

Non VA Care Enhancements Phase III

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Business Requirements Document



January 2015

Revision History

Note: The revision history cycle begins once changes or enhancements are requested after the Business Requirements Document has been accepted.

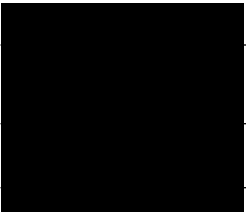
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1. Purpose

The Business Requirements Document (BRD) is authored by the business community for the purpose of capturing and describing the business needs of the customer/business owner. The BRD provides insight into the AS-IS and TO-BE business areas, identifying stakeholders and profiling primary and secondary user communities. It identifies what capabilities the stakeholders and the target users need and why these needs exist, providing a focused overview of the request requirements, constraints, and other considerations identified. This document is a business case and does not mandate a development methodology, however the requirements are written using agile methodology terminology. The intended audience for this document is the Office of Information and Technology (OI&T) to facilitate project planning when the project is approved and funded. These requirements are not documented at a level sufficient for development.

This BRD is written at a level of detail and abstraction that directly conveys the business goals, needs, and expectations from the perspective of the end users and key business stakeholders, without consideration to specific design and solution details. All requirements in this document shall be elaborated upon in order for system architects to design a solution, for developers to write and test software code, and for other technical team members to perform system integration and testing. The collection of documents that will house the set of all elaborated requirements for this project is depicted in the figure below. Note that all requirements—at all levels of detail—must be present in the project Requirements Traceability Matrix (RTM).

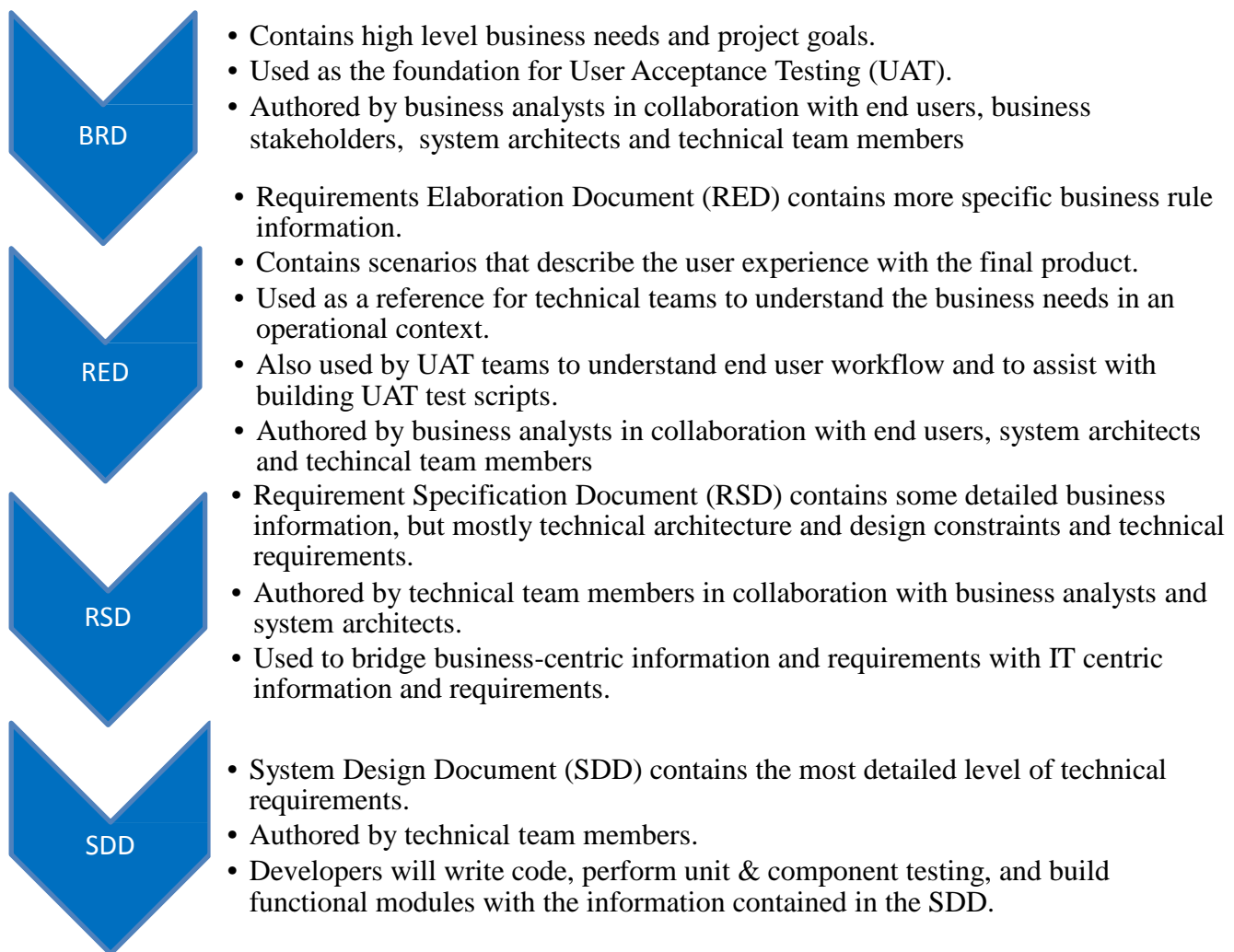


Figure 1 – Anticipated Requirement Document Hierarchy

2. Overview

As part of the Non VA Medical Care program, the Department of Veterans Affairs manually adjudicates approximately 20 to 30 million claims per year for Purchased Care services provided by Non-VA providers in the community. The Veterans Access, Choice and Accountability Act of 2014, has increased the funds available from \$5B (annually) to approximately \$12B for Veterans to receive healthcare from Non-VA providers. This increase in program funding will dramatically increase the number of claims the VA must process and pay for Non-VA care. The Automatic Adjudication functionality requested allows us to increase efficiency in claims processing thus reducing backlog and an increasing claims volume.

In the current system, processing Purchased Care claims requires a claims examiner to manually review and approve each claim. In contrast, organizations in the private sector use claims

processing software to automatically adjudicate 60% to 80% of claims. “Automatic adjudication” is the use of computer software to examine claims and determine if they meet pre-determined standards for acceptance, or rejection. A “claim” may have more than one line item. The use of “claim” includes the review and auto adjudication of each line item found on a claim form.

