**Department of Veterans Affairs**

**Billing Precertification for Fee Care**

**Requirements Specification Document**



**September 2015**

**Version 1.0**

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**1. Introduction**

The Chief Business Office (CBO), Purchased Care Program Office is requesting enhancements to assist the Department of Veterans Affairs Medical Centers (VAMCs) in obtaining timely precertification from third party payers before care is rendered by notifying the appropriate staff as soon as Department of Veterans Affairs (VA) provided outpatient services requiring precertification are scheduled and authorizations are created in the Veterans Health Information Systems and Technology Architecture (VistA) Fee Package for inpatient or outpatient care.

**1.1. Purpose**

This Requirements Specification Document (RSD) specifies the requirements for the 3rd Party Billing Integrated Billing (IB) Precertification Enhancements of the Electronic Data Interchange (EDI) Consolidated Patient Account Center (CPAC) Revenue Enhancements Program. The intended audience is the CBO Purchased Care Program Office, CPAC key stakeholders including the CPAC Revenue Systems Management (RSM) organization, and the CPAC EDI Revenue Enhancements development team.

**1.2. Scope**

This document addresses the Business Need (BN) and requirements proposed in the *3rd Party Billing IB Precertification Enhancements Business Requirements Document (BRD)* dated January 2011, which outlines recommended changes to the VistA Fee Basis and IB applications.

The goals/impacts of the enhancements proposed in the BRD are shown in Table 1.

**Table 1: Goals and Impacts**

|  |  |
| --- | --- |
| **Goal/Objective and Desired Outcome** | **Impact** |
|  Appropriate Revenue Staff would be notified when an authorization is created in the VistA Fee Basis  Package for inpatient or outpatient care.   Appropriate Revenue Staff would be notified when an outpatient service requiring precertification is scheduled.   The modified Potential Cost Recovery Report (PCRR) would provide the information needed for billing to submit third party bills in  a timely manner. |  Revenue Staff has the opportunity to contact third party carriers regarding future Fee Basis appointments before treatment is rendered 100% of the time.   Revenue Staff has the opportunity to contact third party carriers regarding future qualifying outpatient appointments before treatment is rendered 100% of the time.   Billing Staff would be able to use the modified PCRR to submit third party Fee Basis care related bills without having to complete additional research 100% of the time. |

This document addresses only the *3rd Party Billing IB Precertification Enhancements,* one of five enhancements comprising the EDI CPAC Revenue Enhancements Program. Details regarding other enhancements in the program are described in separate RSDs.

During requirements elaboration for this enhancement, the BNs and requirements were discussed from the perspective of the BRD, including the changes recommended in the BRD to address the BN.

The revised understanding of the BNs and goals has revealed that BN 3 is no longer a need since it has been addressed on other Projects and doesn’t need to be implemented. Additionally, BN

2.2 (while the solution will be developed within the VistA IB software, the necessary information from the VistA Surgery Package will need to be pulled onto the report) is not required. These revised BNs will be reflected in this RSD.

The BNs/requirements are shown in Table 2. Table 2 also reflects the obsolescence on BN 3.

**Table 2: Billing Precertification for Fee Care BNs/Owner Requirements (OWNR)**

|  |  |  |  |
| --- | --- | --- | --- |
| **BN** | **Feature**  **Number** | **Functional Capabilities / Feature**  **Description** | **Ranking R=Required O=Optional** |
| BN 1: Appropriate staff would be notified of authorized Fee Basis care upon entry and/or update into the VistA Fee Basis Package. | F 1.1 | Create a mechanism that would notify Utilization Review (UR) Nurses and Insurance Verification Clerks when an authorization is created and/or updated in the VistA Fee Basis package for Veterans with active, billable insurance (excluding Medicare only and Medicare supplemental policies). | R |
| BN 1: Appropriate staff would be notified of authorized Fee Basis care upon entry and/or update into the VistA Fee Basis Package. | F 1.1.1 | With the ability to generate a report of the same, as needed. | R |

