worklist (MRW)

- Provide the ability to view Message Storage Errors for inbound Medicare-equivalent MRAs in the MRW

#### Transactions

- Provide the ability to transmit up to 12 diagnoses on a Professional 837 claim transaction
- Prevent the transmission of the following Property and Casualty data in the Service Facility loop of an institutional/professional 837 claim transaction:
  - Contact Name
  - Contact Telephone Number
  - Contact Telephone Number Extension
- Provide the ability to transmit a Service Line Charge Amt (INS, Piece 9) with a maximum length equal to 18 numeric in an institutional 837 claim transaction
- Provide the ability to transmit a Service Line Non-Covered Charge Amt (INS, Piece 12) with a maximum length equal to 18 numeric in an institutional 837 claim transaction
- Provide the ability to transmit institutional/professional claims with the Rate Type = Worker's Comp.
- Prevent the transmission of institutional/professional 837 claim transactions with an Assignment Code (CL1A, Piece 5) equal to 'C' or null by substituting the value 'A'
- Provide the ability to transmit institutional/professional claims with Line Item Charge Amounts equal to \$0.00

#### Third Party Joint Inquiry (TPJI)

- Display message storage error messages generated when VistA is unable to upload inbound X12n 5010 Health Care Claim Payment/Advice (835) messages in a manner an end-user can understand

#### CMS – 1500 Form

- Modify the print logic for the CMS – 1500 form to comply with the new National Uniform Claim Committee (NUCC) standards

Patch PRCA\*4.5\*300 will include the following:

#### **Accounts Receivable**

##### Data Dictionary

- Provide the ability to define a claim number as 6-10 characters

## 1.2 Acronyms and Definitions

### 1.2.1 Acronyms

Term	Definition
AITC	Austin Information Technology Center located in Austin, TX
AR	Accounts Receivable software version 4.5
COB	Coordination of Benefits
CBO	Chief Business Office
CSA	Claim Status Awaiting Resolution
CMS	Center for Medicare and Medicaid Services
DMI	Data Management Interface
EDI	Electronic Data Interchange
EIN	Employer's Identification Number
EOB	Explanation of Benefits
FSC	Financial Services Center – Austin, Texas
HIPAA	Health Insurance Portability and Accountability Act of 1996
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
PS	Product Services
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

### 1.2.2 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

Term	Definition
	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
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.

### 1.3 References

Name	Location	Date
ASC X12N/005010X221 Health Care Claim Payment/Advice (835) – Technical Report Type 3	REDACTED	May 2006
ASC X12N/005010X222 Health Care Claim - Professional (837) – Technical Report Type 3	REDACTED	May 2006
ASC X12N/005010X223 Health Care Claim - Institutional (837) – Technical	REDACTED	May 2006



Report Type 3		
National Uniform Claim Committee – 1500 Claim Form Reference Manual Version 9.0	REDACTED	July 2013
Patch IB*2*447 ICD (5010)	REDACTED	June 2010

## 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 of 1973.

### 2.2 Business Rules Specification

The changes to the CMS 1500 Claim Form are based on the National Uniform Claim Committee's specification, *1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12*. The changes to the CMS 1500 Claim Form are mandated to be in use by April 1, 2014.

### 2.3 Design Constraints Specification

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

### 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:

- A Current Workflow Analysis Document
- A Future Workflow Analysis Document
- A Requirements Specification Document (RSD)
- A Requirements Traceability Matrix (RTM)
- A Software Design Document (SDD)
- An updated Interface Control Document (ICD)
- An Entity Relationship Diagrams (ERD)
- A Release Notes/Installation Guide
- A Technical/Security Manual
- An Updated EDI User Guide

### 2.6 Functional Specifications

## **2.6.1 System Feature: Enter/Edit Billing Information**

### **2.6.1.1 Functional Requirement: Remove Force Print at HCCH - Institutional**

The IB System shall no longer provide the ability for users to add the value equal to Force Clearing House Print to an institutional electronic claim that forces the claim to be printed at the HCCH.

### **2.6.1.2 Functional Requirement: Remove Force Print at HCCH - Professional**

The IB System shall no longer provide the ability for users to add the value equal to Force Clearing House Print to an professional electronic claim that forces the claim to be printed at the HCCH.