The Fee Basis Claims System TM (FBCS) is designed to improve Fee Basis claims management and adjudication. It brings efficiencies to the processing of claims as well as provides a knowledge base of information needed to strategically guide the decisions made about Non-VA care. Currently, FBCS has thirty-four operating instances throughout the enterprise and over eight thousand FBCS clients installed. On average, FBCS receives and processes 173,920 paper claims and 129,711 EDI claims weekly. The Chief Business Office (CBO), the business stakeholder for Non VA Care, is requesting/sponsoring new system enhancements to FBCS. The target audience for these enhancements includes the CBO, VHA health care facilities, and centralized processing sites such as the Health Administration Center (HAC) and end-users that manually process/ adjudicate Non VA Care claims. HAC is imperative to FBCS claims adjudication because EDI claim information is passed between the systems, which are critical to claims adjudication. (See Process Diagram) Implementation of these enhancements introduce business rules to support auto adjudication (approval and/or denial/rejection) will improve the streamlined claims process and increase automation. A “business rule” is defined as “a rule that defines or constrains some aspect of business and always resolves to either true or false.” The “business rules” are a series of “if then” statements that establish the criteria under which claims can be approved and paid without review by a claims adjudicator. These rules make use of data elements in claim, authorization and member (Veteran) files to evaluate claims and adjudicate them affirmatively or negatively for payment.

3. Scope

The scopes of the enhancements are limited to modification of FBCS to incorporate automated business rules for adjudication.

- Automated business rules for auto-adjudication of claims

4. Customer and Primary Stakeholders

██████████ Director, Non-VA Care Way Forward, representing Chief Business Office (CBO) Purchased Care, is the primary stakeholder for this request.

Review [Appendix C](#) for the complete list of primary and secondary stakeholders.

5. Goals/Objectives and Outcome Measures

Goal/Objective and Desired Outcome	Impact/Benefit	Measurement
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Goal/Objective and Desired Outcome	Impact/Benefit	Measurement
<ul style="list-style-type: none"> Goal 1: Support increase in claims volume, reduce manual burden, and increase compliance/accuracy in claims processing through business rule-driven auto-adjudication of claims. 	<ul style="list-style-type: none"> Benefit 1: Automation of the manual functions/decision points by users. Impact: reduces user interactions that could cause errors in processing Benefit 2: Improved efficiency with measurable increase in claims processing productivity across the enterprise. Impact: Creates standardized business rules, reducing variance across enterprise. Benefit 3: Improved efficiency to retrieve data for claim verification and reporting. Impact: Creates standardized data management reducing variance across the enterprise. 	<p>Measurement 1: Percentage of Non-VA FBCS claims automatically adjudicated (includes both approved and denied/rejected claims).</p> <ul style="list-style-type: none"> 50% will be automatically adjudicated (denied/rejected or approved for payment) <p>Measurement 2: Percentage of auto-adjudicated claims (includes both approved and denied/rejected claims) processed within 30 days.</p> <ul style="list-style-type: none"> 50% will be automatically adjudicated (denied or approved for payment)

6. Enterprise Need/Justification

Public Law (P.L.) 113-146, the Veterans Access, Choice and Accountability Act of 2014, which was enacted on August 7, 2014, improves the access of eligible Veterans to health care through non-VA entities and providers. The Veterans Access, Choice and Accountability Act of 2014, has increased the funds available from \$5B (annually) to approximately \$12B for Veterans to receive healthcare from Non-VA providers. This increase in program funding will dramatically increase the number of claims the VA must process and pay for Non-VA care.

7. Business Requirements

7.1. Themes, Epics (Needs), and User Narratives (Business Requirements)

Themes, epics, user narratives, user stories, and acceptance criteria will be captured in the Requirements Traceability Matrix (RTM). The requirements table below provides a list of the epics that are detailed in the RTM for the FBCS project. The RTM will be stored as a separate document and will be released with the Requirements Elaboration Document (RED).

Prioritization follows the industry standard MoSCoW scheme.

- **Must Have** – If this feature is not available in the 1st delivered iteration of the product, then the Business will not accept delivery of the product since the need for the specified feature is so high.
- **Should Have** – The business would very much like to have the specified feature in the 1st delivered iteration of the product, but is willing to wait until the 2nd iteration if staff, money, or time constraints on the project force that decision.
- **Could Have** – A feature prioritized at this level is of value to the Business, but it is not the greatest need and the Business is willing to wait for a future delivered iteration of the product to receive this feature. These features are more important to the Business than "Would Like to Have" features (see below).
- **Would Like to Have** – Features prioritized at this level are desired by the Business, but are of sufficiently small need that they may be delivered at any time prior to project completion.

FBCS Auto-Adjudication Requirements Table

Identifier	Epic	Priority
Theme001	Automate Claims Adjudication	N/A
Epic001	As a claim adjudicator, I need the ability to automate claims adjudication for PC3 claims based on configurable business rules.	M
Epic002	As a claim adjudicator, I need the ability to automate claims adjudication for Veterans Choice claims based on configurable business rules.	M
Epic003	As a claim adjudicator, I need the ability to automate claims adjudication for Title 38 United States Code (U.S.C) 1725 claims based on configurable business rules.	C
Epic004	As a claim adjudicator, I need the ability to automate claims adjudication for Title 38 United States Code (U.S.C) 1728 claims based on configurable business rules.	C
Epic005	As a claim adjudicator, I need the ability to automate claims adjudication for other claims for services authorized under Title 38 United States Code (U.S.C.) 1703 claims based on configurable business rules.	S
Theme002	Determine Automated Invocation of Scrubber, Pricer and the Program Integrity Tools (PIT)	N/A
Epic006	As claim adjudicator, I need the ability to automate claim scrubber processing determination based upon payment authority and claim type.	M