|  |  |  |  |
| --- | --- | --- | --- |
| **BN** | **Feature**  **Number** | **Functional Capabilities / Feature**  **Description** | **Ranking R=Required O=Optional** |
| BN 1: Appropriate staff would be notified of authorized Fee Basis care upon entry and/or update into the VistA Fee Basis Package. | F 1.1.1.1 | Data elements communicated will include   Name of ordering physician   Diagnosis/Procedure (including International Classification of Diseases – Ninth Revision/Tenth Revision – Clinical Modification [ICD-9/10-CM]/Current Procedural Terminology [CPT] codes if provided) for services authorized   Scheduled date of service (Start  & End Dates)   Name of Non-VA location  (Vendor)   Insurance information on file   Last date insurance verified   Type of service  (inpatient/outpatient)   Existing service related conditions (if applicable)   Outpatient Copayment Status   Medication Copayment  Exemption Status | R |
| BN 2: Modify the existing PCRR to include the data elements needed to submit timely third party Fee Basis care related bills. | F 2.1 | Ability to generate the existing PCRR with additional data elements needed to submit a third party bill. | R |

|  |  |  |  |
| --- | --- | --- | --- |
| **BN** | **Feature**  **Number** | **Functional Capabilities / Feature**  **Description** | **Ranking R=Required O=Optional** |
| BN 2: Modify the existing PCRR to include the data elements needed to submit timely third party Fee Basis care related bills. | F 2.1.1 | Data elements communicated will include:   Station/Facility/Division Number   Type of service  (inpatient/outpatient/prescription)   Name of rendering physician   Name of ordering physician   Diagnosis/Procedure (including all applicable ICD-9/10-CM/CPT codes if provided) for services authorized   Dates of service (Start & End dates)   Name of Non-VA location  (Vendor)   All applicable provider/facility National Provider Identifier (NPI) and taxonomy codes.   Insurance information on file   Last date insurance verified   Existing service connected conditions (if applicable) and special treatment authorities   Outpatient Copayment Status   Medication Copayment  Exemption Status   Indicator signifying whether or not the Fee Basis care related episode of care has been previously billed to a third party carrier   If it has been billed previously, indicate date billed and the associated bill number(s)   Display the authorization number or precertification number UR received from the insurance carrier | R |

|  |  |  |  |
| --- | --- | --- | --- |
| **BN** | **Feature**  **Number** | **Functional Capabilities / Feature**  **Description** | **Ranking R=Required O=Optional** |
| BN 2: Modify the existing PCRR to include the data elements needed to submit timely third party Fee Basis care related bills. | F 2.1.2 | Ability to differentiate and sort the data on this report by 5 digit station number | R |
| BN 2: Modify the existing PCRR to include the data elements needed to submit timely third party Fee Basis care related bills. | F 2.2 | The episodes of care displayed on this modified report would be based on the following criteria: | R |
| BN 2: Modify the existing PCRR to include the data elements needed to submit timely third party Fee Basis care related bills. | F 2.2.1 |  Veteran has active, billable insurance (similar to the current Re-Generate Unbilled Amounts Report [IBT RE-GEN UNBILLED REPORT]), include only Fee Basis care related episodes of care that have not been billed to a third party carrier previously   Insurance effective date   Insurance expiration date   Treatment date falls within effective/expiration dates   Display the authorization number or precertification number UR received from the insurance carrier | R |
| BN 2: Modify the existing PCRR to include the data elements needed to submit timely third party Fee Basis care related bills. | F 2.2 |  While the solution will be developed within the VistA IB software, the necessary information from the VistA Surgery Package will need to be pulled onto the report. | Not  Required |

|  |  |  |  |
| --- | --- | --- | --- |
| **BN** | **Feature**  **Number** | **Functional Capabilities / Feature**  **Description** | **Ranking R=Required O=Optional** |
| BN 3: Appropriate staff would be notified of future VA provided outpatient appointments that meet certain  criteria. (Obsolete) | F 3.1 | Create a mechanism that would notify UR Nurses when a future appointment that meets the following criteria is scheduled: | Not  Required |
| BN 3: Appropriate staff would be notified of future VA provided outpatient appointments that meet certain  criteria. (Obsolete) | F 3.1.1 |  Veteran with active, billable insurance (excluding Medicare only and Medicare supplemental policies). | Not  Required |
| BN 3: Appropriate staff would be notified of future VA provided outpatient appointments that meet certain  criteria. (Obsolete) | F 3.1.2 |  Provide functionality/option that gives certain users the ability to add or delete specific clinic names needed for the precertification process at the local level for optimal use. (Note: Similar functionality has previously been written for  CPAC use and coding can be provided to the Office of  Information and Technology  [OI&T] when needed). | Not  Required |
| BN 3: Appropriate staff would be notified of future VA provided outpatient appointments that meet certain  criteria.  (Obsolete) | F 3.2 | Ability to generate an on demand report listing qualifying patients/appointments. | Not  Required |