### **2.6.1.3 Functional Requirement: Fatal Error for PRNT Values - Institutional**

The IB System shall prevent users from Authorizing an Institutional claim with a Primary Payer ID equal to one of the following:

- HPRNT
- SPRNT
- IPRNT
- PPRNT

### **2.6.1.4 Functional Requirement: Fatal Error for PRNT Values - Professional**

The IB System shall prevent users from Authorizing a professional claim with a Primary Payer ID equal to one of the following:

- SPRNT
- HPRNT
- IPRNT
- PPRNT

### **2.6.1.5 Functional Requirement: Fatal Error for No Procedures – Professional**

The IB System shall prevent users from Authorizing a professional claim that contains no Procedure Codes.

### **2.6.1.6 Functional Requirement: Fatal Error for No Procedures – Institutional**

The IB System shall prevent users from Authorizing an outpatient, institutional claim that contains no Procedure Codes.

### **2.6.1.7 Functional Requirement: Display Payer Sequence – Partial Entry**

The IB System shall display the payer sequence on Billing Screen 3 in the picklist of available payers that is displayed when users enter an ambiguous partial entry at one of the following prompts on Billing Screen 3:

- Primary Insurance Policy
- Secondary Insurance Policy
- Tertiary Insurance Policy

### **2.6.1.8 Functional Requirement: Remove Line Level EPSDT Indicator - Professional**

The IB System shall no longer provide the ability for users to add a line level Early and Periodic Screening, Diagnostic and Treatment (EPSDT) indicator to a professional claim.

#### **2.6.1.9 Functional Requirement: Remove Line Level Attending Physician is not a Hospice Employee - Professional**

The IB System shall no longer provide the ability for users to add the line level text, Attending Physician is not a Hospice Employee to a professional claim.

### **2.6.2 System Feature: Data Dictionary**

#### **2.6.2.1 Functional Requirement: Bill Number Length – Accounts Receivable**

The IB System shall provide the ability for the Bill No. field (.01 field) of the Accounts Receivable file (file 430) to store a 6-10 character claim number plus a 3 character station number and a hyphen.

### **2.6.3 System Feature: Provider Maintenance**

#### **2.6.3.1 Functional Requirement: Outside Facility ZIP Code**

The IB System shall provide the ability for users to enter ONLY a 9 - 10 character value for the ZIP Code in Non-VA Facility→Lab/Facility Info→Zip Code (999999999/99999-9999).

#### **2.6.3.2 Functional Requirement: Outside Facility Address Line 1**

The IB System shall provide the ability for users to enter ONLY a physical street address value (no Post Office Box) for the first line of the street address in Non-VA Facility→Lab/Facility Info→Street Address.

### **2.6.4 System Feature: Insurance Company Entry/Edit**

#### **2.6.4.1 Functional Requirement: Payer Primary ID - Institutional**

The IB System shall prevent users from defining the Inst Payer Primary ID as one of the following:

- HPRNT
- SPRNT
- IPRNT
- PPRNT

#### **2.6.4.2 Functional Requirement: Payer Primary ID - Professional**

The IB System shall prevent users from defining the Prof Payer Primary ID as one of the following:

- SPRNT
- HPRNT
- IPRNT
- PPRNT

#### **2.6.4.3 Functional Requirement: Value for EDI – Transmit? – New Ins. Co.**

The IB System shall set the value for the Transmit Electronically field (File 36, field 3.01) equal to YES – LIVE when users create a new Insurance Company in File 36.

## **2.6.5 System Feature: MRA Management Worklist (MRW)**

### **2.6.5.1 Functional Requirement: Display Message Storage Errors in MRW**

The IB System shall display Medicare-equivalent Remittance Advice (MRA) message storage errors for Medicare claims in the MRA Management Worklist in a human readable format.

## **2.6.6 System Feature: Third Party Joint Inquiry (TPJI)**

### **2.6.6.1 Functional Requirement: Display Message Storage Errors in TPJI**

The IB System shall display X12N 5010 Health Care Claim Payment/Advice (835) message storage errors for non-Medicare and Medicare claims in TPJI in a human readable format.