Identifier	Epic	Priority
Epic007	As claim adjudicator, I need the ability to automate pricer processing determination claims based upon payment authority and claim type.	M
Epic008	As claim adjudicator, I need the ability to automate PIT processing determination claims based upon payment authority and claim type.	S
Theme003	Perform Post Adjudication Processing	N/A
Epic009	As claim adjudicator, I need the ability to perform post adjudication processing when a claim is approved.	M
Epic010	As claim adjudicator, I need the ability to perform post adjudication processing when a claim is denied.	M
Epic011	As claim adjudicator, I need the ability to perform post adjudication processing when a claim requires manual review.	M
Theme004	Maintain Auto-Adjudication Business Rules	N/A
Epic012	As a business rule administrator, I need the ability to input adjudication business rules into the system, via the Administration module, without the need for a patch release.	M
Epic013	As a business rule administrator, I need the ability to manage access through configurable user role permissions.	M
Theme005	Maintain Audit Controls	N/A
Epic014	As a claim adjudicator, I need the ability to maintain processing controls to support audit operating procedures.	W
Theme006	Produce Auto-Adjudication Reports	N/A
Epic015	As a claim administrator, I need the ability to produce audit reports to show the state of adjudication results of all transactions entering auto-adjudication.	W
Theme007	User Training	
Epic016	As a claims administrator, I need the ability to provide training to existing and new users on a continuous basis.	M

7.2. User Access Levels

User Level	Role	Responsibilities	FBCS Access Level
Primary	Field Processing Staff (Claims Clerks, Voucher Examiners, Program Assistants, etc.)	Interact daily with system in order to process submitted claims for payment.	FBCS Authorization and Processing Modules Full Control

User Level	Role	Responsibilities	FBCS Access Level
Primary	Field Program Managers	Oversee day-to-day operations of front line processing staff.	FBCS Administrative Modules; Authorizations & Processing Modules Full Control
Secondary	Business Rule Administrators	Manage auto adjudication business rules, configure user access to scrubber edits, and produce auto adjudication reports within FBCS instance administrative consoles.	FBCS Administrative Modules
Secondary	Field Fiscal Officers	Oversee financial health of VA Medical Center operations and compliance with fiscal policies	Read Only
Secondary	Field Compliance Officers	Monitor program operations to ensure adherence and proper execution of governing regulations and directives.	Read Only
Secondary	Field Business Implementation Managers	Provide network-level oversight of medical center Business Operations.	Read Only
Secondary	Purchased Care Program and Integrity (POI)	Gather and monitor payment data for improper payments, expenditure trend analysis. Assist in recoupment and collection of improper payments.	Read Only

7.3. Known Interfaces and Data Sources

This is the business community's best understanding of known interfaces and may not be a comprehensive listing.

Name of Application	Description of current application	Interface Type	Existing Functionality	Expected Outcome
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Name of Application	Description of current application	Interface Type	Existing Functionality	Expected Outcome
VistA	FBCS pulls the authorization data from VistA and transmits claim and payment information back into VistA This functionality is required to accept information pertinent to claims adjudication in the fee basis package.	Inbound/Outbound	Yes	No changes to the VistA system or interface are expected.
Program Integrity Tool (PIT)	A fraud, waste and abuse management system used to assess the accuracy of payments, potential fraudulent billing by community providers and other concerns that result in significant improper payments from Purchased Care Programs. This functionality is required to accept data from the FBCS system and return proper scoring.	Outbound/Inbound	Yes	No changes to the PIT system or interface are expected.
Fee Payment Processing System (FPPS) / VA Central Server	This functionality is required to accept EDI (Electronic Data Interchange) claims and populate the necessary data for claims adjudication.	Outbound/Inbound	Yes	Outbound/Inbound: Conduit for X12/ EDI processing and messaging

Name of Application	Description of current application	Interface Type	Existing Functionality	Expected Outcome
Health Claims Processing System (HCPS)	This functionality includes integration between HCPS and FBCS. With Patch 46, integration between HCPS – Eligibility & Enrollment (EE) and FBCS represents Phase One of the integration effort.	Outbound/Inbound	Patch 46 anticipated national release date is 04-16-2015	Outbound: FBCS sends Veteran information to HCP (EE) Inbound: FBCS receives EE information for the Veteran
Alpha II Claims Scrubber	This functionality allows for claims to be reviewed for potential errors is billing and alerts the user of issues that could result in non-payment of claim line items.	Outbound/Inbound	Yes	Outbound-claims information is sent to Alpha II Inbound: FBCS receives claims edits to consider for payment * <i>No impacts expected to the interface.</i>
Alpha II Claims Pricer	This functionality prices claim line items based on (centers of Medicaid and Medicare) CMS guidelines	Outbound/Inbound	Yes	Outbound- Claim billed charges out to pricer Inbound- FBCS receives pricing information * <i>No impacts expected to the interface.</i>

Name of Application	Description of current application	Interface Type	Existing Functionality	Expected Outcome
Corporate Data Warehouse (CDW)	The VHA Corporate Data Warehouse is a collection of data inputs that primarily come from VistA. VHA OI&T created an extract of some FBCS reporting data and placed it in a dimension in the VHA CDW so that anyone with the proper credentials could utilize the data. The FBCS reporting data is primarily focused on claims processing timeliness	Outbound	Yes	Outbound- FBCs claims payment information <i>* No impacts expected to the interface.</i>

7.4. Related Projects or Work Efforts

Health Claims Processing System (HCPS):

HCPS EE and FBCS are being integrated as part of FBCS Patch 46 (IOC scheduled for April 2015). Once integrated, selected FBCS EE related data elements may be available and used to support future auto adjudication business rules.

Accelerating Care Initiative: The objective of the Accelerating Care Initiative is to identify Veterans who are currently experiencing long wait times for receipt of their VA health care and to implement very near-term tactics to accelerate these Veterans' access to health care, whether through VA, or through community (e.g. Non-VA) providers.

h [REDACTED]

Veterans Access, Choice and Accountability Act (The Choice Program): In order to improve VA's ability to deliver high-quality health care to Veterans, VACAA was implemented and requires VA to expand the options for eligible Veterans to elect to use non-VA health care for a period of up to three years, based either on the distance a Veteran lives from a VA facility, or if he or she is experiencing wait-times beyond the 30-day standard. Veterans who meet certain eligibility requirements will be able to elect to receive care from eligible non-VA entities and providers through the Program. VA must enter into agreements with eligible non-VA health care entities and providers for them to participate in the Program. Prior to VACAA being passed, VA had mechanisms in place to purchase non-VA care, which are still available to VA. VACAA will enhance VA's non-VA care options.