**1.3. References**

The following documentation/hyperlinks contain information related to this RSD:

 3rd Party Billing Precertification Enhancements BRD, January 2011

 Please refer to Appendix A of the BRD for additional references relevant to this enhancement

**2. Overall Description**

**2.1. Accessibility Specifications**

This project will adhere to all applicable requirements of Section 508 of the Rehabilitation Act of

1973, as amended (29 U.S.C. 794d). A 508 compliance review will be conducted in accordance with Program Management Accountability System (PMAS) standards.

**2.2. Business Rules Specification**

There are no specific new business rules applicable to this enhancement.

A high-level view of the current (as-is) and future (to-be) billing precertification for fee care processes/workflows are available via Technical Services Project Repository (TSPR) here:

**2.3. Design Constraints Specification**

 VA Standards and Conventions for Massachusetts General Hospital Utility Multi- Programming System (MUMPS) development

 VA Technical Reference Model (TRM)

**2.4. Disaster Recovery Specification**

There are no new or specific disaster recovery specifications for this project. The disaster recovery specifications pertaining to any VistA system are applicable to this project.

**2.5. Documentation Specifications**

System documentation to be delivered will be in accordance with PMAS and ProPath System

Development Processes.

Documentation to be delivered includes but is not limited to:

 Installation Guide

 User Guide

 Technical Manual

 Security Guide

 Contingency Plan

 Disaster Recovery Plan

 Deployment Plan

 Release Notes

**2.6. Functional Specifications**

This enhancement seeks to assist the VAMCs in obtaining timely precertification from third party payers before care is rendered by notifying the appropriate staff as soon as VA-provided outpatient services requiring precertification are scheduled and authorizations are created in the VistA Fee Package for inpatient or outpatient care. This would also provide an opportunity for

insurance identification/verification processes (either internally or externally/outsourced) to be completed prior to treatment.

An additional component of this change will modify the existing PCRR to include data elements that would give the Billing Staff the information needed to submit third party bills related to

Non-VA care in a more efficient and timely manner. The expectation is that VA can reduce or eliminate these missed opportunities and increase its third party collections by timely identification and precertification of care. These enhancements would not affect Veterans’ wait times for treatment at the VA or Non-VA facilities. The business processes benefiting from these tools would occur behind the scenes and would not delay patient care.

**2.6.1. Notification of authorized Fee Basis care upon entry into**

**VistA Fee Basis Package**

**2.6.1.1. Functional requirement FRPRE – 1.1**

The system shall notify UR Nurses and Insurance Verification Clerks, via a worklist when an authorization is created in the VistA Fee Basis package for Veterans with active, billable insurance (excluding Medicare only and Medicare supplemental policies).

**2.6.1.2. Functional Requirement FRPRE 1.1.1.1 – 01**

The system shall provide the ability to generate a report in the VistA Fee Basis package for Veterans with active, billable insurance that includes the name of the ordering physician (NPI #, Taxonomy Code, Last Name, First Name MI).

**2.6.1.3. Functional Requirement FRPRE 1.1.1.1 – 02**

The system shall provide the ability to generate a report in the VistA Fee Basis package for Veterans with active, billable insurance that includes the Diagnosis/Procedure for services authorized in free text with unlimited characters.

**2.6.1.4. Functional Requirement FRPRE 1.1.1.1 – 03**

The system shall provide the ability to generate a report in the VistA Fee Basis package for Veterans with active, billable insurance that includes the scheduled date of service which includes date ranges (MM/DD/YY).

**2.6.1.5. Functional Requirement FRPRE 1.1.1.1 – 04**

The system shall provide the ability to generate a report in the VistA Fee Basis package for Veterans with active, billable insurance that includes the name of Non-VA location (may not be populated).

**2.6.1.6. Functional Requirement FRPRE 1.1.1.1 – 05**

The system shall provide the ability to generate a report in the VistA Fee Basis package for Veterans with active, billable insurance that includes all active insurance information on file (may include multiple insurance plans).