## **2.6.7 System feature: CMS – 1500 Printed Claim Form**

### **2.6.7.1 Functional Requirement: Obsolete CMS – 1500 Data Elements**

The IB System shall no longer print the following information on a locally printed CMS – 1500 claim form:

- Box 8
  - Patient Marital Status
  - Patient Employment
  - Patient Student Status
- Box 9
  - 9b – Other Insured's DOB
  - 9b – Other Insured's Gender
  - 9c – Employer's Name
  - 9c – School Name
- Box 11
  - 11b – Employer's Name
  - 11b – School Name
- Box 19
  - EPSDT Flag
  - Attending Not Hospice Employee
  - Homebound Indicator
  - Special Program Indicator
  - Date Last Seen
- Box 30 – Balance Due

### **2.6.7.2 Functional Requirement – New/Changed CMS – 1500 Data Elements**

The IB System shall print the following data on a locally printed CMS – 1500 claim form when available on a professional claim:

- Box 10
  - 10d – NUCC designated Claim Condition Codes
- Box 11
  - 11b – Other Claim ID = Qualifier Y4 and Property and Casualty Number

- Box 14 – Date Qualifier
  - 484 Last Menstrual Period (LMP), or
  - 431 Onset of Current Symptoms or Illness if no date for LMP
- Box 15 – Date Qualifier
  - 439 Accident (Occurrence Codes)
  - 455 Last X-ray (Chiropractic Claim)
  - 453 Acute Manifestation of Chronic Condition (Chiropractic Claims)
  - 471 Prescription (RX Claims)
  - Initial Treatment (Occurrence Code – PT/OT/Speech/Home IV/Cardiac Rehab)
  - Latest Visit or Consultation
- Box 17 – Provider Qualifier
  - DN – Referring Provider
  - DQ – Supervising Provider
- Box 19 – Rate Type = Worker's Comp.:
  - PWK
  - Report Type Code
  - Transmission Type Code
  - Attachment Control Number
- Box 19 – Rate Type not equal to Worker's Comp.
  - Free Text – Maximum 71 characters
- Box 21
  - 21A-L – Up to 12 Diagnoses Codes
- Box 24E
  - Diagnoses Pointers will be A-L values

## **2.6.8 System Feature: Health Care Claim Transactions (837)**

### **2.6.8.1 Functional Requirement: 12 Diagnoses (DXs) – Professional Claim**

The IB System shall provide the ability to transmit 1-12 diagnostic codes (DC1 – DC12) on a professional X12N 5010 Health Care Claim (837) transaction to FSC.

### **2.6.8.2 Functional Requirement: Service Line Charge Amount**

The IB System shall provide the ability to transmit a Service Line Charge Amt (INS, Piece 9) with a maximum length equal to 18 numeric in an institutional X12N 5010 Health Care Claim (837) transaction to FSC.

### **2.6.8.3 Functional Requirement: Service Line Non-Covered Charge Amount**

The IB System shall provide the ability to transmit a Service Line Non-Covered Charge Amt (INS, Piece 12) with a maximum length equal to 18 numeric in an institutional X12N 5010 Health Care Claim (837) transaction to FSC.

### **2.6.8.4 Functional Requirement: Transmit Workman's Compensation Claims - Institutional**

The IB System shall provide the ability to transmit an institutional claim with a Rate Type equal to Worker's Comp. to FSC in an X12N 5010 Health Care Claim (837) transaction.

#### **2.6.8.5 Functional Requirement: Transmit Workman's Compensation Claims - Professional**

The IB System shall provide the ability to transmit a professional claim with a Rate Type equal to Worker's Comp. to FSC in an X12N 5010 Health Care Claim (837) transaction.

#### **2.6.8.6 Functional Requirement: Assignment Code - Institutional**

The IB System shall transmit an Assignment Code with the value of A in all institutional X12N 5010 Health Care Claim (837) transactions to FSC.

#### **2.6.8.7 Functional Requirement: Assignment Code - Professional**

The IB System shall transmit an Assignment Code with the value of A in all professional X12N 5010 Health Care Claim (837) transactions to FSC.

#### **2.6.8.8 Functional Requirement: Diagnoses Pointers – Professional**

The IB System shall provide the ability to transmit 2 A/N diagnoses pointers with diagnoses on a professional claim to FSC in an X12N 5010 Health Care Claim (837) transaction.

#### **2.6.9 System Feature: Miscellaneous Existing Requirements**

The following requirements either exist and require correction or exist and will be deleted along with the existing functionality.

##### **2.6.9.1 *Correct* - FEAT765 Functional Requirement: Transmit Revenue/Procedure Codes With Zero Charge Amount**

The IB System shall transmit Revenue/Procedure codes which generate zero charge amounts in 837 Health Care Claim Transmissions (PRF, Piece 5 and INS, Piece 9).