FBCS Optimization Enterprise Deployment: To optimize and standardize FBCS claims processing across the enterprise for processes related to mailroom/scanning, verification, distribution and processing, clinical review, and call center.

8. Service Level Requirements

8.1. Availability- The requirements are to date as we do not anticipate any changes to hardware to accommodate the requested enhancements of this project

Service Level Requirement (SLR) Question	SLR Criteria	Description
1. How much time should the system be available (and how much down time is acceptable due to incident [unexpected] outage)?	Current system requirement is available 99% (3.65 days down time). This enhancement should not impact current system availability.	
2. When should the system be available (what will be the core operating hours of the system)?	The system is available 7 days a week. The core operating hours are 7:00am—5:00pm standard weekdays for all times zones. There is a potential for adding additional personnel that would work evening shifts (5:00pm-12:00am). This enhancement should not impact current system availability.	
3. How soon should the system fully recover from an outage? (Includes Mean Time to Restore)	2-8 hours	
4. How much data will be restored when outage is recovered?	100% continuous backup	Please note: This will need to be negotiated between CBO and OIT

Service Level Requirement (SLR) Question	SLR Criteria	Description
5. What time period should be considered for maintenance periods?	Afterhours 5pm-10pm and/or Overnight 10pm-6am. Weekends can also be considered for maintenance periods. PIT transfer times are after hours and they should not be impacted.	
6. What standard time zone will the system operate in?	All time zones	

8.2.Capacity & Performance

SLR Question	SLR Criteria	Description
1. How many users will be on the system hourly?	There are 34 instances of FBCS across the enterprise. There is a range of 100-1000 users hourly on the system.	
2. How many transactions will each average user perform each hour?	>10 Transactions are defined as claims that are adjudicated by the user	
3. What are the anticipated peak user times during the day?	Business day- 7:00a-5:00pm	
4. What is the anticipated peak transaction load (when do you think that there will be the most transactions being performed on the system) during the day?	Business Day 7:00am-5:00pm Evenings 5:00pm-12:00am- CBOPC is in the process of adding an additional shift for claims processing to meet the payment timeliness needs of the program.	

SLR Question	SLR Criteria	Description
5. How many new users will be added in one year?	There are no expected new users for these enhancements	
6. How many more (if any) transactions will be added in one year?	Transactions are defined as claims that are adjudicated by a user >10 per hour at each FBCS instance	
7. What kind of information will be stored (specify average of each kind per month)?	Claims data Information from HCFA and UBs (submitted paper or ED) and veteran patient information will be stored. On average, FBCS receives and processes 173,920 paper claims and 129,711 EDI claims weekly	
8. What kind of search capacity is required?	Heavy (greater than 1,000 per hour)	
9. What type of system(s) is/are required?	Local (regional) Currently there are 34 instances/servers and over 8,000 clients with FBCS files installed located throughout the enterprise.	
10. Is there a need for heavy application reporting? If yes, when?	Yes, needed throughout the day, but primarily at the end of the daily shift.	

8.3.Interfaces and Security

SLR Question	SLR Criteria	Description
1. Does this system interact with other existing systems?	Yes, see section 7.3	

SLR Question	SLR Criteria	Description
2. Will this system require additional monitoring for Information Technology system metrics?	No	
3. Will this system contain personally identifiable information, Protected Health Information, Health Insurance Portability and Accountability Act (HIPAA) information, or other confidential/regulated data?	Yes- FBCS is an existing system and contains all of the information described in SLR Question 3	
4. Who will be the anticipated users of this system?	Authorized VHA employees and contract staff.	

9. Other Considerations

9.1. Alternatives

The alternative to implementing this decision is to maintain the current system functionality, which largely depends on user knowledge and decisions with no automation.

9.2. Assumptions

- Necessary data from previously adjudicated claims exists, is available, and is in a format that is usable to determine the criteria by which claims may be auto-adjudicated.
- This project will have sufficient priority that it will not be delayed due to competing resources.
- Sufficient training will be available to train Business Rules Administrators.
- Users will be provided with manuals and web based trainings to ensure proper understanding and use of the new functionality
- The auto-adjudication requirements will be applied to the claims associated with 1703 authorizations (pre-authorized).

9.3. Dependencies

- Patch 38- Separation of Duties- Addresses The Department of Veterans Affairs need to develop an Access and Separation of Duties Review plan that will be used VA-wide as one of the primary preventative controls to stop fraud, theft, collusion, or unauthorized release of sensitive data. Release date yet to be determined

- Patch 27 (Intra-Governmental Payment and Collection System) The Intra-governmental Payment and Collection System (IPAC) provides a standardized inter-agency fund transfer mechanism for Federal Program Agencies (FPA). It facilitates the intra-governmental transfer of funds, with descriptive data, from one FPA to another. Processing payments through IPAC provides the Financial Management Service (FMS) with the ability to meet its statutory requirements for accounting and reporting. Tentative release date is June 2015

9.4. Constraints

- Centers for Medicare and Medicaid (CMS) Rules change/get updated on a regular basis, care must be taken to ensure that changes to CMS can be implemented into FBCS with minimal Vendor interaction.

9.5. Business Risks and Mitigation

Business Risks	Mitigation
If further auto-adjudication enhancements for claims processing of Non-VA Care claims are not implemented, then the continued dependency on manual intervention during the claims process will result in an increase in the current claims backlog.	Coordinate with Business Owners and leadership to ensure project funding.
If auto adjudicated claims are not closely monitored during the implementation of edits there is a possibility of under payment, over payment, or erroneous payment.	Extensive testing and production monitoring of claims that meet auto adjudication edits can significantly reduce this risk.