**2.6.1.7. Functional Requirement FRPRE 1.1.1.1 – 06**

The system shall provide the ability to generate a report in the VistA Fee Basis package for Veterans with active, billable insurance that includes the last date the insurance was verified (MM/DD/YY).

**2.6.1.8. Functional Requirement FRPRE 1.1.1.1 – 07**

The system shall provide the ability to generate a report in the VistA Fee Basis package for

Veterans with active, billable insurance that includes the type of service (inpatient/outpatient).

**2.6.1.9. Functional Requirement FRPRE 1.1.1.1 – 08**

The system shall provide the ability to generate a report in the VistA Fee Basis package for Veterans with active, billable insurance that includes the existing service connected conditions and special treatment authorities in free text (may be multiple service connected conditions, must include all).

**2.6.1.10. Functional Requirement FRPRE 1.1.1.1 – 09**

The system shall provide the ability to generate a report in the VistA Fee Basis package for

Veterans with active, billable insurance that includes outpatient copayment status.

**2.6.1.11. Functional Requirement FRPRE 1.1.1.1 – 10**

The system shall provide the ability to generate a report in the VistA Fee Basis package for

Veterans with active, billable insurance that includes medication copayment exemption status.

**2.6.1.12. Functional Requirement FRPRE 1.1.1.1 – 11**

The system shall be able to use contract numbers as a parameter when generating the pre- certification worklist to filter Choice Program contract numbers from the worklist.

**2.6.2. Modification of the existing PCRR to include the data elements needed to submit timely third party Fee Basis care related bills**

Ability to generate the existing PCRR with additional data elements (Fee Basis Claims System

[FBCS] data elements available in VistA Fee) needed to submit a third party bill.

**2.6.2.1. Functional Requirement FRPRE 2.1.1 – 01**

The system shall provide the ability to generate the existing PCRR with Station/Facility/Division number to support submission of a third party bill.

**2.6.2.2. Functional Requirement FRPRE 2.1.1 – 02**

The system shall provide the ability to generate the existing PCRR with type of service

(inpatient/outpatient/pharmacy) to support submission of a third party bill.

**2.6.2.3. Functional Requirement FRPRE 2.1.1 – 03**

The system shall provide the ability to generate the existing PCRR with name of rendering physician to support submission of a third party bill (NPI #, Taxonomy Code, Last Name, First Name MI).

**2.6.2.4. Functional Requirement FRPRE 2.1.1 – 04**

The system shall provide the ability to generate the existing PCRR with name of ordering physician to support submission of a third party bill (NPI #, Taxonomy Code, Last Name, First Name MI).

**2.6.2.5. Functional Requirement FRPRE 2.1.1 – 05**

The system shall provide the ability to generate the existing PCRR with all available

Diagnosis/Procedure data to support submission of a third party bill.

**2.6.2.6. Functional Requirement FRPRE 2.1.1 – 06**

The system shall provide the ability to generate the existing PCRR with dates of service (start and end dates) to support submission of a third party bill (MM/DD/YY).

**2.6.2.7. Functional Requirement FRPRE 2.1.1 – 07**

The system shall provide the ability to generate the existing PCRR with name of Non-VA

location to support submission of a third party bill.

**2.6.2.8. Functional Requirement FRPRE 2.1.1 – 08**

The system shall provide the ability to generate the existing PCRR with active/effective insurance information on file as of the date of service to support submission of a third party bill.

**2.6.2.9. Functional Requirement FRPRE 2.1.1 – 09**

The system shall provide the ability to generate the existing PCRR with last date insurance was verified to support submission of a third party bill (MM/DD/YY).

**2.6.2.10. Functional Requirement FRPRE 2.1.1 – 10**

The system shall provide the ability to generate the existing PCRR with existing service connected conditions (if applicable), including Special Treatment Authorities, to support submission of a third party bill.

**2.6.2.11. Functional Requirement FRPRE 2.1.1 – 11**

The system shall provide the ability to generate the existing PCRR with outpatient copayment status from the most recent Means Test adjudication results (MT COPAY EXEMPT or MT COPAY REQUIRED) to support submission of a third party bill.

**2.6.2.12. Functional Requirement FRPRE 2.1.1 – 12**

The system shall provide the ability to generate the existing PCRR with medication copayment exemption status (Medication Copayment Exemption Status: EXEMPT or Medication Copayment Exemption Status: NON-EXEMPT) to support submission of a third party bill.