##### **2.6.9.2 *Delete* - FEAT602 Functional Requirement: Transmit Service Facility Contact Data**

The IB system shall transmit the following data with a Professional 837 claim transmission when an Service Facility Communication Number is present on a claim (2310C PER01, PER03):

- Contact Function Code: IC Information Contact
- Communication Number Qualifier: TE Telephone
- Communication Number: Telephone
- Communication Number Qualifier: EX Telephone Extension
- Communication Number: Extension Number

**\*\*\*NOTE\*\*\*** *We will continue to transmit the Property and Casualty data entered on Billing Screen 8. The above fields will be relabeled as Property and Casualty data but will not be transmitted in the Service Facility loop.*

## **2.7 Multi-divisional Specifications**

There are no multi-divisional specifications associated with this project.

## **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 and AR software will be affected by this project:

### **Integrated Billing**

- Enter/Edit Billing Information
- Data Dictionary
- Provider Maintenance
- Insurance Company Enter/Edit
- MRA Management Worklist
- TPJI
- CMS – 1500 Claim Form
- X12N 5010 Health Care Claim (837)

### **Accounts Receivable**

- Data Dictionary

## **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:

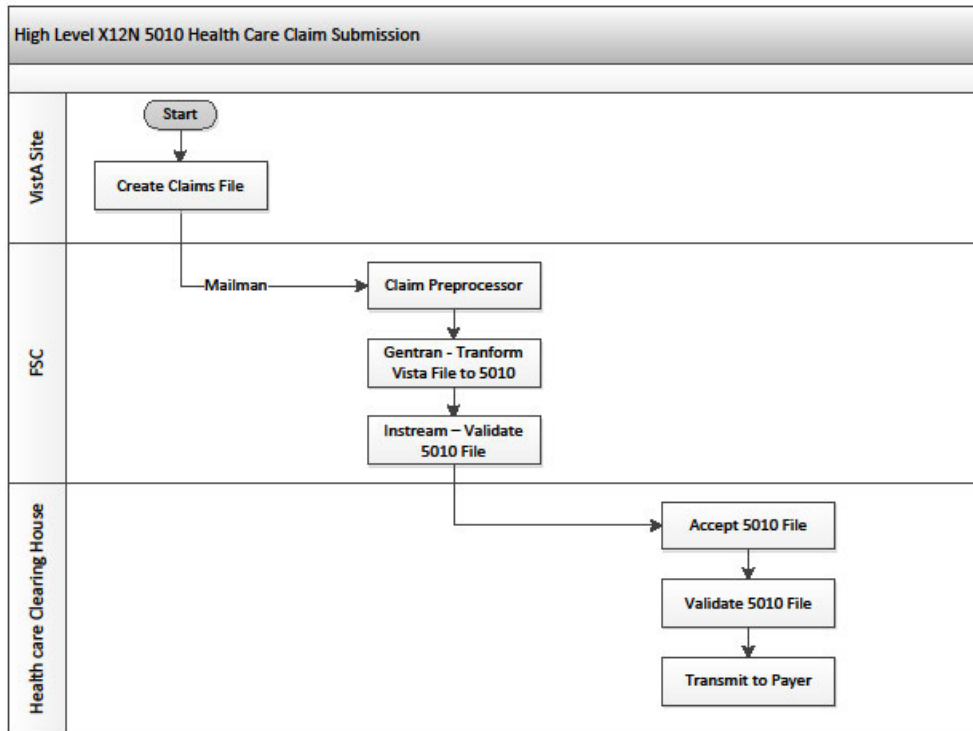
- 837 Health Care Claim: Professional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006
- 837 Health Care Claim: Institutional ASC X12 Standards for Electronic Data Exchange Technical Report Type 3 – May 2006
- NUCC, 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12.



## 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, Charge Master. These are existing interfaces.

The AR module communicates with other VistA modules such as IB and IFCAP as well as external systems such as the Financial Management System (FMS).

The Claim Scrubber, a 3<sup>rd</sup> 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:



RE DELIVERABLE  
Provider Operating R

Signed: REDACTED 1/9/2014 \_\_\_\_\_  
Integrated Project Team (IPT) Chair Date



FW DELIVERABLE  
Provider Operating R

\_\_\_\_\_ REDACTED 1/9/2014 \_\_\_\_\_  
Business Sponsor Date



RE DELIVERABLE  
Provider Operating R

Signed: REDACTED 1/9/2014 \_\_\_\_\_  
IT Program Manager Date



RE DELIVERABLE  
Provider Operating R

Signed: REDACTED 1/9/2014 \_\_\_\_\_  
Project Manager Date