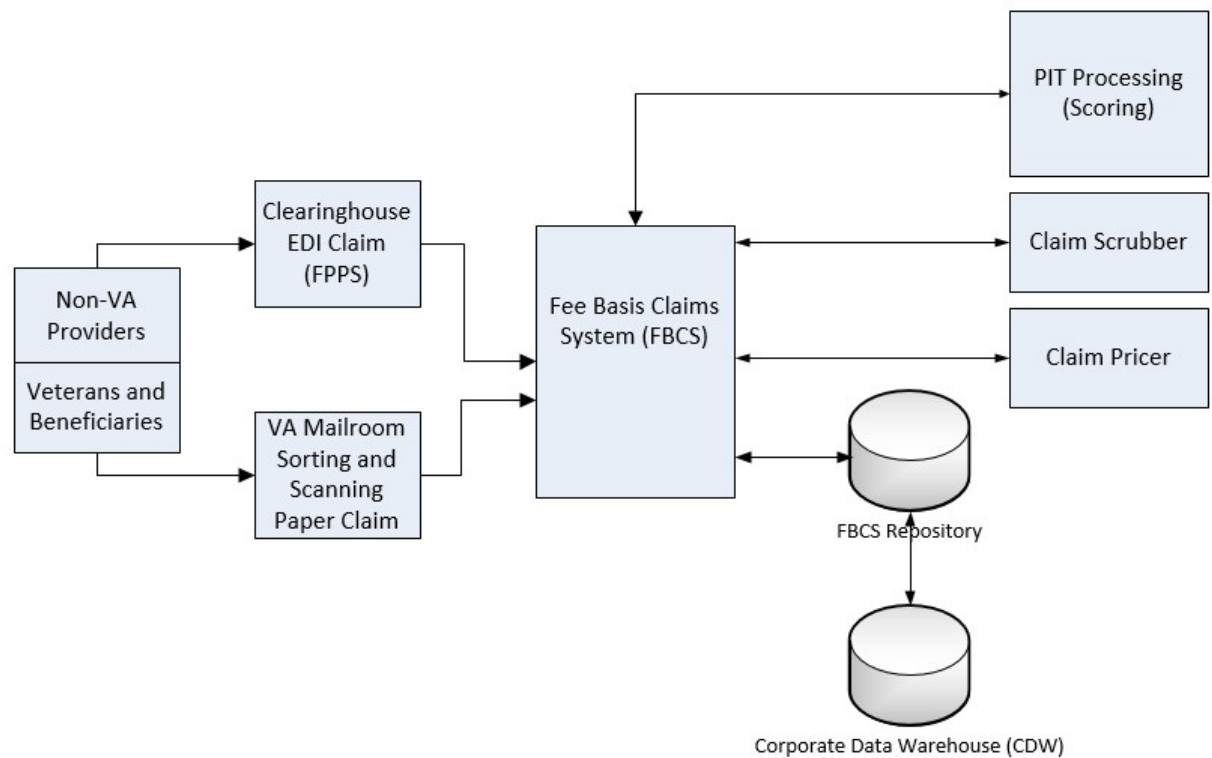
Appendix A References

- VA Handbook 6500 – Information Security Program
[REDACTED]
- Veterans Access, Choice, and Accountability Act of 2014 (VACAA)
<http://www.gpo.gov/fdsys/pkg/BILLS-113hr3230enr/pdf/BILLS-113hr3230enr.pdf>
 - Title 38 U.S. Code 1703
<http://www.gpo.gov/fdsys/granule/USCODE-2011-title38/USCODE-2011-title38-partII-chap17-subchapI-sec1703/content-detail.html>
 - Chief Business Office Purchased Care – external site to CBO PC programs -
<http://www.va.gov/PurchasedCare/>

Appendix B Models

Two component views are contained in this BRD, the “As-Is,” and the “To-Be.” These diagrams are to be viewed as a high level concept of how the system functions, rather than a literal representation of physical architecture or implementation. Thus, the component boxes on the diagram can be thought of as functional containers, rather than a specific system implementation.

Figure 2 – As-Is Component Diagram:



The “As-Is” component view above represents current functionality and how information flows as triggers (a signal to “start” something) or messages (data transfer, such as a claim) throughout the components. The narrative below provides an overview of the diagram and is not intended to provide a detailed architecture or implementation description. In other words, it is intended to set the context for understanding the “To-Be” component diagram.

The lines from the Clearinghouse/FPPS and Mailroom going to FBCS represent existing electronic and paper claim routing of currently supported claim benefit types.

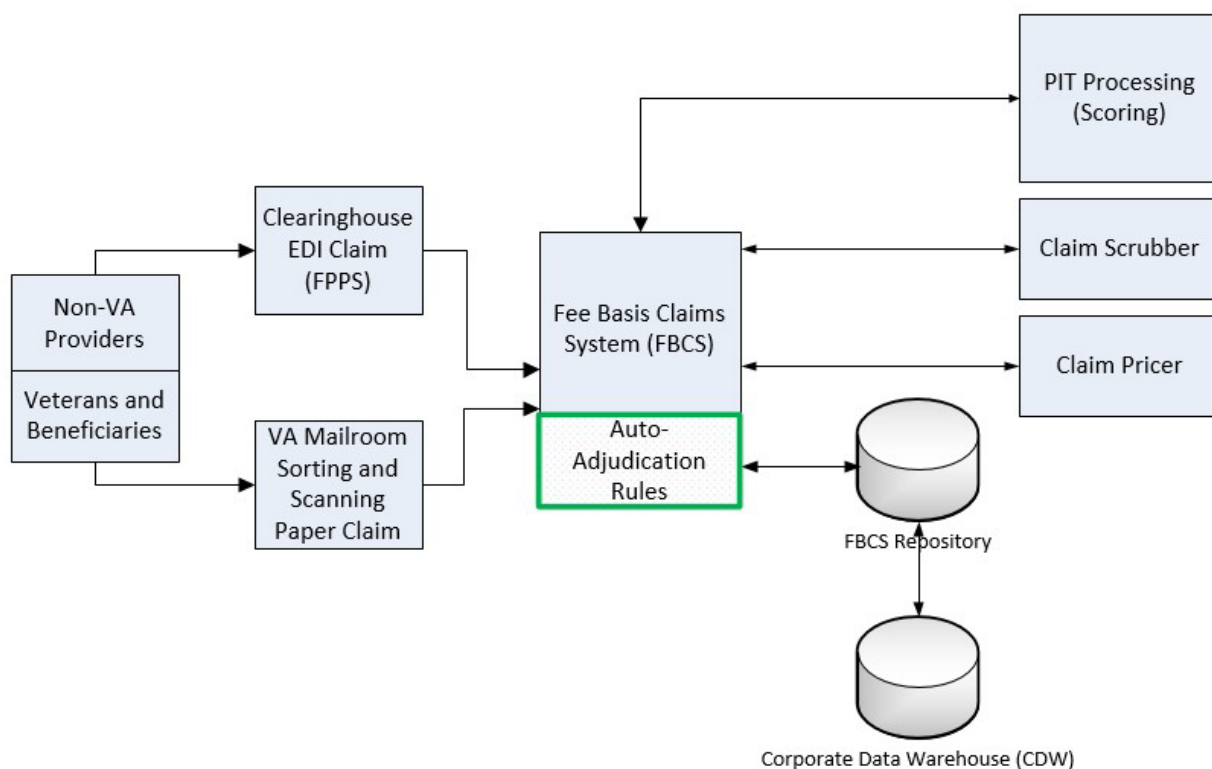
The existing process receives electronic and paper claims for multiple benefit types from Non-VA Providers. In addition, Veterans and Beneficiaries may submit paper claims for some benefit types. Electronic claims are transmitted through the Emdeon Clearinghouse and paper claims are received by various VA facilities’ mail rooms where it is sorted and routed to service center personnel. For the paper claims, the claims are scanned and verified through optical character recognition (OCR).