**2.6.2.13. Functional Requirement FRPRE 2.1.1 – 13**

The system shall provide the ability to generate the existing PCRR with Indicator signifying whether or not the Fee Basis care related episode of care has been previously billed to a third party carrier, utilizing the new VistA Fee Basis / IB / Claims Tracking Interface File (to be developed as part of concurrent Fee Revenue Enhancements project). Current claim data (including corrected claims) would be accessed and reported, utilizing the new interface file.

**2.6.2.14. Functional Requirement FRPRE 2.1.1 – 13.1**

The system shall provide the ability to indicate date billed and the associated bill number(s) if it has been billed previously utilizing the new VistA Fee Basis / IB / Claims Tracking Interface File (to be developed as part of concurrent Fee Revenue Enhancements project).

**2.6.2.15. Functional Requirement FRPRE 2.1.1 – 14**

The system shall provide the ability to generate the existing PCRR with the ability to display the authorization number or precertification number UR received from the insurance carrier.

**2.6.2.16. Functional Requirement FRPRE 2.1.2**

The system shall provide the ability to generate the existing PCRR with ability to differentiate and sort the data on this report by the 3 or 5 digit station number (tied to obligation number) utilizing a question/answer prompt at runtime.

**2.6.2.17. Functional Requirement FRPRE 2.2.1 – 01**

The system shall be able to display if the Veteran has active, billable insurance (similar to the current Re-Generate Unbilled Amounts Report [IBT RE-GEN UNBILLED REPORT]), include only Fee Basis care related episodes of care that have not been billed to a third party carrier previously.

**2.6.2.18. Functional Requirement FRPRE 2.2.1 – 02**

The system shall be able to display the insurance effective date (MM/DD/YY).

**2.6.2.19. Functional Requirement FRPRE 2.2.1 – 03**

The system shall be able to display insurance expiration date (MM/DD/YY).

**2.6.2.20. Functional Requirement FRPRE 2.2.1 – 04**

The system shall be able to display if treatment date falls within insurance effective/expiration dates (MM/DD/YY).

**2.6.2.21. Functional Requirement FRPRE 2.2.1 – 05**

The system shall be able to display the authorization number or precertification number UR

received from the insurance carrier.

**2.7. Graphical User Interface (GUI) Specifications**

This enhancement does not involve a GUI.

**2.8. Multi-divisional Specifications**

No new multi-divisional requirements are being introduced as part of this enhancement. This enhancement will use existing multi-divisional functionality and will continue to operate in a multi-division and/or multi-site environment.

**2.9. Performance Specifications**

No performance specifications have been identified.

It is implied that this enhancement will not introduce performance degradation to the existing system.

**2.10. Quality Attributes Specification**

The software associated with this enhancement shall be released with zero high or medium impact defects. Test defect logs will be submitted after internal Quality Assurance (QA) and site testing for VA review.

MUMPS code developed for this project will be compliant to all VA MUMPS Coding Standards and Conventions.

**2.11. Reliability Specifications**

As specified in the BRD, system availability should be 24 hours per day, 365 days per year except during periods of scheduled maintenance.

**2.12. Scope Integration**

This enhancement will be limited to changes to the VistA Fee Basis and IB applications. This enhancement will also provide modifications to the PCRR.

**2.13. Security Specifications**

There are no explicit security specifications stated for this enhancement.

All VA and Veterans Health Administration (VHA) security requirements will be adhered to. Cross-cutting security requirements are contained in the VA Enterprise Requirements Repository (ERR). Efforts that involve the collection and maintenance of individually identifiable information must be covered by a Privacy Act system of records notice.

**2.14. System Features**

This enhancement modifies an existing VistA application.

The System Features introduced by this project are detailed in Section 2.6.

**2.15. Usability Specifications**

The existing Fee Basis interface will be used for this enhancement, including existing usability specifications. The user interface features of the existing VistA Fee Basis Application will not be modified, and therefore no performance degradation will be introduced.

Additional functionality will be described from a user standpoint in the user guide. Training needed to begin using the new functionality is expected to be minimal.

**3. Applicable Standards**

Configuration Management (CM) processes provide the release and control of the system, hardware, and software to which this document applies, including identification number(s), title(s), abbreviation(s), version number(s), and release number(s).

Listed below are VA reference and guidance documentation and standards applicable to or tailored for the EDI PC Project. This guidance is used to fulfill the performance requirements of this contract.

 44 U.S.C. § 3541, “Federal Information Security Management Act (FISMA) of 2002”

 Federal Information Processing Standards (FIPS) Publication 140-2, “Security

Requirements For Cryptographic Modules”

 Software Engineering Institute, Software Acquisition-Capability Maturity Modeling (SA- CMM) Level 3 procedures and processes

 VA Directive 6102, “Internet/Intranet Services,” July 15, 2008

 36 C.F.R. Part 1194 “Electronic and Information Technology (IT) Accessibility

Standards,” July 1, 2003

 Office of Management and Budget (OMB) Circular A-130, “Management of Federal

Information Resources,” November 28, 2000

 32 C.F.R. Part 199, “Civilian Health and Medical Program of the Uniformed Services

(CHAMPUS)”

 An Introductory Resource Guide for Implementing the Health Insurance Portability and

Accountability Act (HIPAA) Security Rule, March 2005

 Sections 504 and 508 of the Rehabilitation Act (29 U.S.C. § 794d), as amended by the

Workforce Investment Act of 1998 (P.L. 105-220), August 7, 1998

 Homeland Security Presidential Directive (12) (HSPD-12)

 VA Directive 6500, “Information Security Program,” August 4, 2006

 VA Handbook 6500, “Information Security Program,” September 18, 2007

 VA Handbook, 6500.5, Incorporating Security and Privacy in System Development

Lifecycle.

 VA Handbook 6500.6, “Contract Security,” March 12, 2010

 PMAS portal (reference Performance Work Statement [PWS] References – Technical

Library)

 Office of Enterprise Development (OED) ProPath Process Methodology (reference PWS References) – Technical Library and ProPath Library. Note: In the event of a conflict, OED ProPath takes precedence over other processes or methodologies.

 TRM

 National Institute Standards and Technology (NIST) Special Publications (SP) 800-60 and 800-53

 IT Asset Management (ITAM) and Enterprise Management Foundation (EMF) BR-0006, version 002.1-14052008, dated 10/30/2007 [Note informational, Context, and ITAM- EMF Conceptual link]

 HIPAA of 1996; Pub.L 104-191.

 Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, 124 Stat. 119, H.R. 3590, enacted March 23, 2010

 Prompt Payment Act

 The aim of this project is to make certain that the EDI PC systems are compliant with the Committee on Operating Rules for Information Exchange (CORE) Rules as published by Council for Affordable Quality Healthcare (CAQH)

 VA Section 508 policies and procedures 6221 Accessible Electronic and IT, Directive/Handbook, published by VA’s Section 508 Product Development Product Assessment Competency Division

 VA MUMPS Programming Standards and Conventions. Revised 04/03/2007

 VA Section 508 policies and procedures 6221 Accessible Electronic and IT, Directive/Handbook, published by VA’s Section 508 Product Development Product Assessment Competency Division (reference at)

**4. Interfaces**

**4.1. Communications Interfaces**

No new communications interfaces are required for this enhancement.

**4.2. Hardware Interfaces**

No new communications interfaces are required for this enhancement.

**4.3. Software Interfaces**

No new software interfaces are required for this enhancement.

These enhancements will be modifications to the Vista Fee Basis and IB applications but don’t

affect the Software Interfaces.

**4.4. User Interfaces**

This enhancement will use the existing VistA Fee Basis roll and scroll user interface. No modifications are specified to the user interface.

**5. Legal, Copyright, and Other Notices**

This effort is sponsored by an agency of the United States Government. Neither the United States Government nor any agency thereof, nor any of its subcontractors, nor any of their employees, makes any warranty, express or implied, or assumes any legal liability or responsibility for the accuracy, completeness, or usefulness of any information, apparatus, product, or process disclosed, or represents that its use would not infringe on privately owned rights. Reference

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**6. Purchased Components**

Not applicable.

**6.1. Defect Source (TOP 5)**

Not applicable.

**7. User Class Characteristics**

The modifications identified in this enhancement are primarily used by UR Nurses, Insurance Verification Clerks, Billers and secondary users; Accounts Receivable Technicians, Revenue Managers, and CBO Revenue Operations Staff.

**8. Estimation**

TBD.