Claims from FBCS are sent to the Claim Scrubber, Claim Pricer, and PIT for scoring prior to adjudication.

For PIT processing, FBCS places the claim in a “hold state,” waiting for a scoring response from PIT. Following the returned PIT response, the claim is adjudicated manually and the adjudication information is sent to PIT.

FBCS claim data is housed in the FBCS repository and Corporate Data Warehouse (CDW).

Figure 3 – To-Be Component Diagram:



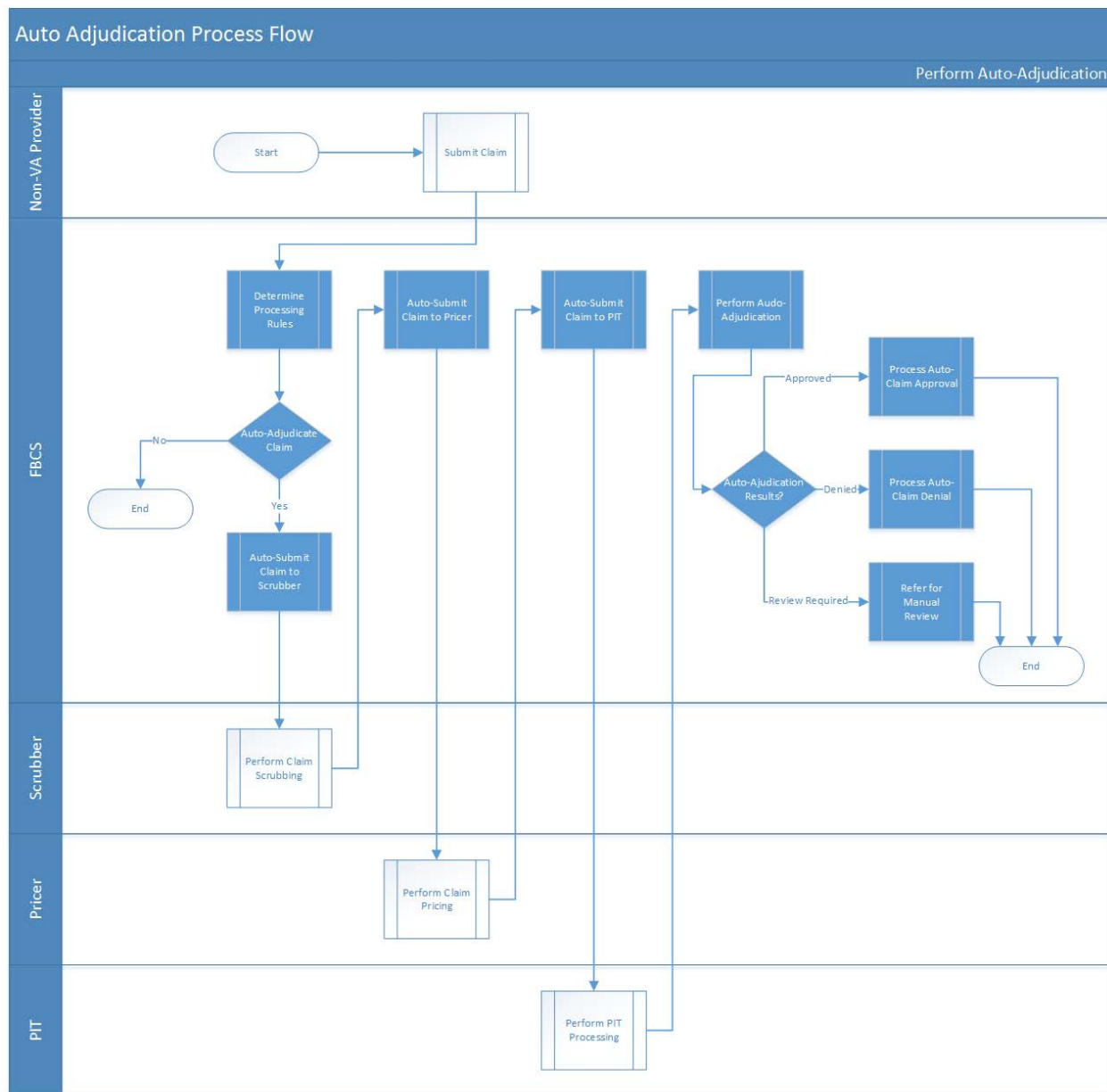
The To-Be component view above represents how this BRD impacts current functionality. The narrative below describes these impacts. Note that the highlighted component represents a logical view of the functionality and does not dictate or represent where or how the actual software changes are to be made. The purpose of the BRD is to describe the business need in such a way that high-level requirements can be derived and documented herein. Further analysis is required to determine what software modules or designs are necessary to achieve the requirements in this BRD.

The components within the scope of this BRD are described below.

1. Fee Basis Claims System (FBCS) – This component represents the new functionality required to automate claim adjudication described in the scope and requirements.

Figure 4 - Process Model 1:

The swim lane diagram below is a complementary view that supports a further decomposition for understanding auto-adjudication processing requirements in this BRD.



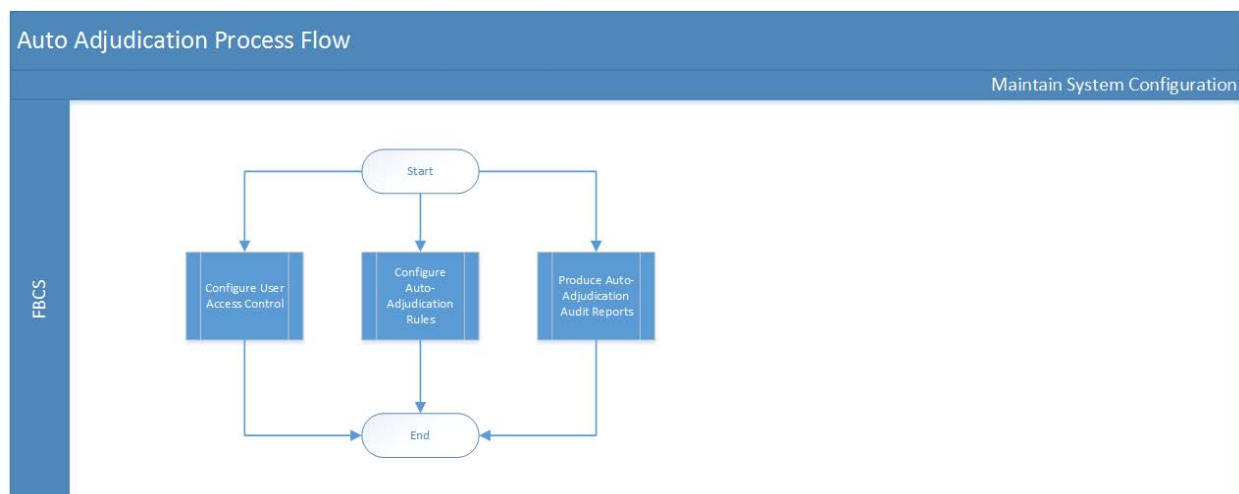
Component	Description	Trace Epic
Model Description	The swim lane diagram below is a complementary view that supports a further decomposition for understanding auto-adjudication processing requirements in this BRD.	

Start	The reader should begin at the “Start” node. This indicates the preconditions that exist. In this case, a patient has seen a provider, and the provider has performed a billable service.	
Submit Claim	The provider will code and submit a paper or electronic claim to the VA for one of the following claims: PC3 Veterans Choice Mill/Bill Unauthorized Other claims for services authorized under Title 38 United States Code (U.S.C.) 1703	
Determine Processing Rules	FBCS will determine the processing rules which apply for routing this claim through the system. This includes considerations for auto-adjudication and which sub-systems or components will be utilized, to include the claims scrubber, the claims pricer, PIT and auto-adjudication. Specific routing (such as scrubber, pricer) and edits performed may vary based on payment authority and / or claim type.	Epic001, Epic002, Epic003, Epic004, Epic005, Epic006, Epic007, Epic008
Auto-Adjudicate Claim?	The decision point references if the claim is to be auto-adjudicated or manually adjudicated. Claims manually adjudicated are not considered relevant for this process diagram.	
Auto-Submit Claim to Scrubber	When indicated by Determine Processing Rules the scrubber is automatically invoked.	Epic006
Perform Claim Scrubbing	The scrubber remains unchanged by this project.	
Auto-Submit Claim to Pricer	When indicated by Determine Processing Rules the pricer is automatically invoked.	Epic007
Perform Claim Pricing	The pricer remains unchanged by this project.	
Auto-Submit Claim to PIT	When indicated by Determine Processing Rules PIT is automatically invoked.	Epic008
Perform PIT Processing	PIT remains unchanged by this project.	
Perform Auto-Adjudication	When indicated by Determine Processing Rules auto-adjudication rules are performed.	Epic009, Epic010, Epic011

Auto-Adjudication Results?	The decision point references the results of auto-adjudication.	
Process Auto-Claim Approval	Specific post adjudication processing may vary based on payment authority and / or claim type.	Epic009, Epic010, Epic011
Process Auto-Claim Denial	Specific post adjudication processing may vary based on payment authority and / or claim type.	Epic010
Refer for Manual Review	A manual review is required. Establish a queue for review (wordsmith this). Specific post adjudication processing may vary based on payment authority and / or claim type.	Epic011
End	This node indicates the business process terminates.	

Figure 5 - Process Model 2:

The swim lane diagram below is a complementary view that supports a further decomposition for understanding auto-adjudication configuration and audit control requirements in this BRD.



Component	Description	Trace Epic
Start	The reader should begin at the “Start” node. This indicates the preconditions that exist. In this case, a user is authorized to perform configuration maintenance.	
Configure User Access Control	An authorized user will have the ability to perform user access control management.	Epic013
Configure Auto-Adjudication Rules	An authorized user will have the ability to perform auto-adjudication rule configuration. Note: These are not the same as the scrubber edits.	Epic012

Produce Auto-Adjudication Audit Reports	An authorized user will have the ability to produce audit reporting of the system, individual users, and the auto-adjudicator.	Epic014, Epic015
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Appendix C Stakeholders, Users, and Workgroups

Stakeholders

Stakeholder Support Team (BRD Development)

Type of Stakeholder	Description	Responsibilities
Requester	•	Submitted request. Submits business requirements. Monitors progress of request. Contributes to BRD development.
Endorser	•	Endorsed this request. Provides strategic direction to the program. Elicits executive support and funding. Monitors the progress and time lines.
Business Owner(s)/Program Office(s)	• •	Provides final acceptance of BRD with sign-off authority. Provides strategic direction to the program. Elicits executive support and funding. Monitors the progress and time lines.
Business Subject Matter Expert(s) (SME)	• •	Provide background on current system and processes. Describe features of current systems, including known problems. Identify features of enhancement.
Technical SME(s)	• • •	Provide technical background information about the current software and requested enhancements.
User SME(s)	• •	Ensure that the enhancements will account for current business processes and existing software capabilities.