**Project Software Functional Size and Size-Based**

**Effort and Duration Estimate**

**Application**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Item** | **A** | **B** | **C** | **D** | **E** | **Total** |
| Counted Function  Points |  |  |  |  |  | TBD |
| Estimated Scope  Growth |  |  |  |  |  | TBD |
| Estimated Size at  Release |  |  |  |  |  | TBD |

|  |  |  |
| --- | --- | --- |
| **Size-Based Effort Estimates** | **Labor Hours** | **Probability** |
| Low-Effort Estimate – With indicated probability, project will consume no more than: | TBD |  |
| High-Effort Estimate – With indicated probability, project will consume no more than: | TBD |  |

|  |  |  |
| --- | --- | --- |
| **Size-Based Duration Estimates** | **Work Days** | **Probability** |
| Low-Duration Estimate – With indicated probability, project will consume no more than: | TBD |  |
| High-Duration Estimate -- With indicated probability, project will consume no more than: | TBD |  |

**TBD**

**Figure 1: Cumulative Probability (“S-curve”) Chart**

**Attachment A – Approval Signatures**

Signed: Date:

xxxxx

Business Sponsor

Signed: Date:

xxxxx

CPAC Program Manager, Integrated Project Team (IPT) Co-Chair

Signed: Date:

xxxx

CPAC Project Manager, IPT Co-Chair

**Attachment B – Acronym List and Glossary**

**Table 3: Acronym List**

|  |  |
| --- | --- |
| **Term** | **Definition** |
| BN | Business Need |
| BRD | Business Requirements Document |
| CAQH | Council for Affordable Quality Healthcare |
| CBO | Chief Business Office |
| CCD | Continuity of Care Document |
| CHAMPUS | Civilian Health and Medical Program of the Uniformed Services |
| CM | Configuration Management |
| CORE | Committee on Operating Rules for Information Exchange |
| CPAC | Consolidated Patient Account Center |
| CPT | Current Procedural Terminology |
| EDES | Emergency Department Encounter Summary |
| EDI | Electronic Data Interchange |
| EMF | Enterprise Management Foundation |
| ERR | Enterprise Requirements Repository |
| FBCS | Fee Basis Claims System |
| FIPS | Federal Information Processing Standards |
| FISMA | Federal Information Security Management Act |
| GUI | Graphical User Interface |
| HIPAA | Health Insurance Portability and Accountability Act |
| HITSP | Health IT Standards Panel |
| HSPD-12 | Homeland Security Presidential Directive (12) |
| IB | Integrated Billing |
| ICD-9/10-CM | International Classification of Diseases – Ninth Revision/Tenth  Revision – Clinical Modification |
| IHE | Integrating the Healthcare Enterprise |
| IPT | Integrated Project Team |
| IT | Information Technology |
| ITAM | IT Asset Management |
| MUMPS | Massachusetts General Hospital Utility Multi-Programming System |

|  |  |
| --- | --- |
| **Term** | **Definition** |
| NIST | National Institute Standards and Technology |
| NPI | National Provider Identifier |
| OED | Office of Enterprise Development |
| OI&T | Office of Information and Technology |
| OMB | Office of Management and Budget |
| OWNR | Owner Requirements |
| PCRR | Potential Cost Recovery Report |
| PMAS | Program Management Accountability System |
| PPACA | Patient Protection and Affordable Care Act |
| PWS | Performance Work Statement |
| QA | Quality Assurance |
| RMR | Requirements Management Repository |
| RSD | Requirements Specification Document |
| RSM | Revenue Systems Management |
| SA-CMM | Software Acquisition-Capability Maturity Modeling |
| SDS | Standard Data Services |
| SP | Special Publications |
| TRM | Technical Reference Model |
| TSPR | Technical Services Project Repository |
| UR | Utilization Review |
| VA | Department of Veterans Affairs |
| VAMC | Department of Veterans Affairs Medical Center |
| VETS | VA Enterprise Terminology Services |
| VHA | Veterans Health Administration |
| VistA | Veterans Health Information Systems and Technology Architecture |

**Attachment C – Enterprise Requirements**

Below is a subset of Enterprise-level Requirements that are of particular interest to the business community. These requirements MUST be addressed within each project resulting from this work effort. If OI&T cannot address these Enterprise-level requirements, the Business Owners responsible for each area MUST be engaged in any waiver discussions prior to any decisions being made. This section is not meant to be a comprehensive list of all Enterprise-level

requirements that may apply to this work effort and should not preclude the technical community from reviewing all Enterprise-level requirements, and identifying others that should apply to this work effort as well.