Type of Stakeholder	Description	Responsibilities
Security Requirements SME(s)	• [REDACTED]	Responsible for determining and providing guidance on compliance with HIPAA.
Service Coordination SME(s)	• [REDACTED]	Responsible for ensuring all aspects of non-functional requirements have been accurately recorded for this request.
Business Liaison	• [REDACTED] • [REDACTED] • [REDACTED]	Serves as direct liaison to Business Owners and provides final acceptance of BRD with sign-off authority. Provides strategic direction to the program. Elicits executive support and funding. Monitors the progress and time lines.
Business Liaison Staff	• [REDACTED] • [REDACTED]	Serve as the liaison between the Program Office (Business Owner) and Product Development throughout the lifecycle.
Requirements Analyst(s)	• [REDACTED]	Responsible for working with all stakeholders to ensure the business requirements have been accurately recorded for this request.

Appendix D User Interface/User Centered Design Principles

User Experience encompasses direct and indirect interactions between the user and the system. Improving usability over the prior version is a key requirement for this application. The International Organization for Standardization (ISO) defines usability as “the extent to which a product can be used by specified users to achieve specified goals with effectiveness, efficiency, and satisfaction in a specified context of use” (1998).

For an optimal user experience, the system must meet the requirements outlined in this section, which involve attributes of the application and the process required to achieve them.

In order to improve usability of VA-developed or purchased applications, the following actions are required:

- In accordance with the Office of the National Coordinator for Health Information Technology’s Meaningful Use Stage 2 final ruling, employ an industry recognized User Centered Design (UCD) process. The methods for UCD are well defined in documents and requirements such as ISO 9241–11, ISO 13407, ISO 16982, National Institute of Standards and Technology Interagency Report 7741, ISO/International Electrochemical Commission 62366, and ISO 9241-210. Developers will choose their UCD approach; one or more specific UCD processes will not be prescribed.
- Adhere to an industry recognized User Interface (UI) Best Practices Guideline or Style Guide. For example, first follow UI guidelines for the development platform. In instances where platform guidelines are not available, adhere to VA’s Best Practices Guidelines/Style Guide.
- Inform requirements and designs with detailed human factors work products that have been/will be completed for the specific project. Examples of specific human factors activities might include heuristic evaluations, site visits, interviews, application-specific design guides, and usability testing on existing systems or prototypes.

A sound UCD and development process based on human factors should include the following activities:

- Understanding of the users, the users’ tasks, and the users’ environments
- Review of similar or competitive systems to inform requirements and design
- Heuristic evaluation of prior versions, prototypes, or baseline applications, if applicable
- Iterative design and formative usability testing (formative usability testing is used to discover usability problems during the design and development process)
- User risk analysis
- Summative validation usability testing (summative usability testing is used to quantify and validate usability of a product with measures of effectiveness, efficiency, user perceptions, etc.)

To demonstrate high usability, the application should be:

- Intuitive and easy to learn, with minimal training
- Effective by allowing users to successfully complete tasks

- Efficient by allowing users to complete their work in a manner consistent with clinical practice and workflow
- Perceived to have high usability, as demonstrated by appropriate survey measures
- Designed to aid users in meeting task goals without being an additional burden

The system must be reliable and enable user trust by providing:

- Stable and reliable performance
- Accurate data
- Display of all data that is available in native or interfaced systems and intended to be available in the application
- Accessible information related to the source of data

The application should include a modern Graphical User Interface that allows the user to view data from multiple sources and include:

- Integrated display of structured and unstructured data
- Rich data visualization and graphical display of data
- Ability to switch between tabular and graphical data views
- Ability to interact with displayed data to obtain additional details related to the data and source of the data
- User customizable components and settings

The application must provide for advanced and up-to-date searching, to include:

- Fast search functionality with auto-complete and real-time display of matched results during typing
- Search history

The application must provide for advanced filtering capabilities, to include:

- Filtering of data tables, lists, and grids
- Filtering of search results

The application design should be modified to:

- Address the specific findings from a human factors heuristic evaluation conducted on the prior version of the application
- Address the specific findings reported from field use of the prior version
- Address the specific findings reported from usability testing of the prior version or relevant prototypes

Appendix E Acronyms and Abbreviations

Term	Definition
BRD	Business Requirements Document
BSM	Business Systems Management
CBOPC	Chief Business Office Purchased Care
CMS	Centers for Medicare and Medicaid
EDI	Electronic Data Interchange
EE	Eligibility & Enrollment
FBCS	Fee Basis Claims System
HAC	Health Administration Center
HCPS	Health Claims Processing System
HIPAA	Health Insurance Portability and Accountability Act
IOS	International Organization for Standardization
NSR	New Service Request
OI&T	Office of Information and Technology
OCR	Optical character recognition
PC3	Patient-Centered Community Care
PIT	Program Integrity Tools
POI	Program Oversight and Informatics
RTM	Requirements Traceability Matrix
SLR	Service Level Requirements
SME	Subject Matter Expert
UCD	User Centered Design
UI	User Interface
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

Appendix F Acceptance Signatures

The requirements defined in this document are the high level business requirements necessary to meet the strategic goals and operational plans of the Chief Business Office Purchased Care. Further elaboration to these requirements may be done in more detailed artifacts.

Business Owner

Signifies that the customer accepts the documented requirements, that they adequately represent the customers desired needs, and that the customer agrees with the defined scope.

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Business Liaison

Signifies appropriate identification and engagement of necessary stakeholders and the confirmation and commitment to quality assurance and communication of business requirements to meet stakeholder expectations.

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Office of Information and Technology

Indicates agreement that the requirements have been received, are clear, understandable, and are documented sufficiently to facilitate project planning when the project is approved and funded. It is understood that negotiations may need to occur with the Business Owner during project planning as a result of technical reviews and feasibility.

X

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OIT Project Manager