Enterprise-level requirements are contained in the VA Requirements Management Repository (RMR). Contact the RMR Team to gain access to the RMR and to obtain the comprehensive allocation of Enterprise-level requirements for the project development iteration at.

**Table 4: Enterprise Requirements**

|  |  |  |
| --- | --- | --- |
| **ReqPro**  **Tag** | **Requirement**  **Type** | **Description** |
| ENTR99 | Security | All VA security requirements will be adhered to. Based on FIPS 199 and NIST SP 800-60, recommended Security Categorization is High.  The Security Categorization will drive the initial set of minimal security controls required for the information system. Minimum security control requirements are addressed in NIST SP 800-53 and VA Handbook 6500, Appendix D. |
| ENTR10 | Privacy | All VA Privacy requirements will be adhered to. Efforts that involve the collection and maintenance of individually identifiable information must be covered by a Privacy Act system of records notice. |
| ENTR95 | 508 Compliance | All Section 508 requirements will be adhered to. Compliance with Section 508 will be determined by fully meeting the applicable requirements as set forth in the VHA Section 508 checklists (1194.21, 1194.22, 1194.24,  1194.31 and 1194.41) located at: <http://xxxxxxxxxxxxxxxxxxxxxx/>or as otherwise specified. Checkpoints will be established to ensure that accessibility is incorporated from the earliest possible design or acquisition phase and successfully implemented throughout the project. |
| ENTR7 | Executive Order | All executive order requirements will be adhered to. |
| ENTR8 | Identity  Management | All Enterprise Identity Management requirements will be adhered to. These requirements are applicable to any application that adds, updates, or performs lookups on persons. |

|  |  |  |
| --- | --- | --- |
| **ReqPro**  **Tag** | **Requirement**  **Type** | **Description** |
| ENTR103 | Terminology  Services | Application/services shall reference the Standard Data Services (SDS) as the authoritative source to access non- clinical reference terminology. |
| ENTR104 | Terminology  Services | Application/Services shall use the VA Enterprise Terminology Services (VETS) as the authoritative source to access clinical reference terminology. |
| ENTR105 | Terminology  Services | Applications recording the assessments and care delivered in response to an Emergency Department visit shall conform to standards defined by the VHA-endorsed version of C 28 – Health IT Standards Panel (HITSP) Emergency Care Summary Document Using Integrating the Healthcare Enterprise (IHE) Emergency Department Encounter Summary (EDES) Component. |
| ENTR106 | Terminology  Services | Applications exchanging data summarizing a patient’s medical status shall conform to standards defined by the VHA-endorsed version of C 32 – HITSP Summary Documents Using Health Level Seven (HL7) Continuity of Care Document (CCD) Component. |

**Attachment D – Change Log**

|  |  |  |  |
| --- | --- | --- | --- |
| **Version** | **Change** | **Notes** | **Status/Resolution** |
| 0.04 | Modified format and added requirement.  New Requirement: 2.6.1.12 – Add contract number parameter for Choice Program filtering. |  |  |
| 0.03 | BN1 updated to read: “Appropriate staff would be notified of authorized Fee Basis care upon entry and/or update into the VistA Fee Basis Package.” | Accounts for downstream dependencies with updates/amendments to the initial entry. |  |
| 0.03 | BN1, F.1.1. Updated to read: “…when an authorization is created and/or updated in the VistA Fee Basis package…” | Accounts for downstream dependencies with updates/amendments to the initial entry. |  |
| 0.03 | BN1, F.1.1.1.1 updated to include: All applicable ICD-9/10 codes  Defining date of service as eligibility range (Start and End dates)  Identifying Non-VA location as  ‘Vendor’ |  |  |
| 0.03 | BN2, F.2.1.1:  All data elements included in FBCS Required Field Listings for VistA Fee\_FBCS Table Inclusion.xlsx document  All applicable ICD-9/10 codes  Defining dates of service (Start and End Dates)  Identifying Non-VA location as  'Vendor'  Added in "All applicable provider/facility NPI and taxonomy codes" |  |  |
| 0.03 | F2.1.2: “Tied to obligation number used to make the payment” |  |  |